Q&A on Federal Authorities to Extend Pregnancy Medicaid Coverage

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The U.S. has the worst maternal mortality rate among high-income countries and is one of only two countries to report a significant increase in their maternal mortality ratio since 2000.[1] More than half of maternal deaths occur after the date of delivery, and 12% happen between 43 and 365 days postpartum.[2] Because of interpersonal, institutional, and structural racism, Black and Indigenous people are dying at exponentially higher rates than their white counterparts.[3] The overwhelming majority of pregnancy related health complications and deaths are preventable.[4] This status quo stems from socially structured imbalances in access to power and resources (*e.g.*, comprehensive health care access before, during, and after pregnancy free from discrimination; stable and healthy housing; food security; clean water; a living wage) which shape maternal health.[5] The pervasiveness and persistence of these reproductive injustices are political choices.

As the largest payer of pregnancy related care in the U.S. and payer for 65% of Black pregnant peoples' labor and delivery care nationwide, Medicaid has a strong influence on maternal health outcomes and equity.[6] This issue brief answers the following questions:

- Q.1 What are the Medicaid Act's minimum requirements for pregnancy Medicaid coverage?
- Q.2 How can states provide pregnancy Medicaid coverage beyond the Medicaid Act's minimum?
- Q.3 Do § 1115 waivers to extend pregnancy Medicaid coverage meet statutory requirements?
- Q.4 What are the reproductive health equity implications of these § 1115 waiver proposals?
- Q.5 How has CMS responded to state proposals to restrict post-pregnancy coverage extensions by duration or pregnancy outcome?

Q. 1: What are the Medicaid Act's minimum requirements for pregnancy Medicaid coverage?

From 1984 to 1990, Congress passed a series of reforms to expand Medicaid eligibility for pregnant people with low incomes by creating new mandatory and optional eligibility groups.[7] Under the Medicaid Act, states are required to provide Medicaid coverage with full-scope benefits to qualified pregnant women with household incomes below their income threshold for the former Aid to Families with Dependent Children (AFDC) program as of May 1, 1988.[8] In addition, if a pregnant person's household income exceeds that income threshold, they may be eligible for "pregnancy Medicaid" coverage.[9] States are required to provide people in this latter eligibility category with coverage for services related to their pregnancy.[10] Mandatory eligibility (*i.e.*, the minimum that states must provide) only lasts through the end of the month in which the sixty-day period (beginning on the last day of a pregnancy) ends, long before many of the complications that result in pregnancy related morbidity or mortality manifest.[11] States must provide this post-pregnancy coverage regardless of an individual's pregnancy outcome (*e.g.*, childbirth, stillbirth, miscarriage, abortion).[12]

The Medicaid Act's limited federal floor for post-pregnancy coverage makes losing or experiencing disruptions in coverage during a critical period the norm for many Black, Indigenous, and other people of color with low incomes. While some are able to maintain coverage through other eligibility categories after their pregnancy coverage expires, many become uninsured within particularly the six months following the end of their pregnancies.[13] This post-pregnancy coverage gap is dangerous for people with low incomes with complex unmet health and health-related social needs.[14] It directly contributes to the Black and Indigenous maternal mortality epidemic.[15] It also subjects people with low incomes to unjust financial strain.[16] Ultimately, this coverage gap reinforces racism, intergenerational health inequities, and reproductive oppression.[17]

Q. 2: How can states provide pregnancy Medicaid coverage beyond the Medicaid Act's minimum?

In 2021, Congress passed the American Rescue Plan Act (ARPA), which created a temporary state plan amendment (SPA) option to extend pregnancy Medicaid and Children's Health Insurance Program (CHIP) coverage to full-scope benefits for a full year after pregnancies end.[18] While the SPA option was initially set to sunset after just 5 years, Congress made it permanent in the Consolidated Appropriations Act of 2023.[19] As of May 10, 2024, 47 states, D.C., and the U.S. Virgin Islands have used the SPA option or an § 1115 waiver to extend post-pregnancy coverage to a full 12 months, resulting in an estimated total of 641,000 newly

eligible people.[20] The U.S. Centers for Medicare & Medicaid Services (CMS) has not approved any such § 1115 waivers since Congress authorized the SPA option. CMS continues to work with other states who have proposed extensions.[21] Emerging research shows that extended eligibility stabilizes coverage post-pregnancy and enables people to access care for a range of health issues, such as postpartum depression (among the leading causes of maternal death) and chronic health conditions.[22]

While states that adopted the SPA option have made measurable progress toward reducing maternal health inequities, experience with other optional Medicaid eligibility categories suggests that the small number of recalcitrant states could postpone adopting the SPA option for years, withholding lifesaving coverage with potentially deadly results.[23]

Q. 3: Do § 1115 waivers to extend pregnancy Medicaid coverage meet statutory requirements?

Some state approaches to extending post-pregnancy coverage via § 1115 waivers raise serious legal concerns. Several states have considered, have pending applications for, or have received approval for § 1115 waivers that would provide less coverage than the SPA authority to extend pregnancy Medicaid and CHIP to a full year after pregnancy.[24] These states aim to restrict pregnancy Medicaid or CHIP coverage extensions by pregnancy outcome (*i.e.*, only for those whose pregnancies end in childbirth and/or miscarriage), duration (*i.e.*, for fewer than twelve months after pregnancy), or other factors. CMS has not approved any such requests since the SPA option went into effect on April 1, 2022.

For the Secretary of the U.S. Department of Health and Human Services (HHS) to approve a demonstration project under § 1115, the proposal must satisfy statutory requirements. First, the project must promote the Medicaid Act's objectives. The Act's "central objective" is "to provide medical assistance[—]" that is, to provide health coverage.[25] As courts have held, the relevant baseline for determining a project's effect on coverage is whether the state is providing that coverage in compliance with statutory requirements.[26]

When we evaluate states § 1115 waiver proposals to extend pregnancy coverage against the ARPA SPA option's baseline, it is clear that they are not seeking permission to increase coverage, but rather to skirt federal standards. Consistent with the Medicaid Act's minimum pregnancy coverage, the ARPA SPA option extends coverage after pregnancy without restrictions on pregnancy outcomes (*i.e.*, Congress requires coverage regardless of whether pregnancy ends in childbirth, miscarriage, or abortion). Congress also made clear that if a

state takes up the SPA option, it must provide coverage for the entire 12-month period.[27] States' pending or future requests to deviate from federal law do not promote access to medical assistance relative to the SPA's baseline.[28]

Second, § 1115 authority is limited to waivers necessary to test "experimental, pilot, or demonstration" projects. This means they must present a "novel approach" to program administration.[29] Limited-scope pregnancy coverage extension proposals are not true experiments as required under § 1115. That is because repeated research has already established that providing additional Medicaid coverage after pregnancy ends improves continuity of care, access to preventive services, pregnancy related health outcomes, and the outcomes of future pregnancies.[30] More than half of pregnancy related deaths occur during the 12-month period after pregnancy.[31] Maternal and other public health experts agree that individuals should have Medicaid coverage for at least this period.[32] In response to broad consensus among researchers and other technical experts, Congress amended the Medicaid Act to allow states to provide that coverage. Providing less medical assistance than Congress requires in the SPA is not a valid experiment. We already know that less coverage will increase severe morbidity and mortality and corresponding inequities.

Third, the HHS Secretary can only waive Medicaid Act requirements "to the extent and for the period . . . necessary" to enable the state to carry out its experiment.[33] Congress intended for projects to be time limited.[34] The Secretary cannot use § 1115 to permit states to make long-term policy changes.

Q. 4: What are the reproductive health equity implications of these § 1115 waiver proposals?

Anti-abortion state lawmakers' efforts to use § 1115 waivers to restrict extended post-pregnancy coverage in duration or solely to individuals whose pregnancies end in childbirth not only violate the Medicaid Act, but further reproductive oppression. For example, they neglect the realities that some people who seek abortions later in pregnancy do so due to medical complications, such as maternal life endangerment or lethal fetal anomalies.[35] Individuals who terminate their pregnancies may need access to critical mental, behavioral, and physical health services and health-related social services in the months that follow.

In a similar vein, it is normal for people to experience depression and anxiety after pregnancy loss.[36] To cut off pregnancy coverage in these cases but not for people whose pregnancies end in childbirth punishes people based on forces that are outside of their control. It devalues the health and lives of people whose pregnancies do not result in childbirth. It also misses an

opportunity to provide access to prepregnancy care, which can improve maternal and infant health outcomes for future pregnancies.[37] Ensuring that people with low incomes can access a full 12 months of full-scope coverage after their pregnancies end regardless of how their pregnancies end is an essential step toward achieving reproductive health equity.

Q. 5: How has CMS responded to state proposals to restrict extended post-pregnancy coverage by duration or pregnancy outcome?

In State Health Official Letter #21-007, "Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP)[,]" CMS affirmed that states cannot restrict post-pregnancy coverage by duration or pregnancy outcome under the SPA option.[38] The agency stated that, "[s]imilar to the current 60-day postpartum period, under the extended postpartum coverage option, individuals are entitled to the extended postpartum coverage regardless of the reason the pregnancy ends."[39] Further, "[s]tates extending postpartum coverage under the state plan option do not have the flexibility to establish a different postpartum period."

While CMS's guidance does not speak to § 1115 waiver proposals to restrict extended coverage eligibility by pregnancy outcome or duration, CMS has not approved any such § 1115 waiver since the ARPA SPA option went into effect on April 1, 2022. Further, CMS correspondence with states indicates that the agency does not intend to do so. For example, in May 2023, Utah proposed an amendment to its "Utah Medicaid Reform 1115 Demonstration" that would restrict eligibility for extended post-pregnancy coverage by pregnancy outcome.[40] In September 2023, CMS Deputy Administrator and Director of the Center for Medicaid and CHIP Services Dan Tsai sent a letter to Jennifer Strohecker, Utah's State Medicaid Director, informing her that CMS did not intend to approve the state's proposed amendment to its "Utah Medicaid Reform 1115 Demonstration."[41] CMS directed Utah to pursue an extension that provides coverage consistent with the ARPA SPA option. In alignment with CMS's guidance in State Health Official Letter #21-007, the agency stressed that the option, like the Medicaid Act's 60-day post-pregnancy coverage mandate, applies without regard to the manner in which a pregnancy ends.[42] In response, Utah applied for a SPA under the ARPA authority. CMS approved the SPA on March 25, 2024, retroactively effective January 1, 2024.[43]

In 2022, Texas proposed a § 1115 waiver to solely extend post-pregnancy coverage to individuals with certain pregnancy outcomes.[44] The following year, its legislature passed House Bill 12, which directed the State Medicaid agency to apply for the ARPA SPA option.[45] The law includes a legislative purpose section specifying that it solely extends Medicaid coverage for people "whose pregnancies end in the delivery of the child or end in the natural loss of the

child," thus excluding pregnancies that end in abortion. On October 20, 2023, the State Medicaid agency applied for an ARPA SPA, which CMS approved on January 17, 2024, effective March 1, 2024.[46] In its letter of approval, CMS stressed that "[t]his approval is subject to the condition that Texas will implement the SPA consistent with § 1902(e)(16) of the Act and all sub-regulatory guidance contained in State Health Official Letter #21-007 and subsequent related guidance." Since then, Texas withdrew its § 1115 waiver proposal.[47]

Conclusion

Extending pregnancy Medicaid as Congress envisioned in the ARPA offers a critical opportunity for states to alleviate the Black and Indigenous maternal health crisis and promote intergenerational health equity. With mounting attacks on abortion, sexual and reproductive health as a whole, and Medicaid, it is critical that advocates in the remaining ten holdout states ensure that such extensions meet statutory requirements. It is also essential that advocates in states that have already extended coverage remain vigilant against future attempts to use § 1115 waivers to restrict eligibility by pregnancy outcome or lessen the duration of coverage.

ENDNOTES

[1] *See* Eugene Declercq & Laurie Zephyrin, Commonwealth Fund, Maternal Mortality in the United States: A Primer (Dec. 2020) https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer.

[2] People use "postpartum" to describe the period following pregnancy, regardless of how pregnancy ends (*e.g.*, childbirth, stillbirth, miscarriage, or abortion). For purposes of this issue brief, we use "post-pregnancy" to further clarify that we are referring to the period following pregnancy regardless of outcome. *See id*.

[3] CDC, Pregnancy Mortality Surveillance System, https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy mortality-surveillance-system.htm#trends (last visited Dec. 1, 2021) (finding pregnancy related mortality ratios over three and two times higher for non-Hispanic Black women and non-Hispanic American Indian or Alaska Native women, respectively, than their non-Hispanic white counterparts).

[4] *See* Susanna Trost et al., CDC, Pregnancy Related Deaths: Data from Maternal Mortality Review Committees in 36 US States 2017-2019, https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html (last visited Mar. 5, 2024).

[5] *See* Jamila Taylor, *Structural Racism & Maternal Health Among Black Women*, 48 J.L., MED & ETHICS 506, 506–14 (2020), https://journals.sagepub.com/doi/full/10.1177/107311052095887; Aster Bey et al., Ancient Song Doula Servs., *Advancing Birth Justice: Community-Based Models as a Standard of Care for Ending Racial Disparities* 6 (2019), https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf.

[6] *See, e.g.*, Joyce Martin et al., CDC, *Births in the United States* 1 (2020), https://www.cdc.gov/nchs/data/databriefs/db387-H.pdf; CMS, Postpartum Care, https://www.medicaid.gov/state-overviews/scorecard/postpartum-care/index.html (last visited Feb. 29, 2024).

[7] *See* Medicaid & CHIP Payment & Access Comm'n, *Advancing Maternal and Infant Health by Extending the Postpartum Coverage Period at* 29–30 (2021), https://www.macpac.gov/wp-content/uploads/2021/03/Chapter-2-Advancing-Maternal-and-Infant-Health-by-Extending-the-Postpartum-Coverage-Period.pdf (last visited Feb. 29, 2024).

[8] 42 U.S.C. §§ 1396a(a)(10)(A)(i)(III), 1396d(n)(1)(A), 1396u-1(b)(1)(A); 42 C.F.R. § 435.116(a)(1).

[9] In this *Q&A*, we strive to use gender inclusive language to reflect the scope of people with various health needs and reproductive experiences. We employ "women" in limited instances when referencing statutory or regulatory terms or the scope of cisgender women-centered research. More inclusive legal terms and research are needed. States must provide pregnancy Medicaid coverage to people with household incomes up to the higher of: (1) 133% FPL; or (2) the state's Medicaid income limit for pregnant women as of December 19, 1989 (up to 185% FPL). Thus, many people who are not eligible for Medicaid expansion because their incomes exceed the income cap or who live in coverage gap states are eligible for

pregnancy Medicaid instead. 42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV), 1396a(l)(1)(A), 1396a(l)(2)(A)(i–ii, iv).

[10] 42 C.F.R. § 440.210(a)(2)(i), (ii).

[11] At a minimum, states must provide pregnancy coverage until the last day of the month in which the 60-day post-pregnancy period ends, regardless of income changes during that time. 42 U.S.C. § 1396a(e)(5); *see generally* Amy Chen, Nat'l Health Law Prog., *Q&A on Pregnant Women's Coverage Under Medicaid and The ACA* (Sep. 2018), https://healthlaw.org/resource/qa-on-pregnant-womens-coverage-under-medicaid-and-the-aca/; *see also* Declercq & Zephyrin, *supra* note 1.

[12] CMS, SHO #21-007: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP), 3, 15, Dec. 7, 2021, https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf (hereinafter SHO #21-007).

[13] Sara Federman & Akeiisa Coleman, Commonwealth Fund, Improving Maternal Health by Extending Medicaid Postpartum Coverage, https://www.commonwealthfund.org/blog/2022/improving-maternal-health-extending-medicaid-postpartum-coverage (last visited Feb. 29, 2024).

[14] *See* Jamila Taylor, The Century Found., Advancing Maternal Health Equity in the Next Reconciliation Package (Sep. 2021), https://tcf.org/content/commentary/advancing-maternal-health-equity-next-reconciliation-package/ (last visited Jun. 7, 2024).

[15] *Id.*

[16] *Id.*

[17] *Id.*

[18] American Rescue Plan Act of 2021, Pub. L. No. 1172, 117th Cong. § 9812(a) (2021) (amending 42 U.S.C. 1396a(e)).

[19] Pub. L. No. 1172, 117th Cong. § 9812(b) (2021); Pub. L. No. 328,117th Cong. § 5113 (2022).

[20] CMS, Biden-Harris Administration Announces Utah's Medicaid and CHIP Postpartum Coverage Expansion; 45 States Now Offer Full Year of Coverage After Pregnancy (Mar. 8, 2024), https://www.cms.gov/newsroom/press-releases/biden-harris-administration-announces-utahs-medicaid-and-chip-postpartum-coverage-expansion-45 (last visited May 24, 2024); *see also* Catherine McKee & Jane Perkins, Nat'l Health Law Prog., *Primer State Plan Amendments v. Section 115 Waivers* 2–3 (2021), https://healthlaw.org/wp-content/uploads/2021/06/Primer-on-SPA-v.-1115-FINAL.pdf.

[21] *Id.*

[22] *See* Federman, *supra* note 13.

[23] Madeline T. Morcelle, Nat'l Health Law Prog., For Congress's Medicaid Coverage Gap Fix, Racial Justice Relies on the Details (Oct. 20, 2021), https://healthlaw.org/for-congress-medicaid-coverage-gap-fix-racial-justice-relies-on-the-details/ (last visited Jun. 7, 2024).

[24] American Rescue Plan Act of 2021, Pub. L. No. 1172, 117th Cong. § 9812(a) (2021) (amending 42 U.S.C. 1396a(e)(16)); *see* Wisc. Dep't Health Servs., *Wisconsin Postpartum Coverage 1115 Waiver* (2022), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wi-postpartum-coverage-pa.pdf (pending as of June 7, 2024); UT Dep't of Health & Human Servs., *Twelve-Month Extended Postpartum Coverage* (2023),

https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-primary-extnd-postprm-covrge-pa.pdf [hereinafter UT § 1115 proposal] (since withdrawn); CMS, *Technical Corrections to Approval for M.O.'s Targeted Benefits for Postpartum Women* 2 (2021), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mo-targeted-benefit-for-postpartum-women.pdf (approved prior to Congress's authorization of the ARPA SPA option); Tex. Health & Hum. Servs. Comm'n, *THTQIP Amendment Request: Postpartum Coverage Extension* (2022), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tx-healthcare-transformation-postpartum-covrg-amen-pa.pdf (since withdrawn) [hereinafter TX § 1115 waiver proposal]. Because Texas did not paginate its proposal, the page numbers I use in related citations refer to the page of the PDF document available on Medicaid.gov.

[25] Stewart v. Azar, 366 F. Supp. 3d 125, 138 (D.D.C. 2019); *id.* at 144 (rejecting "promoting health" as an independent objective because the Medicaid Act is "designed . . . to address not health generally but the provision of care to needy populations" through a health insurance program).

[26] *See*, *e.g.*, *Stewart*, 366 F. Supp. 3d at 154 (D.D.C. 2019) (noting that § 1115 "assumes the implementation of the [Medicaid] Act").

[27] *Id.*; 42 U.S.C. § 1396a(e)(16)(B)(ii).

[28] *See Stewart*, 366 F. Supp. 3d at 153 (rejecting the notion that through § 1115, a state could implement Medicaid expansion as an à la carte exercise, picking and choosing which of Congress's mandates it wishes to implement").

[29] Beno v. Shalala, 30 F.3d 1057, 1069 (9th Cir. 1994).

[30] *See, e.g.*, Sarah H. Gordon et al., *Extended Postpartum Medicaid Eligibility is Associated with Improved Continuity of Coverage in the Postpartum Year*, 41 HEALTH AFF. 69 (2022), https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00730?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed (comparing continuity of coverage for one year postpartum among people eligible for Medicaid through the expansion and people ineligible for Medicaid and finding retention of Medicaid coverage was associated with a 12% increase in the probability of continuous coverage during the first year after birth); Jamie R. Daw et al., *Medicaid Expansion Improved Perinatal Insurance Continuity for Low-Income Women*, 39 HEALTH AFF. 1531 (2020), https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01835 (finding Medicaid expansion significantly increased insurance continuity in the perinatal period for low-income women); Sarah H. Gordon et al., *Effects of Medicaid Expansion on Postpartum Coverage and Outpatient Utilization*, 39 HEALTH AFF. 77 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7926836/ (finding Medicaid expansion was associated with lower rates of Medicaid coverage loss and more Medicaid-covered outpatient visits among new mothers during the six months postpartum, and the effects of expansion were largest among women who experienced significant maternal morbidity at delivery); Claire E. Margerison et al., *Impacts of Medicaid Expansion on Health Among Women of Reproductive Age*, 58 AM. J. PREVENTIVE MED. 1 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6925642/pdf/nihms-1543952.pdf (finding Medicaid expansion was associated with increased coverage, increased utilization of services, and better self-rated health among women of reproductive age); Erica L. Eliason, *Adoption of Medicaid Expansion is Associated with Lower Maternal Mortality*, WOMEN'S HEALTH ISSUES 147

(2020), https://www.whijournal.com/action/showPdf?pii=S1049-3867%2820%2930005-0 (finding Medicaid expansion was significantly associated with lower maternal mortality, with the effects concentrated among non-Hispanic Black women); Chintan B. Bhatt & Consuelo M. Beck-Sagué, *Medicaid Expansion and Infant Mortality in the United States*, 108 AM. J. PUB. HEALTH 565 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5844390/pdf/AJPH.2017.304218.pdf (comparing infant mortality rates in non-expansion states and expansion states from 2010 to 2015 and finding expansion was associated with a greater decline in informant mortality rate, particularly in African American infants).

[31] *See* Declercq, *supra* note 11.

[32] *See, e.g.*, Am. Coll. of Obstetricians and Gynecologists, Extend Postpartum Medicaid Coverage, https://www.acog.org/advocacy/policy-priorities/extend-postpartum-medicaid-coverage (last visited July 18, 2024); Am. Pub. Health Ass'n, Policy Number LB21-02, Expanding Medicaid Coverage for Birthing People to One Year Postpartum (Oct. 2021), https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2022/01/07/Expanding-Medicaid-Coverage-for-Birthing-People-to-One-Year-Postpartum (last visited Jul. 18, 2024); Am. Medical Ass'n, Policy D-290.974, Extending Medicaid Coverage for One Year Postpartum (2021), https://policysearch.ama-assn.org/policyfinder/detail/Extending%20Medicaid%20Coverage%20for%20One%20Year%20Postpartum%20D-290.974?uri=%2FAMADoc%2Fdirectives.xml-D-290.974.xml (last visited Jul. 18, 2024); Soc'y for Maternal-Fetal Med., *Continuing Medicaid Coverage for 12 Months Postpartum* (Feb. 2020), https://s3.amazonaws.com/cdn.smfm.org/media/2261/Final_PDF.pdf.

[33] 42 U.S.C. § 1315(a); *see also* § 1315(e)(2), (f)(6) (limiting the extension of "state-wide, comprehensive demonstration projects" to one initial extension of up to 3 years (5 years, for a waiver involving dual eligible individuals) and one subsequent extension not to exceed 3 years (5 years, for Medicare-Medicaid waivers)).

[34] As one court found, "it is clear that the Secretary would abuse his discretion if he were to approve a project . . . which subject[ed] an unreasonably large population to the experiment or continu[ed] it for an unreasonably long period." *Cal. Welf. Rts. Org. v. Richardson*, 348 Fed. Supp. 491, 498 (N.D. Cal. 1972).

[35] Ivette Gomez et al., Kaiser Family Found., Abortions Later in Pregnancy in a Post-*Dobbs* Era, https://www.kff.org/womens-health-policy/issue-brief/abortions-later-in-pregnancy-in-a-post-dobbs-era/ (last visited Jun. 5, 2024).

[36] Nazanin Silver, Am. Coll. of Obstetrics and Gynecology, Finding Emotional Support After Pregnancy Loss, https://www.acog.org/womens-health/experts-and-stories/the-latest/finding-emotional-support-after-pregnancy loss (last visited Mar. 1, 2024).

[37] March Clapp et al., *Preconception Coverage Before and After the Affordable Care Act Medicaid Expansions*, 132(6) OBSTETRICS & GYNECOLOGY 1394 (Dec. 2018); *see also* Am. College of Obstetricians and Gynecologists, Good Health Before Pregnancy: Prepregnancy Care (Feb. 2020), https://www.acog.org/womens-health/faqs/good-health-before-pregnancy-prepregnancy-care (last visited Jul. 18, 2024).

[38] SHO #21-007, *supra* note 12, at 3, 15.

[39] *Id.* at 3.

[40] *See* UT § 1115 proposal, *supra* note 24.

[41] Letter from Dan Tsai, CMS Deputy Administrator, to Jennifer Strohecker, Utah State Medicaid Director (Sept, 8, 2023), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-primary-cms-ltr-to-st-09082023.pdf.

[42] *Id*. at 2.

[43] CMS, Letter from James G. Scott to Jennifer Strohecker re: Utah State Plan Amendment (SPA) # 23-0016, Mar. 25, 2024, https://www.medicaid.gov/medicaid/spa/downloads/UT-23-0016.pdf.

[44] *See* TX § 1115 waiver proposal, *supra* note 24.

[45] Texas H.B. 12 (88th Texas Legislature, Regular Session 2023).

[46] CMS, Letter from James Scott, Director of the Division of Program Operations, to Emily Zalkovsky, State Medicaid Director, re: Approval of State Plan Amendment TX-23-0028, https://www.medicaid.gov/medicaid/spa/downloads/TX-23-0028.pdf .

[47] Texas Health and Human Services Commission, Letter from Emily Zalkovsky, State Medicaid Director, to Jamie John, Project Officer, Apr. 4, 2024, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tx-healthcare-transformation-withdrw-postp-covrg-amend.pdf.