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December 14, 2018

**VIA ELECTRONIC SUBMISSION**

U.S. Commission on Civil Rights  
1331 Pennsylvania Ave., NW, Suite 1150  
Washington, DC 20425  
[enforcement@usccr.gov](mailto:enforcement@usccr.gov)

**RE: Are Rights A Reality? Evaluating Federal Civil Rights Enforcement**

Dear Chair Lhamon, Vice Chair Timmons-Goodson, and Commissioners:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care. Founded in 1969, we protect and advance health rights of low-income and underserved individuals and families by advocating, educating, and litigating at the federal and state levels. We appreciate the opportunity to provide written comments on the U.S. Commission on Civil Rights' November 2, 2018 briefing, "Are Rights A Reality? Evaluating Federal Civil Rights Enforcement."

The Trump administration is dismantling essential health care protections that exist to protect access to care for low-income individuals and families, people of color, people living with disabilities, immigrants, Lesbian, Gay, Bisexual, Transgender, and Queer ("LGBTQ") individuals, and other underserved communities. We outline some of our primary concerns with the

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administration's activities curtailing civil rights in the next pages. NHeLP strongly urges the U.S. Commission on Civil Rights ("Commission") to further investigate, report upon, and make legislative and administrative recommendations concerning these violations of civil rights protections.

### **I. The Trump administration is actively working to undermine the nondiscrimination provision, Section 1557, of the Affordable Care Act.**

The Trump administration has continued to sabotage the Affordable Care Act (ACA) despite failed Congressional efforts to repeal this law. This administration has eliminated Department of Health and Human Services (HHS) payments for Cost Sharing Reduction (CSRs), removed the penalty for the individual mandate, and drastically reduced budgets for outreach and advertising for the marketplace's open enrollment. In addition, the administration has allowed the proliferation of Short-Term Limited Duration Insurance (STLDI) plans and Association Health Plans (AHPs) which do not provide coverage of comprehensive care and lack consumer protections.<sup>1</sup> This administration is now seeking to undermine the nondiscrimination provision of the Affordable Care Act (Section 1557), also known as the Health Care Rights Law.

Section 1557 of the ACA has been in effect since the ACA was signed into law in 2010. The statute prohibits discrimination on the basis of race, color, national origin, sex, age or disability in programs or activities that receive federal financial assistance; in any program or activity administered by an executive agency; and by any entity established under Title I of the ACA.<sup>2</sup> It is the first-ever federal law to ban sex discrimination in health care. After issuing a "request for information" to seek input from stakeholders on how to implement Section 1557, HHS issued a proposed rule that received comments from thousands of individuals. The final regulations interpreting the law were released in 2016 by HHS' Office for Civil Rights (OCR). The final rule defined sex protections in Section 1557 to include discrimination against transgender individuals. Section 1557 builds on protections from other federal civil rights laws – such as Title IX of the Education Amendment of 1972, Title VI of the Civil Rights Act, and Section 504 of the Rehabilitation Act of 1973. Section 1557 applies to a wide range of entities including hospitals, clinics, and clinicians' offices if they received funding from HHS as well as

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<sup>1</sup> HHS, Fact Sheet: Final Rules on Religious and Moral Exemptions and Accommodation for Coverage of Certain Preventive Services Under the Affordable Care Act, <https://www.hhs.gov/about/news/2018/11/07/fact-sheet-final-rules-on-religious-and-moral-exemptions-and-accommodation-for-coverage-of-certain-preventive-services-under-affordable-care-act.html> (last visited December 13, 2018).

<sup>2</sup> 42 U.S.C. § 18116 (ACA § 1557).

federally facilitated marketplaces and all plans offered by issuers selling health insurance plans in those marketplaces.<sup>3</sup>

Section 1557 provides an important federal protection against discrimination in health care. Prior to the passage of the ACA, many communities experienced discrimination in health care and continue to experience discrimination in health care settings to this day. Women were charged more than men for insurance or were denied coverage for necessary services, such as maternity care and contraception.<sup>4</sup> Twenty-eight percent of transgender individuals have postponed medical care due to discrimination, even when they were sick or injured.<sup>5</sup> People of color continue to face bias and discrimination in health care settings.<sup>6</sup> Individuals with limited English proficiency and individuals with disabilities face discrimination when needing interpreters, accessible facilities, or auxiliary aids and services. In addition to discrimination based on a particular protected group, Section 1557 is critical in ensuring that individuals who belong to multiple protected classes are able to receive coverage and care without discrimination in a more holistic way rather than based on whether the discrimination falls under one or another of the pre-existing civil rights laws.

Despite eight years of being the law, the implementation and enforcement of Section 1557 remains uneven at best. As one example, many states are not meeting their nondiscrimination obligations. Earlier this year, a U.S. district court found that Wisconsin likely violated the rights of two transgender individuals enrolled in Medicaid by refusing to cover their medically necessary gender affirming care.<sup>7</sup> Wisconsin is one of

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<sup>3</sup> Jen Lav, Nat'l Health Law Prog., Q & A: *Section 1557 of the Affordable Care Act: Protections for Transgender Individuals in Health Care Settings*, (2018), [https://9kqpw4dcaw91s37koz5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/03/NHeLP-1557-QA\\_March-15-final.pdf](https://9kqpw4dcaw91s37koz5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/03/NHeLP-1557-QA_March-15-final.pdf).

<sup>4</sup> Theresa Chalhoub, et al., Ctr. for Amn. Progress, *Moving Backward: Efforts to Undo Pre-Existing Condition Protections Put Millions of Women and Girls at Risk*, <https://www.americanprogress.org/issues/women/news/2018/06/21/452643/moving-backward/> (last visited December 13, 2018).

<sup>5</sup> Jaime M. Grant et al., Nat'l Ctr. for Transgender Equality, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* (2011), [http://www.transequality.org/sites/default/files/docs/resources/NTDS\\_Report.pdf](http://www.transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf).

<sup>6</sup> Michael O. Schroder, U.S. News & World Report, Racial Bias in Medicine Leads to Worse Care for Minorities, <https://health.usnews.com/health-news/patient-advice/articles/2016-02-11/racial-bias-in-medicine-leads-to-worse-care-for-minorities> (last visited December 11, 2018).

<sup>7</sup> *Flack v. Wis. Dep't Health Servs*, No. 3:18-cv-00309 (W.D. Wis. Jul. 25, 2018) (order granting preliminary injunction), <https://healthlaw.org/resource/flack-v-wisconsin-department-of-health-services-preliminary-injunction-decision/>.

approximately ten states that explicitly exclude coverage for gender-affirming services in their Medicaid program.<sup>8</sup>

As another example, the Administration plans on rolling back Section 1557's protections based on gender identity and termination of pregnancy. On April 13, 2018, the Office of Information and Regulatory Affairs in the Office of Management and Budget received a proposed rule titled 'Nondiscrimination in Health Programs or Activities' (RIN 0945-AA11).<sup>9</sup> While it is uncertain when the proposed rule will be published, the Trump administration has made it clear that HHS plans to rewrite the regulations that implemented Section 1557. In proceedings in *Franciscan Alliance v. Price*, HHS has suggested that they would address the contested issues in the case relating to gender identity and termination of pregnancy in future rule-making.<sup>10</sup> In 2017, HHS removed the words "gender identity" and "sex stereotypes," as well as associated training materials from its "Section 1557: Frequently Asked Questions" webpage.<sup>11</sup> Most recently, *The New York Times* obtained a leaked memo from HHS that describes an effort to establish a narrow, legal definition of sex that would exclude and deny people's gender identity.<sup>12</sup> HHS' definition of sex would define sex as a binary identity -- either male or female -- and as unchangeable, determined by one's genitalia and sex assigned at birth. HHS may adopt this narrow definition presumably as part of their effort to rewrite the regulations implementing Section 1557.

The Administration's failure to effectively implement Section 1557 as well as efforts to rollback its protections through rulemaking raise serious concerns that the Commission should investigate.

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<sup>8</sup> Movement Advancement Project, Healthcare Laws and Policies: Medicaid, [http://www.lgbtmap.org/equality-maps/healthcare\\_laws\\_and\\_policies](http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies) (last visited December 11, 2018).

<sup>9</sup> Unified Agenda and Regulatory Plan for HHS/OCR, Spring 2018. (<https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201804&RIN=0945-AA11>).

<sup>10</sup> *Franciscan Alliance v. Price*, No. 7:16-cv-00108-O (N.D. Tex. Jul. 10, 2017) (order granting in part defendants' motion for voluntary remand and stay).

<sup>11</sup> Web Integrity Project, Sunlight Foundation, *Language Removals Pertaining to Sex Discrimination from HHS's Office for Civil Rights Webpages about Section 1557 of the Affordable Care Act* (2018), <http://sunlightfoundation.com/wp-content/uploads/2018/07/CCR-9-HHS-OCR-1557-180716.pdf>; HHS, Section 1557: Frequently Asked Questions, <https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html> (last visited December 13, 2018).

<sup>12</sup> Erica L. Green et al., *The New York Times*, 'Transgender' Could Be Defined Out of Existence Under Trump Administration, <https://www.nytimes.com/2018/10/21/us/politics/transgender-trump-administration-sex-definition.html> (last visited December 13, 2018).

## II. The Trump administration is dismantling critical sexual and reproductive health programs and protections.

The Trump administration continues to attack sexual and reproductive health care in this country. The administration's efforts particularly harm low-income women, youth, LGBTQ individuals, and others who already struggle to access reproductive health care. During this past year, the Trump administration has established the Division of Conscience and Religious Freedom in OCR, has proposed regulations to expand the ability of entities and providers to deny reproductive health care on the basis of religious and moral beliefs, and has finalized and proposed other regulations that will undermine access to contraception and erode the safety net of reproductive health providers.

Currently, OCR has the authority to investigate and enforce a variety of religious refusal laws. These laws allow providers and health care entities to opt out of providing the standard of medical care, particularly abortion services, on the basis of religious or other beliefs. In January of this year, OCR created the Division of Conscience and Religious Freedom, vastly expanding OCR's authority to investigate religious refusals and enforcement powers. Yet the Division was created without any additional funding. Since OCR is a historically understaffed and under-resourced office within HHS, the addition of this new division will necessarily take resources away from the enforcement of other federal civil rights protections within OCR's mandate, such as Section 1557 of the Affordable Care Act, Title VI and the Rehabilitation Act.

Further, the Trump administration is seeking to expand religious refusals through a proposed regulation, entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority."<sup>13</sup> The proposed regulation would introduce broad and poorly defined language to the interpretation of existing laws that already provide ample protection for the ability of health care providers and entities to refuse to participate in health care services to which they have moral or religious objections.<sup>14</sup> The proposed rule would grant unprecedented license to anyone engaged in the health care system, and possibly to entities not engaged in the delivery of health care, to refuse services or care. For example, a nurse assistant could refuse to serve lunch to a transgender patient or a billing specialist could refuse to help a patient who had sought contraceptive counseling.<sup>15</sup> In fact, the proposed regulation does not require a moral or religious

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<sup>13</sup> 83 Fed. Reg. 3880 (Jan. 26, 2018).

<sup>14</sup> Nat'l Health Law Prog., *National Health Law Program Urges HHS to Withdraw Conscience Rights Rule* (July 2018), <https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/03/NHeLP-Conscience-NPRM-RIN-0945-ZA03-FINAL.pdf>.

<sup>15</sup> *Id.*

objection; instead, the preamble uses language such as “those who choose not to provide” or “would rather not” as justification for a refusal.<sup>16</sup> This is concerning because the proposed regulation contains no mechanism to ensure that patients receive the care they need if their provider refuses to furnish a service or provide notice regarding how this regulation will impede their access to care once it is finalized. The proposed regulation has the potential to harm low-income women, people of color, LGBTQ individuals, people living with disabilities, and other communities who continue to face rampant discrimination in health care settings and experience pervasive health disparities. If implemented, the proposed regulation will only compound existing barriers to care.

Additionally, the Trump administration has directly weakened access to contraceptive coverage. Recently, HHS finalized regulations that expand exemptions from the ACA’s contraceptive coverage requirement. The finalized regulations allow any employer or university to deny contraceptive coverage based on religious objections and allow all non-profits, for-profits that are not publicly traded, and universities to deny contraceptive coverage based on “moral” objections. These regulations virtually allow any employer or university to deny contraceptive coverage, leaving their employees on their own to find and afford contraception.

HHS also proposed regulations that will gut the Title X program, the only federal program in the country dedicated solely to providing family planning and related preventive services. The proposed changes will remove critical care that low-income individuals and families have historically needed and received. Specifically, this proposed rule will reduce low-income individuals’ access to the full range of contraceptive methods and services; impose onerous financial and operational requirements on Title X providers, prevent patients from receiving full and accurate information about their pregnancy options; deter minors from seeking needed services; and redefine “low-income family” in a way that is contrary to the text and purpose of Title X, harming the populations it intended to serve.<sup>17</sup>

When all of these actions are combined – the establishment of the Division of Conscience and Religious Freedom, the proposed regulation to expand religious refusals, and the attacks on comprehensive family planning – the results will have devastating consequences. These efforts will deter providers who are willing to provide reproductive health services from providing the standard of care their patients need.

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<sup>16</sup> *Id.*

<sup>17</sup> Susan Berke Fogel, Nat’l Health Law Prog., *National Health Law Program in Comments to HHS Opposes Changes to Title X* (Jan. 2018), <https://9kgpw4dcaw91s37kozm5ix17-wpengine.netdna-ssl.com/wp-content/uploads/2018/09/NHeLP-Title-X-Comments.pdf>.

Moreover, these actions, once implemented, will enable providers and health care entities to opt out of providing evidence-based care and discriminate against particular communities, including women, especially women of color, LGBTQ individuals, and persons living with disabilities. It is essential that the government ensure patients' ability to receive health care that is not driven by provider bias and prejudice, but rather, informed by the highest standards of medical care. Because of the Trump administration's persistent and appalling attacks on sexual and reproductive health care, the Commission should investigate and report how OCR now prioritizes enforcement across its jurisdictional areas and study how these final and proposed regulations impact the priorities and work of HHS.

### **III. The Trump administration is implementing policies and proposals to dismantle access to health care for immigrant families.**

The Trump administration continues to pursue policies to instill fear in immigrant communities. The Muslim Ban, the family separation policy that separated more than 2,500 children from their families,<sup>18</sup> and the administration's refusal to accept refugees at the border (and subsequently attacking these families with tear gas and rubber bullets), are but three salient examples of these deplorable fear tactics. In the midst of these attacks, the administration released a proposed rule, which envisions radical changes to the "public charge" determination and undermines access to health coverage for lawfully present immigrants and their families in the United States.

U.S. immigration officials make a "public charge" determination when a person applies to enter the U.S., or to adjust their status to Lawful Permanent Resident status ("LPR," otherwise known as "green card" holders). The proposed rule would drastically change the definition of what it means to be a "public charge" by considering immigrants' use of public benefits, including Medicaid, beyond those used for subsistence. It would improperly penalize immigrants who use public benefits to augment their standard of living and ultimately achieve self-sufficiency.

By stigmatizing and disincentivizing Medicaid enrollment and the use of other public benefits that address social determinants of health (e.g. SNAP and housing assistance), the proposed rule will chill the use of vital public benefits that ensures the neediest in society have access to health care services and resources needed to keep them healthy. Foregoing use of Medicaid, as well as use of other services included in the proposed rule, leads to a less healthy and costlier society for all.

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<sup>18</sup> Am. Civil Liberties Union, Family Separation By the Numbers, <https://www.aclu.org/issues/immigrants-rights/immigrants-rights-and-detention/family-separation> (last visited December 11, 2018).

Disenrollment from and forgone enrollment in Medicaid due to the proposed rule's chilling effect would perpetuate disparities in insurance status, especially harming children of immigrants. Low-income children with immigrant parents are already less likely to receive Medicaid than those with U.S. born parents.<sup>19</sup> The Kaiser Family Foundation predicts the total number of persons disenrolling from Medicaid to fall between 2.1 million and 4.9 million, depending on varying rates of disenrollment.<sup>20</sup> An estimated 1.5 million children are expected to lose Medicaid coverage, 1.1 million of whom would remain uninsured.<sup>21</sup> The proposed rule's chilling effects erect new barriers to immigrant families' abilities to seek appropriate health care.

The benefits of insurance coverage are key to a family's financial stability and providing safe environments for children. Enrolling in Medicaid enables low-wage workers to: find and retain employment,<sup>22</sup> decrease reliance on cash assistance,<sup>23</sup> save more and contribute more to the local economy,<sup>24</sup> address previously unmet medical needs,<sup>25</sup> pay

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<sup>19</sup> Wendy Cervantes et al., CLASP, *Our Children's Fear Immigration Policy's Effects on Young Children* (2018),

[https://www.clasp.org/sites/default/files/publications/2018/03/2018\\_ourchildrensfears.pdf](https://www.clasp.org/sites/default/files/publications/2018/03/2018_ourchildrensfears.pdf).

<sup>20</sup> *Id.*

<sup>21</sup> Samantha Artiga et al., Kaiser Fam. Found., *Potential Effects of Public Charge Changes on Health Coverage for Citizen Children* (2018), <http://files.kff.org/attachment/Issue-Brief-Potential-Effects-of-Public-Charge-Changes-on-Health-Coverage-for-Citizen-Children> (their estimate uses Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)-era disenrollment rate of 25 percent).

<sup>22</sup> Larisa Antonisse & Rachel Garfield, Kaiser Fam. Found., *The Relationship Between Work and Health: Findings from a Literature Review* (2018), <http://files.kff.org/attachment/Issue-Brief-The-Relationship-Between-Work-and-Health-Findings-from-a-Literature%20Review>.

<sup>23</sup> Aparna Soni et al., *Medicaid Expansion And State Trends In Supplemental Security Income Program Participation*, 36 HEALTH AFF. (2017),

<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1632>; Marguerite Burns & Laura Dague, *IRP Discussion Paper: The Effect of Expanding Medicaid Eligibility on Supplemental Security Income Program Participation* (2016), <https://www.irp.wisc.edu/publications/dps/pdfs/dp143016.pdf>.

<sup>24</sup> Karina Wagerman et al., Georgetown Ctr. for Children & Fams., *Medicaid Is A Smart Investment in Children* (2017), <https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf>.

<sup>25</sup> Robin Rudowitz & Larisa Antonisse, Kaiser Fam. Found., *Implications of the ACA Medicaid Expansion: A Look at the Data and Evidence* (2018), [http://nasuad.org/sites/nasuad/files/KFF\\_Implications-of-the-ACA-Medicaid-Expansion\\_May-2018.pdf](http://nasuad.org/sites/nasuad/files/KFF_Implications-of-the-ACA-Medicaid-Expansion_May-2018.pdf); Loujia Hu et al., *The effect of the affordable care act Medicaid expansions on financial wellbeing*, 163 J. OF PUB. ECON. (2018), <https://www.sciencedirect.com/science/article/abs/pii/S0047272718300707>; Benjamin D. Sommers et al., *Health Insurance Coverage and Health — What the Recent Evidence Tells Us*, 377 N. ENGL. J. MED. (2017), <https://www.nejm.org/doi/10.1056/NEJMs1706645>.

bills in a timely way,<sup>26</sup> purchase better quality food and housing,<sup>27</sup> access credit and reduce debt,<sup>28</sup> and achieve financial stability.<sup>29</sup>

To penalize the receipt of Medicaid that helps those lawfully eligible for such services achieve and maintain robust health and self-care is wholly incongruent with the purpose of Medicaid.<sup>30</sup> In particular, Medicaid and health-related public benefits programs improve both individual quality of life and population health of the U.S.<sup>31</sup> No person should have to question whether accessing the health care they need will hurt their or their family's immigration status or ability to remain in the U.S. The Commission should investigate how this rule will directly affect people of color, particularly immigrant families. For more information on the impact of the proposed Public Charge rule, see the National Health Law Program's comments on our website.<sup>32</sup>

#### **IV. The Trump administration's misuse of § 1115 waivers threatens the Medicaid program, which provides health coverage for 1 in 5 people in the United States.**

Medicaid is the country's largest health care program, providing high quality, affordable coverage to more than 76 million low-income individuals.<sup>33</sup> It is an important lifeline for

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<sup>26</sup> *Id.*

<sup>27</sup> Karina Wagerman et al., *supra* note 25.

<sup>28</sup> Robin Rudowitz & Larisa Antonisse, *supra* note 26; Kyle J. Caswell & Timothy A. Waidmann, *The Affordable Care Act Medicaid Expansions and Personal Finance*, MED. CARE RESEARCH & REVIEW (2017), <http://journals.sagepub.com/doi/full/10.1177/1077558717725164>.

<sup>29</sup> Sarah Miller et al., *Working Paper: The ACA Medicaid Expansion in Michigan and Financial Health*, NAT'L BUREAU OF ECON. RESEARCH (2018), <http://www.nber.org/papers/w25053>; The Ohio Department of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly* (Jan. 2017), <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf>.

<sup>30</sup> See generally CMS, *Medicaid & CHIP: Strengthening Coverage, Improving Health* (2017), <https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf>; Kaiser Fam. Found., *Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act* (2013), <https://kaiserfamilyfoundation.files.wordpress.com/2013/06/8445-key-lessons-from-medicaid-and-chip.pdf>.

<sup>31</sup> *Id.*

<sup>32</sup> Nat'l Health Law Prog., *National Health Law Program Comments Filed on Proposed Public Charge Rule Change* (Dec. 2018), <https://9kqpw4dcaw91s37koz5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/12/National-Health-Law-Program-Public-Charge-Comments-FINAL-12.10.18.pdf>.

<sup>33</sup> Robin Rudowitz & Rachel Garfield, Kaiser Fam. Found., *10 Things to Know about Medicaid: Setting the Facts Straight* (2018), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/>.

the 40 million women, 61 percent of LGBTQ people, and 11 million people with disabilities who are enrolled in the program.<sup>34</sup>

Section 1115 of the Social Security Act (42 U.S.C. § 1315) authorizes the Secretary of HHS to waive certain Medicaid Act requirements to allow a state to carry out an “experimental, pilot or demonstration” project that is likely to promote the objectives of the Medicaid Act. Congress enacted the Medicaid Act to enable states to provide medical assistance to eligible individuals.<sup>35</sup> Nevertheless, the Trump administration has approved a number of Section 1115 projects that block, rather than facilitate, access to medical assistance, threatening the health care coverage of low-income and underserved individuals.<sup>36</sup> Approved projects restrict eligibility and enrollment by, for example, imposing work requirements, requiring very low-income individuals to pay premiums, prohibiting individuals who are terminated for failure to meet these or other requirements from re-enrolling in the program for a period of months, and limiting retroactive eligibility.

Arkansas is the first state to implement a work requirement as a condition of Medicaid eligibility, and the experience there is telling. Under the work requirement, Medicaid enrollees in the State’s expansion population ages 19 to 49 must engage in 80 hours of work or other specified activities every month. They must report compliance with (or an exemption from) the requirement using an online portal, which is only accessible to enrollees between the hours of 7 a.m. and 9 p.m. If enrollees subject to the work requirement do not meet the requirement for any three months of the year, Arkansas

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<sup>34</sup> The 40 million women covered by Medicaid include 31 percent of Black women of reproductive age, 27 percent of Latinas of reproductive age, 19 percent of all Asian American and Pacific Islander women, and 27 percent of American Indian and Alaskan Native adults. Kaiser Fam. Found., Medicaid Enrollment by Gender, <https://www.kff.org/medicaid/state-indicator/medicaid-enrollment-by-gender/?dataView=1&currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Dec. 10, 2014); Candace Gibson & Priscilla Huang, Nat’l Health Law Prog., *Fact Sheet: Medicaid & Reproductive Justice* (2018), [https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/08/Joint-NHeLP\\_Medicaid-and-RJ.pdf](https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/08/Joint-NHeLP_Medicaid-and-RJ.pdf); Kaiser Fam. Found., Medicaid Enrollees by Enrollment Group, <https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/?currentTimeframe=0&selectedDistributions=disabled&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Dec. 10, 2018).

<sup>35</sup> 42 U.S.C. § 1396-1.

<sup>36</sup> See generally Jane Perkins & Ian McDonald, Nat’l Health Law Prog., *Fact Sheet: Legal Issues in Section 1115 Medicaid Waivers* (2018), <https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/09/Fact-Sheet-Medicaid-1115-Waivers-July-2018-with-ToC.pdf>.

terminates their coverage for the remainder of the year.<sup>37</sup> The State has already terminated over 12,000 Arkansans for failure to meet these requirements.<sup>38</sup> These alarming figures led the Medicaid and CHIP Payment and Access Commission (MACPAC) to write to the Secretary and call for a “pause” in implementation.<sup>39</sup>

The work requirement is deeply troubling for many individuals in Arkansas who rely on Medicaid for their health coverage and care, such as Adrian McGonigal and Charles Gresham.<sup>40</sup> Mr. McGonigal has several medical conditions that require monitoring and treatment, including chronic obstructive pulmonary disease (COPD), degenerative disc disease, depression, and an anxiety disorder. In the past, Medicaid coverage allowed him to access vital medical care, including the eight prescription medications he currently takes and regular visits to a primary care doctor and pulmonologist. Mr. McGonigal was recently disenrolled from the Arkansas Medicaid Program for failing to comply with work requirements. Meanwhile, Mr. Gresham has several serious health conditions that need to be monitored and treated, including asthma, extreme social anxiety, and a seizure disorder. The threat of losing his health coverage has increased his anxiety, as he worries that without medical coverage his conditions will get worse.

As additional states implement similar work requirements, thousands more individuals enrolled in Medicaid will lose their health care coverage, and as a result, access to the care they need to participate fully in their communities. The Commission should investigate how work requirements in the Medicaid program will impact access to essential coverage for low-income individuals.

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<sup>37</sup> Amended Complaint, *Gresham v. Azar*, No. 1:18-cv-01900 (D.D.C. Nov. 5, 2018), <https://healthlaw.org/resource/gresham-v-azar-complaint-legal-pleading/>.

<sup>38</sup> Jennifer Wagner, Ctr. On Budget & Pol’y Priorities, Another 3,815 Arkansans Lost Medicaid in November Due to Rigid Work Requirement, <https://www.cbpp.org/blog/another-3815-arkansans-lost-medicaid-in-november-due-to-rigid-work-requirement> (last visited December 13, 2018).

<sup>39</sup> Penny Thompson, Medicaid & CHIP Payment & Access Comm’n, *MACPAC letter to HHS Secretary Regarding Work Requirements Implementation* (Nov. 8, 2018), <https://www.macpac.gov/wp-content/uploads/2018/11/MACPAC-letter-to-HHS-Secretary-Regarding-Work-Requirements-Implementation.pdf>.

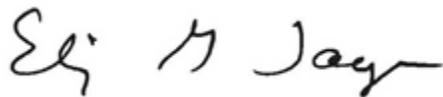
<sup>40</sup> Adrian McGonigal and Charles Gresham are two of the plaintiffs in the NHeLP lawsuit challenging the approval of AR Works Amendment. For more information, see the legal pleading on the National Health Program website, at <https://healthlaw.org/resource/gresham-v-azar-complaint-legal-pleading/>. See also PBS News Hour, ‘With new work requirement, thousands lose Medicaid coverage in Arkansas,’ at <https://www.youtube.com/watch?v=a02spylGLJc>.

## Conclusion

In summary, the U.S. Commission on Civil Rights should investigate the ways in which the Trump administration has actively worked to dismantle important federal civil rights laws that exist to protect the health rights of low-income people, people of color, LGBTQ people, immigrants, and other underserved communities. By increasing barriers to care, particularly for communities that are already underserved, the Trump administration has not only threatened the ability of individuals to access quality care, but additionally, the ability of health facilities to provide quality care to those patients. Further, the Trump administration's actions to subvert established civil rights protections and to politicize institutions whose goal is to implement these protections to meet their own agenda sets a dangerous precedent for the enforcement of federal laws that ensure access to health care and coverage. Equal access to necessary health care is an important right that should be protected and enforced by each administration, including this one.

We appreciate your consideration of our comments. If you have questions about these comments, please contact Rachel Holtzman ([holtzman@healthlaw.org](mailto:holtzman@healthlaw.org)) or Candace Gibson ([gibson@healthlaw.org](mailto:gibson@healthlaw.org)).

Sincerely,



Elizabeth G. Taylor  
Executive Director