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MEDICAID DEMONSTRATION WAIVERS & REPRODUCTIVE JUSTICE

FACT SHEET
AUGUST 2018

Medicaid is an important lifeline for the 25 million women enrolled in the program. Women of color, women with disabilities, single mothers, and women from other underserved populations disproportionately depend on Medicaid for affordable health care coverage. However, the Centers for Medicare & Medicaid Services (CMS) at the U.S. Department of Health and Human Services (HHS) is putting women's access to Medicaid coverage at risk with recent policy changes it is implementing through Section 1115 Medicaid waivers.

OVERVIEW OF MEDICAID WAIVERS

Section 1115 of the Social Security Act allows the Secretary of HHS to grant states waivers of certain, otherwise mandatory Medicaid requirements in order to test experimental projects that promote the objectives of the Medicaid program. Medicaid's objectives are to help states furnish medical assistance, rehabilitation, and other services to individuals with incomes and resources that are insufficient to meet the costs of needed medical care.¹ As noted, historically, the Secretary and states have used these waivers to create state-specific policy approaches to better serve low-income people. Research has shown that Medicaid coverage enables individuals to obtain care and use preventive services such as cervical cancer screenings and family planning.²

States typically operate their Medicaid programs through state Medicaid plans that are approved by the Secretary of HHS and detail the mandatory and optional population groups and services that the state is covering. States have used Section 1115 waivers to go outside the boundaries of their state Medicaid plans in order to implement experimental projects designed to expand Medicaid eligibility and services and to

improve access to quality health care. Since enactment of the Affordable Care Act (ACA), however, some states—with CMS's encouragement—are seeking to use the Section 1115 waiver authority to place new limits on eligibility and enrollment and impose onerous restrictions on Medicaid enrollees.

CMS reviews and approves Section 1115 waiver requests. In addition to meeting program objectives, the requests should have robust evaluation components and must be budget neutral. CMS's authority to approve waivers is limited and must meet the following criteria:

1. The waiver must implement an "experimental, pilot, or demonstration" project;
2. The experiment must be likely to promote Medicaid's objectives;
3. The waiver must be limited to Medicaid provisions in 42 U.S.C. §1396a, which pertain to mandatory and optional components of a state Medicaid plan; and
4. The waiver must be limited to the extent and period needed to carry out the experiment.³

WAIVERS USED TO EXPAND ELIGIBILITY

Beginning in the 1990s, some states used Section 1115 demonstration projects to expand coverage to certain groups of individuals who were not otherwise eligible for Medicaid, redesign service delivery systems often times through managed care models, and/or cover services that were not typically covered under a state's Medicaid plan. For example, a number of states expanded family planning programs through 1115 waivers. These experiments showed coverage to be effective and cost efficient. Subsequently, Congress amended the Medicaid Act to

add coverage of family planning services as a state plan amendment. As a result, states have been phasing out their use of Section 1115 waiver authority to provide family planning services. Family planning expansion programs have been a critical source of limited Medicaid coverage for individuals seeking a range of reproductive and sexual health care services, and a great source of budgetary savings for states.⁴ Several states also conducted or are currently conducting demonstration projects to provide earlier access to treatment for people living with HIV.⁵



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WAIVERS USED TO LIMIT ELIGIBILITY AND ENROLLMENT

The waivers CMS has approved under the Trump Administration impose unprecedented and harmful restrictions on current and future Medicaid enrollees. If allowed to stand, these waivers will fundamentally transform the nature of the Medicaid program and exacerbate health inequities.

Work requirements

On January 11th, for the first time in the 50-year history of the Medicaid program, the Trump Administration released a new policy allowing states to add work requirements to their Medicaid program through section 1115.⁶ The new policy encourages states to apply “work and community engagement” requirements to some Medicaid recipients. Those subject to the requirement will be terminated from their health care unless they can meet a monthly minimum of work hours and show proof that they work, looked for work, volunteer, go to school, or participate in a job-training program in order to receive benefits. The D.C. federal court has vacated the approval of Kentucky’s waiver project, which included work requirements, and has remanded the matter to HHS for further review.⁷

Work requirements are a threat to an individual’s reproductive health and economic security. They are unnecessary and have been shown to be ineffective in other public benefits programs. Work requirements attack a person’s ability to make thoughtful decisions about their health and where they apply, interfere with the time some parents spend with their children and families. The waivers are designed with exceptions for some populations such as pregnant women, primary caretakers of dependents or people with disabilities, students, and others. However, these individuals will be subject to reporting and documentation requirements that may be so confusing and complex that some will lose their Medicaid coverage because they are unable to navigate these processes and/or unable to meet the administrative requirements to qualify for exemptions.

Work requirements are also unworkable for some women in the workforce. For example, women are concentrated in certain low-wage jobs with inconsistent work hours and/or have jobs in the informal economy that do not provide proof of employment. Moreover, work requirements prey on historical stereotypes that stigmatize people of color.

Drug testing and screening

Wisconsin recently proposed a Section 1115 waiver that would require drug screening, testing, and treatment as a condition of Medicaid eligibility. If included in the program, the State would be the first to require individuals to complete drug screening and testing for current and prior use of controlled substances. If an applicant or enrollee tests positive, entering treatment would be the condition for eligibility.

Drug testing in Medicaid will only increase barriers for those most in need of timely health care. Drug testing requirements create a culture of fear for those living with substance-abuse disorders and ties life-saving care and health care benefits to costly and invasive practices. Moreover, other safety net programs that included drug testing and screening perpetuated a culture where individuals living with low-incomes, especially women of color, were criminalized for their socioeconomic status and for seeking help. Medicaid should promote programs that focus on prevention and treatment-based solutions, not implementing an approach that is discriminatory and a waste of resources.

Time limits and enrollment caps

There currently are no time limits in the Medicaid program. However, four states have submitted waivers that would permit caps on how long Medicaid beneficiaries can receive coverage. Recently, CMS rejected Kansas’ request to impose time limits on its Medicaid beneficiaries.⁸ If any of these waivers were approved, these policies would limit the total number of months an individual can receive Medicaid over the course of their life. For the states currently pursuing this waiver, CMS approval would allow those states to limit enrollees to only 60 months of Medicaid coverage. This means that a single mother working full time at minimum wage and qualifying for Medicaid might lose access to health care, even if her job does not offer coverage.

Enrollment caps also add an unnecessary restriction on eligible individuals seeking Medicaid coverage. These restrictions impose an arbitrary limit on the number of people who can access coverage that has nothing to do with meeting program requirements. Enrollment caps will also have a disproportionate impact on women of



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color, who are more likely to have low-incomes and more likely to be enrolled in Medicaid coverage for longer periods of time.

Lockout periods

Lockouts bar otherwise eligible individuals from receiving health care during the lockout period. The length of the lockout period can vary from state-to-state and ranges from 6 months to 9 months. Lockout periods can apply to individuals who fail to pay premiums, meet work requirements, complete paperwork or report changes in circumstances. For example, Indiana recently implemented a waiver that authorizes a 3-month lockout

period for adults who gained coverage under Medicaid expansion. For those locked out as a result of failing to meet work requirements, this complication only increases the barriers to finding steady employment that meets the criteria of the state.

For most Medicaid beneficiaries, being locked out of the program means they have no other viable and affordable health care coverage option. Many individuals rely on Medicaid coverage because they do not have access to marketplace coverage. The disruption of a lockout period can be the difference of accessing life-saving care. This is another way that otherwise eligible individuals are being denied access to health care coverage.

WAIVERS USED TO LIMIT BENEFITS AND INCREASE COSTS

Waiving freedom of choice

Some states are seeking to use family planning waivers as a vehicle to restrict the delivery of reproductive health services under Medicaid. On June 28, 2017, Texas applied for a demonstration project seeking to waive the “freedom of choice” protection for the purpose of excluding abortion providers.⁹ The Texas waiver is a clear attack on Planned Parenthood and other abortion providers. It violates the longstanding “freedom of choice” protection that allows Medicaid enrollees to seek family planning services from any Medicaid provider, whether or not the provider is in the enrollee’s managed care network. If implemented, the proposed waiver program would not cover counseling for or provision of emergency contraception, and would not pay for family planning services that include a “diagnosis related to elective termination of pregnancy or emergency contraception.”¹⁰

service to Medicaid and is considered the gold standard for children’s health care. CMS has not historically waived EPSDT for traditional Medicaid populations; however, the Trump administration granted Utah a waiver of EPSDT for 19 and 20 year olds as part of a limited substance use/mental health demonstration project.¹¹

Premiums and co-pays

States are seeking to impose premiums and excessive co-pays on individuals enrolled in Medicaid. Under federal law, premiums are generally prohibited for individuals with incomes below 150% of Federal Poverty Level (FPL) in the Medicaid program, and certain groups are exempt. Medicaid includes flexibility for states to use copayments, but they must generally be nominal in amount. These protections are in place because individuals enrolled in the Medicaid program lack the financial resources to pay high fees to access care. Premiums and co-pays impede individuals’ access to health care services and their ability to enroll in health insurance. In one study of the Alabama Children’s Health Insurance Program, the increase in premiums reduced the number of Black parents who renewed their child’s enrollment by 5.9 percent.¹² Co-pays deter individuals from seeking the care they need. Studies demonstrate that even small levels of cost-sharing are associated with reduced use of *necessary* health services by low-income people, including preventive and primary care.¹³ Premiums will lead to individuals losing coverage under the Medicaid program.

Elimination of vital services

Several state waiver applications include proposals to eliminate coverage of key Medicaid benefits, such as non-emergency medical transportation (NEMT). NEMT is an important benefit because it provides a means for Medicaid enrollees—such as women with disabilities, women living in rural communities and other areas with limited public transportation options—to travel to their providers and access care.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive health care benefit for children and youth under age 21. EPSDT is a core



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RECOMMENDATIONS

1. Oppose efforts to restrict eligibility or services in Medicaid and other public programs through Section 1115 waivers.
2. Assess and examine CMS's implementation of the Medicaid program, including exceeding statutory authority through the Section 1115 waiver process.
3. Partner with on-the-ground advocates to improve education and awareness among constituents about Medicaid waivers.

RESOURCES

Founded in 1969, the National Health Law Program (NHeLP) protects and advances the health rights of low-income and underserved individuals and families. NHeLP advocates, educates and litigates at the federal and state levels. For more information, please contact: Candace Gibson at gibson@healthlaw.org.

The National Latina Institute for Reproductive Health is the only national reproductive justice organization dedicated to advancing health, dignity, and justice for the 28 million Latinas, their families, and communities in the United States. Our vision is to create a society in which Latinas have the economic means, social capital, and political power to make and exercise decisions about their own health, family, and future. For more information, please contact: Nina Esperanza Serrienne at nina@latinainstitute.org.

In Our Own Voice: National Black Women's Reproductive Justice Agenda is a national/state partnership with eight Black women's Reproductive Justice organizations: Black Women for Wellness (CA), Black Women's Health Imperative (National), New Voices for Reproductive Justice (PA, OH), SisterLove, Inc. (GA), SisterReach

(TN), SPARK Reproductive Justice NOW (GA), The Afiya Center (TX), and Women With A Vision (LA). Our goal is to lift up the voices of Black women leaders on national, regional, and state policies that impact the lives of Black women and girls. For more information, please contact: Jessica Pinckney at jessica@blackrj.org.

National Asian Pacific American Women's Forum (NAPAWF) is the only national organization building a movement to advance social justice and human rights for AAPI women and girls in the US. Using a reproductive justice framework, we organize and advocate for reproductive rights, immigrant rights, and economic justice. For more information, please contact: Jaclyn Dean at jdean@napawf.org.

All* Above All unites organizations and individuals to build support for lifting the bans that deny abortion coverage. Our vision is to restore public insurance coverage so that every woman, however much she makes, can get affordable, safe abortion care when she needs it. For more information, please contact: Kelsey Ryland at kelsey@allaboveall.org.

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- 4 Every \$1 invested in publicly funded family planning services saves \$7.09 in Medicaid expenditures. Guttmacher Institute, Publicly Funded Family Planning Services in the United States (Sept 2016), <https://www.guttmacher.org/fact-sheet/publicly-funded-family-planning-services-united-states>.
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- 7 *Stewart v. Azar*, No. 18–152 (JEB), F.Supp.3d, 2018 WL 3203384 (D.D.C. June 29, 2018).
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- 9 Tex. Health & Human Services Comm'n, Healthy Texas Women, Section 1115 Demonstration Waiver Application, 3, (2017), <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/tx-healthy-women-pa.pdf>
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- 12 David Becker et al., The Effects of Premium Changes on ALL Kids, Alabama's CHIP Program, 2 Medicare & Medicaid Res. Rev. E12 (2012), https://www.cms.gov/mmrr/Downloads/MMRR2012_002_03_A01.pdf
- 13 See generally Samantha Artiga, et al., The Henry J. Kaiser Family Found., The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings, (2017) http://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-issue-brief/#endnote_link_220856-75.