No. 20-35521

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

STATE OF WASHINGTON,

Plaintiff-Appellee,

v.

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

Defendants-Appellants.

On Appeal from the United States District Court
for the Eastern District of Washington

BRIEF FOR APPELLANT

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STATEMENT OF JURISDICTION

Plaintiff challenged a federal regulation and invoked the district court's jurisdiction under 28 U.S.C. §§ 1331, 1346, and 5 U.S.C. §§ 701-706. On plaintiff's motion for partial summary judgment, the district court declared the challenged regulation "invalid and without force in the State of Washington," ER 16, and directed the clerk to close the file. ER 17. The court entered final judgment on April 9, 2020. ER 4. Defendants timely filed a notice of appeal on June 8, 2020. ER 1. 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 federal regulations provide that, to comply with this "separate payment" requirement, an insurer must send a policyholder a separate bill and instruct the policyholder to pay the amount through a separate transaction. 45 C.F.R. § 156.280(e)(2)(ii)(A), (B).

Washington law, by contrast, requires insurers to "[b]ill enrollees and collect payment through a single invoice that includes all benefits and services covered by the qualified health plan." Wash. Rev. Code § 48.43.074(2)(a). The question presented is:

Whether the district court erred in ruling that this state law falls within the scope of section 1303's non-preemption clause, which provides that nothing in the ACA shall be construed to preempt 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 an abortion on a minor." ACA § 1303(c)(1).

PERTINENT STATUTES AND REGULATIONS

Pertinent statutes and regulations are set forth in the addendum to this brief, pages A1-A6.

STATEMENT OF THE CASE

I. Statutory and Regulatory Background

A. Section 1303 of the ACA

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 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"). This provision 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), and to "deposit all such separate payments into separate allocation accounts" to segregate funds collected and used to pay for coverage of non-Hyde abortion services from funds collected and used to pay for coverage of other services, ACA § 1303(b)(2)(B)(ii)-(C); *see also* ACA § 1303(b)(2)(D)(ii)(III) (indicating that the separate payment shall not be less than $1 per enrollee per month).

Paragraphs (c) and (d) provide for the continued application of certain state and federal laws regarding abortion. For example, they specify that nothing in the ACA shall be construed to have any effect on federal laws regarding conscience protection, ACA § 1303(c)(2)(A)(i), to alter the rights and obligations of employers and employees under Title VII of the Civil Rights Act of 1964, ACA § 1303(c)(3), or to relieve health care providers from providing emergency services as required by state

or federal law, ACA § 1303(d). As directly relevant here, the non-preemption clause in paragraph (c)(1) specifies that nothing in the ACA 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 an abortion on a minor." ACA § 1303(c)(1).

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 GAO 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 new 45 C.F.R. § 156.280(e)(2)(ii)(A), (B)).

[1] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Section-1303-Bulletin-10-6-2017-FINAL-508.pdf.

In issuing these amended regulations, HHS explained that they "better align with the intent of section 1303 of the PPACA." 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 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 regulations prohibit insurers from terminating coverage or placing a policy holder in a grace period simply because the policy holder makes a combined payment rather than two separate payments. 84 Fed. Reg. at 71,685; *see also* 45 C.F.R. § 156.280(e)(2)(ii)(B). In addition, to address the risk that coverage could be lost due to a policy holder's inadvertent failure to pay the separately billed amount for non-excepted abortion services, HHS indicated that, although insurers ultimately have to collect such premiums, it will not take enforcement action against an insurer that adopts a uniform policy of maintaining coverage despite non-payment of the separate amount for non-excepted abortion services. 84 Fed. Reg. at 71,686. HHS also indicated, in consideration of consumers who object to purchasing coverage that includes coverage

of non-excepted abortion services, that it will not take enforcement action against insurers offering qualified health plans that modify the benefits of a plan either at the time of enrollment or during a plan year to effectively allow enrollees to opt out of coverage of such services by not paying the separate bill for such services. *Id.* HHS explained that it expected insurers to take appropriate measures to distinguish between a policy holder's inadvertent non-payment of the separate bill for coverage of non-Hyde abortion services and an intentional nonpayment. *Id.* at 71,687.

II. Factual Background And Prior Proceedings

In 2019, after HHS had issued its notice of proposed rulemaking, *see* 83 Fed. Reg. 56,015 (Nov. 9, 2018), Washington enacted the state law at issue here. In relevant part, the state law requires issuers of qualified health plans to "[b]ill enrollees and collect payment through a single invoice that includes all benefits and services covered by the qualified health plan." Wash. Rev. Code § 48.43.074(2)(a).

Washington then filed this action under the Administrative Procedure Act, 5 U.S.C. § 701 *et seq.*, alleging (as relevant here) that the amended HHS regulations conflict with this state law; that the state law falls within the scope of section 1303's non-preemption clause; and that the amended regulations cannot be applied in the State of Washington.[2]

[2] Washington also challenged the amended regulations on other grounds, but moved for summary judgment on non-preemption grounds only. With respect to the issue of preemption, Washington also relied on the ACA's general non-preemption

The district court ruled in Washington's favor, holding that "Washington's Single-Invoice Statute is a state law 'regarding' abortion coverage and funding, which falls squarely within the scope of § 1303(c)." ER 15. The court concluded that "[t]he wording of § 1303(c) clearly expresses Congress's intent to preserve broad categories of state law from preemption, including billing practices related to the funding of abortions." *Id.*

The district court also noted that "Washington State supports a women's [sic] right to choose, as well as her right to access safe and legal abortion care, evidenced by its requirement that if any [qualified health plan] includes coverage for maternity care or services, it must also include substantially equivalent coverage for abortion services." ER 15-16 (citing Wash. Rev. Code § 48.43.073). The court stated that the amended regulations "intrude on the State's right to do so by imposing onerous, arbitrary, and unnecessary billing practices that have little to do with providing efficient and effective medical coverage and everything to do with trying to prevent Washington State's recognition of a women's [sic] right to assess [sic] safe and legal abortions." ER 16.

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clause, which provides that nothing in title I "shall be construed to preempt any State law that does not prevent the application of the provisions of this title." ACA § 1321(d) (codified at 42 U.S.C. § 18041(d)). However, the district court did not analyze that clause or suggest that Washington's law would be saved by it if the state law does not fall within the scope of section 1303's specific non-preemption clause for laws regarding abortion.

The district court thus declared the amended regulations "invalid and without force in the State of Washington." ER 16.

SUMMARY OF ARGUMENT

Federal law requires insurers to bill separately for non-Hyde abortion coverage and instruct enrollees to pay each of the separate amounts through a separate transaction. Washington law forbids insurers from doing so. Under bedrock principles of conflict preemption, the state law is preempted.

The district court's contrary ruling rests on a basic misunderstanding of the non-preemption clause in section 1303(c) of the ACA. That clause makes clear that the ACA does not occupy the field with respect to the regulation of abortion-related requirements and prohibitions. The clause thus permits states to enforce certain abortion-related laws that do not conflict with federal requirements, such as state laws that prohibit state funding for abortion services or require coverage of abortion services. The clause, however, does not allow a state to undo the substantive requirements of section 1303(b) of the ACA or the implementing regulations, including requirements regarding the manner in which insurers collect premiums. Therefore, the judgment of the district court should be reversed.

STANDARD OF REVIEW

This Court reviews the district court's grant of summary judgment de novo. *Whitman v. Mineta*, 541 F.3d 929, 931 (9th Cir. 2008).

ARGUMENT

A. The Washington Law At Issue Here Conflicts With Federal Law And Is Thus Preempted

Under basic principles of preemption, a federal statute prevails over conflicting state law. *See Murphy v. National Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1480 (2018). The same principle applies when state law conflicts with federal regulations that reasonably interpret a statute's substantive requirements. *See Smiley v. Citibank (S.D.), N.A.*, 517 U.S. 735, 743-44 (1996). Accordingly, the Second Circuit recently held that HHS regulations implementing the ACA's risk-adjustment program preempt inconsistent state law. *See UnitedHealthCare of N.Y., Inc. v. Lacewell*, _ F.3d _, No. 18-2583, 2020 WL 4045365, at *6-8 (2d Cir. July 20, 2020).

Application of these bedrock principles of conflict preemption shows that the Washington statute at issue here is preempted. Section 1303 of the ACA establishes special rules regarding abortion coverage. As relevant here, section 1303(b)(2)(B)(i) requires insurers to "collect from each enrollee . . . a separate payment" for the portion of the premium that covers non-excepted abortion services. The implementing regulations thus require insurers to send enrollees a separate bill for that amount and to instruct enrollees to pay the amount in a separate transaction. 45 C.F.R. § 156.280(e)(2)(ii)(A), (B).

Washington law conflicts with the substantive requirement in section 1303(b)(2)(B)(i). Whereas section 1303(b)(2)(B)(i) requires that an insurer

"collect from each enrollee . . . a separate payment" for the portion of the premium that covers non-excepted abortion services, Washington law requires insurers to "[b]ill enrollees and collect payment through a single invoice that includes all benefits and services covered by the qualified health plan." Wash. Rev. Code § 48.43.074(2)(a). It would be impossible for an insurer to comply with both of these mandates, because federal law requires an insurer to bill for and collect a separate payment and state law forbids an insurer from doing so.

The district court incorrectly concluded that "the Washington statute does not conflict with the ACA or frustrate its purposes and objectives." ER 15. The court noted that HHS's prior guidance had indicated that an insurer could send the enrollee a single itemized bill and collect payment in a single transaction. *See* ER 8, 16. But as HHS explained when it amended the regulations, Congress intended that insurers "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." 84 Fed. Reg. at 71,684. Indeed, the sponsor of the amendment that became section 1303 emphasized that if a plan "has any [non-Hyde] abortion coverage, the insurance company must bill you separately, and you must pay separately." 155 Cong. Rec. S14134 (daily ed. Dec. 24, 2009) (statement of Sen.

Nelson). HHS properly amended its regulations to better align with the intent of Congress in enacting section 1303, which preempts contrary state law.[3]

B. The Washington Law Does Not Fall Within The Scope Of Section 1303's Non-Preemption Clause

The district court incorrectly ruled that section 1303's non-preemption clause authorizes states to enforce requirements that conflict with federal law. That is a misreading of the non-preemption clause. The clause makes clear that the ACA does not occupy the field with respect to certain abortion-related prohibitions and requirements. The clause permits states to enforce certain abortion-related laws that do not conflict with federal requirements, such as state laws that prohibit state funding for abortion services or require coverage of abortion services. But the clause does not allow a state to undo the substantive requirements of section 1303(b) or the implementing regulations. *Cf. Geier v. American Honda Motor Co.*, 529 U.S. 861, 869 (2000).

Section 1303's non-preemption clause provides: "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 an

[3] The district court stated that it is "under no obligation to defer to HHS's interpretation of § 1303" because "[t]he language of the statute comes from Congress, not HHS." ER 16. It is always the case that the language of a statute comes from Congress. That is not a basis to withhold deference to an agency's reasonable interpretation of statutory text.

abortion on a minor." ACA § 1303(c)(1). By providing that states may continue to enforce laws regarding the prohibition or requirement of "coverage" of abortions, the non-preemption clause preserves state laws such as another Washington statute noted by the district court, which requires that a plan that provides coverage for maternity care or services also provide substantially equivalent coverage for abortion services. *See* Wash. Rev. Code § 48.43.073.[4]

Similarly, by providing that the ACA does not preempt state laws regarding the prohibition or requirement of "funding" of abortions, the non-preemption clause allows states to continue to enforce laws that prohibit state funding for abortion services. Many states have such laws. California, for example, prohibits grants awarded by the California Department of Health Services from being used to perform abortions. Cal. Welf. & Inst. Code § 14509(b). Likewise, Florida prohibits certain state agencies, local government agencies, and managed care plans from "expend[ing] funds for the benefit of, pay[ing] funds to, or initiat[ing] or renew[ing] a contract with an organization that owns, operates, or is affiliated with one or more clinics that . . . perform abortions" except in cases of rape or incest, or where the abortion is deemed "medically necessary." Fla. Stat. § 390.0111(15). *See also, e.g.*, Mo. Rev. Stat. § 188.205; N.C. Gen. Stat. § 143C-6-5.5; Va. Code Ann. § 32.1-92.1.

[4] Such laws would be subject to other federal laws such as the conscience protections described in section 1303(c)(2).

Contrary to the district court's understanding, the non-preemption clause does not allow states to negate the requirements of federal law.

On the district court's logic, a state could require insurers to use federal funds for non-excepted abortion services—notwithstanding section 1303(b)(2)'s express "prohibition on the use of federal funds" for such services (capitalization omitted)—on the theory that the state is enforcing a state law "'regarding' abortion coverage and funding." ER 15. Likewise, the district court's logic would allow states to authorize health plans to discriminate against healthcare providers who are unwilling to pay for or provide coverage of abortions, despite section 1303(b)(4)'s express antidiscrimination provision. That is an untenable reading of the clause. As the Supreme Court has admonished, a court "cannot interpret federal statutes to negate their own stated purposes." *King v. Burwell*, 576 U.S. 473, 493 (2015).

Indeed, both the Supreme Court and this Court have recognized that a "savings clause"—like section 1303's non-preemption clause—"does *not* bar the ordinary working of conflict pre-emption principles." *Geier*, 529 U.S. at 869; *see also In re Volkswagen "Clean Diesel" Mktg., Sales Practices, and Prods. Liability Litig.*, 959 F.3d 1201, 1213-14 (9th Cir. 2020) ("We may not interpret a saving clause as preserving a state law that would so conflict and interfere with a federal enactment that it would defeat the federal law's purpose or essentially nullify it; rather, such a state law is preempted under ordinary preemption principles."). Accordingly, this Court "infer[s] that Congress did not intend the saving provisions in a federal law to be interpreted in

a way that causes the federal law 'to defeat its own objectives, or potentially, as the [Supreme] Court has put it before, to destroy itself.'" *In re Volkswagen*, 959 F.3d at 1214 (quoting *Geier*, 529 U.S. at 872).

The district court's application of the savings clause in section 1303 also fails on its own terms. The district court stated that the Washington statute "is a state law 'regarding' abortion coverage and funding, which falls squarely within the scope of" § 1303(c)(1). ER 15. But § 1303 does not save from preemption state laws "regarding" abortion coverage and funding, but rather "[s]tate laws regarding *the prohibition of (or requirement of)* coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor." ACA § 1303(c)(1) (emphasis added). A state law concerning billing for insurance coverage of abortion services, like Washington's single-invoice statute, neither prohibits nor requires coverage or funding of abortions. The district court's analysis effectively reads these words out of the statute.

C. Congress Did Not Regard The Separate Payment Requirement In Section 1303 As Unnecessary

The district court also stated (without elaboration) that HHS's amended regulations impose "onerous, arbitrary, and unnecessary billing practices that have little to do with providing efficient and effective medical coverage and everything to do with trying to prevent Washington State's recognition of [] women's right to

[access] safe and legal abortions." ER 16. There was no basis for that pronouncement, either as a procedural or substantive matter.

As a procedural matter, although Washington alleged that the amended regulations are arbitrary and capricious, Washington did not move for summary judgment on that ground. Instead, Washington's summary-judgment motion relied on its non-preemption theory.

As a substantive matter, section 1303 itself mandates that insurers collect a separate payment for the portion of the premium that covers non-excepted abortion services. Congress evidently did not regard that mandate as onerous, arbitrary, or unnecessary, and that congressional judgment is entitled to respect. Moreover, the implementing regulations mitigate the burden of added postage and mailing costs by allowing insurers to send separate bills in a single envelope (for transactions that occur in paper form rather than electronic form). 45 C.F.R. § 156.280(e)(2)(ii)(A). Furthermore, the regulations protect enrollees from coverage loss by prohibiting insurers from terminating an enrollee's coverage or placing the enrollee in a grace period simply because the policy holder makes a combined payment rather than two separate payments. *Id.* § 156.280(e)(2)(ii)(B)). In addition, to address the risk that coverage could be lost due to a policy holder's inadvertent failure to pay the separately billed amount for non-excepted abortion services, HHS indicated that it will not take enforcement action against an insurer that adopts a uniform policy of maintaining coverage despite non-payment of the separate amount for non-excepted abortion

services. 84 Fed. Reg. at 71,685. The district court did not acknowledge these protections for enrollees, and its pronouncement therefore finds no support in ACA § 1303.

CONCLUSION

The district court's judgment should be reversed.

Respectfully submitted,

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STATEMENT OF RELATED CASES

Pursuant to Ninth Circuit Rule 28-2.6, appellant knows of no related case pending in this Court. On July 20, 2020, the district court in *State of California v. HHS*, No. 20-cv000682 (N.D. Cal.), issued a decision invalidating the federal regulation at issue here.

/s/ Amanda L. Mundell
Amanda L. Mundell

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 3920 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 August 14, 2020, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth 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

§ 1303. Special rules

(a) State opt-out of abortion coverage

(1) In general

A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition.

(2) Termination of opt out

A State may repeal a law described in paragraph (1) and provide for the offering of such services through the Exchange.

(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.

* * *

(c) Application of State and Federal laws regarding abortion

(1) No preemption of State laws regarding abortion

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 an abortion on a minor.

(2) No effect on Federal laws regarding abortion

(A) In general

Nothing in this Act shall be construed to have any effect on Federal laws regarding—

(i) conscience protection;

(ii) willingness or refusal to provide abortion; and

(iii) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(3) No effect on Federal civil rights law

Nothing in this subsection shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

(d) Application of emergency services laws

Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as "EMTALA").

45 C.F.R. § 156.280

§ 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.

Wash. Rev. Code § 48.43.074

§ 48.43.074 Qualified health plans—Single invoice billing—Certification of compliance required in the segregation plan for premium amounts attributable to coverage of abortion services.

(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[1] 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:

(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.