

WHOLE HEALTH: A COMMUNITY APPROACH TO HEALTHCARE

KEYNOTE SPEAKER:

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[edited for reading]

FEBRUARY 8, 2019

Speaker 1: If everybody will please go ahead and take their seat, we will move on to the next segment.

Speaker 1: So just a quick reminder we have the updated CLE forms at the registration table, whenever you can fill those just go ahead and drop them off there so we can get sent in for you. Um at this point I will go ahead and introduce our next speaker Professor Laura Hermer from Mitchell Hamline School of Law. Laura Hermer is a professor of law at Mitchell Hamline School of Law in Saint Paul, Minnesota. Her current research focus is on changes in access of health coverage and care under the Affordable Care Act with particular focus on underserved populations.¹ She also recently created and obtained funding for a medical legal partnership and associated coursework between this law school and the United Fellow of Medicine... United Family Medicine, a federally qualified health center in Saint Paul/Minneapolis, Minnesota. In part through the support funded by the Robert Lloyd Johnson Foundation, part of her appointment at Mitchell Hamline Professor Hermer was an Assistant Professor in the Department of Preventative Medicine and Community Health and a member of the Institute of for the Medical Communities at the University of Texas Medical Branch in Galveston, Texas. Please welcome Professor Hermer.

Prof. Laura Hermer:: Thank you everyone, thank you yes. I understand that I am the only thing standing between you and lunch so I am going to try to keep my remarks brief. I often say that and then something quite the opposite happens so let me try to do a better job in that regard. Um what I'd like to talk with you today is um this waiver amendment that Tennessee has under consideration, has just submitted to CMS uh regarding work requirements or instituting work requirements or as they call them community engagement

¹ PATIENT PROTECTION AND AFFORDABLE CARE Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

requirements in the TennCare program.² So we've been talking about social determinants of health and we've been having a rather uh broad discussion of that and so this is going to focus it in um much more carefully and on one particular issue. So first I'd like to talk briefly about poverty, personal responsibility, and health um and then give a very very brief uh history of personal responsibility requirements in the Medicaid program, um then I'd like to talk about proposed Amendment 38 to TennCare uh and how many of you are familiar with this going on right now at least somewhat, excellent excellent.³ Um and then I'd like to talk a bit about defining problems and solutions and just a little bit about what we're really trying to do here and how we might better go about doing that. Okay so um this oh wow this light is super bright, okay um so it is it is uh very unhealthy to be poor and there is plenty of research out there showing that if you're poor you're much more likely to be sick, you are much more likely to live a shorter life than people who are wealthier and there are many studies out there. There's a nice study by Olivia Egen and her colleagues that came out just a little while ago uh I mean 2016 in the American Journal of Public Health that takes all the counties in the United States, so over 3000 counties in the United States, and then ranks them from poorest to wealthiest um and then out of that collection of counties makes new states.⁴ Okay and Tennessee actually was one of only five states to contribute a county to both the poorest state and the richest state okay um and as you can see there are rather different population characteristics here.⁵ So if we look at the median income the richest state's nearly 90,000 dollars for median income, the poorest state a little under 25,000 dollars.⁶ So see the poorest state the 75% of the population is rural, um 37% of the population is African American, nearly half the children are in poverty, and the employment level is more than double that in the richest state.⁷ And it also differed, the richest state and the poorest state, they differed based on life

² MEDICAID, AMENDMENT 38, December 28, 2018, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-pa6.pdf>.

³ Id.

⁴ Olivia Egen, *Health and Social Conditions of the Poorest versus Wealthiest Counties in the United States*, American Journal of Public Health, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5308159/>.

⁵ Id.

⁶ Id.

⁷ Id.

expectancy and also on so-called personal behaviors and I could call them choices but there not always quite as contingent on individual choice as one might uh might originally think.⁸ So you can see that there is about a six year difference for both men and women in life expectancy between the richest and the poorest states, and when we look at certain health behaviors um you can see maybe there might be some correlations here.⁹ So smoking rate is nearly double that in the poorest state than it is in the richest state um the obesity rate is much higher in the poorest state as is the rate of physical inactivity okay um and well these are behaviors they do have a real impact on medical care.¹⁰ So we've been talking today about health versus medical care and really what is the correlation between these um so "Lara" was talking about in the beginning saying that uh medical care counted for only about 10% of a person's total health outcomes um and that uh you have uh population health care characteristics, you have social and economic determinants of health, you have genetic characteristics, those account for about 90% of the rest. These are going to be uh big contributors and so we see for instance with respect to obesity, um 87% of people with Type II Diabetes, Americans with Type II Diabetes, are overweight or obese and um this probably comes as no surprise people who are morbidly obese are more than six times as likely as people who have normal weight to have Type II Diabetes and um diabetes by the way is um is a terribly expensive condition and so on average people with diabetes will cost about, depending on their age, about 6,000 dollars more per year, much more if they're older um than individuals who don't have diabetes so a very expensive condition. This also correlated obesity is correlated with hypertension, certain cancers, myocardial infarction, asthma, and stroke. And just being obese alone costs on average or it adds about 1,900 dollars per year in medical care than people who have a normal BMI. And with respect to smoking the evidence on this is very clear, so smoking is associated strongly with an increased risk of ischemic heart disease, with various cancers, lung cancer, uh aortic aneurisms, respiratory infections, uh impaired fertility, and um a variety of other problems and it adds about 2,500 dollars per year to the health care costs uh to the medical costs um that individuals incur. Um physical inactivity uh is a much lower contributor in terms of health care costs but it certainly factors into

⁸ Id.

⁹ Id.

¹⁰ Id.

the mix so its associated with a variety of cancers, diabetes, stroke, and also ischemic heart disease. But when you look at low socio-economic status alone okay so if you control for all of those other factors um which are more common in lower income populations, you put those aside, low socio-economic status alone um diminishes a person's lifespan on average by about 2.1 years um so and this is lower or it contributes uh it causes a person uh to have less years of life or is associated with fewer years of life even than alcohol overuse, obesity, and hypertension. So in itself it is unhealthy to be poor. Okay um so what do we do about this? Um in the 1980s Lawrence Mead, a variety of other people um developed this school of thought called the New Paternalism and it holds that people you know many of us have been poor or low income at times in our lives but for individuals who are poor for a much longer period of their life or poor for most of their life, the New Paternalism school hold that these individuals are poorer in large part because they don't know how to live their lives properly. They don't know how to behave. And this is the school of thought that was instrumental in getting the old cash welfare program, aid to Families with Dependent Children or FDC, um repealed and changed into TANF, Temporary Aid to Needy Families, through the personal uh the um Personal Responsibility and Work Opportunity Reconciliation Act of 1996.¹¹ Um and um and so TANF um cat um or I'm sorry cat um TANF um time limited cash welfare and it also instituted work requirements in the program but it also delinked Medicaid from cash welfare. Why would that be the case? Okay so certain individuals who were pushing the bill wanted Medicaid to still be uh connected with TANF eligibility um but legislators knew that you know poor mothers were going out, they had to work and probably getting very low wage jobs and they're probably not going to have access to private employer sponsored health coverage and when you think about the economics this makes very good sense. And so just looking at you know today's dollar um so if a woman or man for that matter is earning minimum wage is earning about 14,000 dollars per year gross and if they're going to have employer sponsored coverage and employer sponsored coverage costs well north of 6,000 dollars per year on average for employer sponsored coverage for an individual policy, nearly 20,000 dollars for a family policy, so we're talking about tacking on a huge amount of you know

¹¹ PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996, Pub. L. No. 104-193, 110 Stat. 2105 (1996).

compensation for this individual or diminishing their paycheck um well below what is permitted by law. So that makes sense that you would want them to still have access to Medicaid and if you look in Tennessee, for example, only about 15% of people who are earning poverty level or less and are working um have access to employer sponsored coverage. Um and this is not unusual. Tennessee is not unusual in this regard. So Medicaid was delinked from cash welfare and the eligibility standards are set differently now um but there were some for whom this sat rather badly and they thought that uh individuals on Medicaid should have to do something, show something, they'd have to do something in order to get their Medicaid benefits. And so we started to see these personal responsibility requirements start to creep into the program and they started entering into the program basically um through state impetus. So in Medicaid and in other federal state uh um uh cooperative federalism programs usually welfare programs you can get what's called a section 1115 waiver, section 1115 of Social Security Act allows the Secretary of the relevant department, here Health and Human Services, to waive certain Medicaid requirements if uh he believes in his judgment that they will further the goals of Medicaid.¹² We'll look at what some of those are in just a moment. So states started to seek waivers and were especially encouraged to do so starting under the George W. Bush administration to institute higher co-payments, uh to create uh health savings accounts of various sorts, and to have to make contributions to them, incurring higher penalties for non-emergent use in the emergency department uh, and then also reducing benefits for non-compliant beneficiaries. And these waivers were uh granted with not increasing frequency but with there was an increase in the amount or number or intensity of the personal responsibility requirements that were being requested and granted through the George W. Bush administration. This ratcheted back significantly initially under the Obama administration and then with NFIB v. Sebelius, which made the Medicaid expansion under the Affordable Care Act optional, um HHS started granting these waivers um more regularly or they became more lenient just in an effort to get states to expand their Medicaid population.¹³ Okay and now under the Trump administration under Seema Verma who was a major proponent and

¹² 42 U.S.C.A. § 1315 (West 2014).

¹³ National Federation of Independent Business et al. v. Sebelius, 567 U.S. 519 (2012).

is a major proponent of these personal responsibility requirements um now she has expressly endorsed this notion of allowing work requirements in the program which the Obama administration, even the George W. Bush administration, had held back from doing. And so in the state Medicaid director letter um just a little over a year ago uh she announced that those were going to be available and a number of states have taken CMS up on this.¹⁴ Okay so already approved and implemented in Arkansas, and just recently in Indiana. Indiana just started up. They are approved but not implemented in a number of other states and then uh in Maine it was approved and then the Governorship changed and that was withdrawn, but they're pending in a variety of other states. Note that most of these states are non-expansion states. Okay so Arkansas and Indiana expanded Medicaid under the Affordable Care Act.¹⁵ Um all of these states have expanded Medicaid or in the case of Wisconsin already have the eligibility up at the Medicaid expansion rate. Um Tennessee of course has not expanded Medicaid, you have somewhat expansive uh eligibility for parents under Medicaid uh but otherwise have not expanded it per se. So let's look at this proposed Amendment 38.¹⁶ The proposal is that all non-disabled, non-elderly, non-pregnant um adults in TennCare will have to work or otherwise fulfill community engagement requirements but basically work. Um and the Department of TennCare did not provide an estimate of the number of individuals who would be impacted with their waiver application um but the financial review board for the General Assembly did some calculations when the bill was going through your legislature um and found that out of the about 300,000 individuals who would be subject to this only about 37,000 of them will not be exempt from reporting for some reason or another. There are tons of exemptions in the waiver application as there are nearly all the other waiver applications. Um so about 37,000 people would be impacted, and they estimated that of those probably about 22,000 will end up losing eligibility because they will fail to report or won't have a job or something of that sort. They will have to work at least 20 hours

¹⁴ Seema Ferma, *Letter to State Medicaid Director*, Dep't of Health and Human Services, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd19002.pdf>.

¹⁵ PATIENT PROTECTION AND AFFORDABLE CARE Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

¹⁶ MEDICAID, AMENDMENT 38, December 28, 2018, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-pa6.pdf>.

per week on average and this is going to be averaged over a six-month period.¹⁷ And so, for at least four out of those six months, they have to meet this twenty-hour a week requirement. And note, that virtually nothing is said in the waiver application about implementation.¹⁸ Compliance will be assessed bi-annually – so, we do know that much – and noncompliant members will be suspended from TennCare until they can show that they have been compliant for at least one month.¹⁹

Okay. There are a number of problems with this waiver. I'd like to just talk about some of the legal problems, first, before we go into some of the policy issues. Okay. So, I said that we're going to talk about the purpose of Medicaid. And, you can see it here, and it is found in forty-two USC section thirteen, ninety-six dash one.²⁰ So, Medicaid was enacted for the purpose of enabling each state as far as practicable under those conditions to furnish: one, medical assistance to eligible individuals; or two, rehabilitative and other services to enable people to obtain or retain capacity for independence or self-care.²¹

So, let's talk about those two purposes of the Medicaid program. First, if we're talking about medical assistance that means healthcare. That means healthcare. So, states must furnish healthcare for eligible individuals. As you might imagine, the states that are seeking these community engagement waivers aren't really trying to do so under that first prong. They're going mostly for this second one, rehabilitation of other services. And, saying that, work will help individuals stay independent, and independence is good – you know, people should work for living – they should be able to support themselves. The problem is that when you look at the definition of rehabilitative services and other services in Medicaid, you're talking about services that have been recommended by a physician or other healthcare provider, mostly to help elderly or disabled people stay in the community or to

¹⁷ MEDICAID, AMENDMENT 38, December 28, 2018, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenn-care-ii-pa6.pdf>.

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ 42 U.S.C. § 1396-1 (West 2018).

²¹ *Id.*

improve their physical functioning. It is not about helping people work – whether that will get them out of poverty or not.²²

So, Medicaid was enacted in 1965, and it's a really traditional program.²³ Soler was talking earlier about bringing medical care back to 1970. You know, if we're talking about bringing medical care back to 1970, or here in 1965, we are really talking about old-fashioned, really old-school medical care, and we are not talking about the social determinants of health. And, that was not something that was included in the program at all. And so, you might think, well Medicaid is a welfare program, and certainly with cash welfare, we have work requirements, we have all these personal responsibility requirements.

So, let's look at TANF's purpose, okay? The purpose of TANF is to provide assistance to needy families so the children may be cared for in their own homes or homes of relatives too.²⁴ And, the dependence of needy parents on government benefits by promoting job preparation, work and marriage.²⁵ Work requirements absolutely fit into the definition of TANF as enacted by Congress – okay? So, Congress repealed AFDC and enacted TANF.²⁶ This is what we have now. Congress has not done the same thing, yet, to Medicaid. And so, if the Secretary wants to approve these work requirement waivers, and I can get really in the weeds on this – I will spare you all. If the Secretary wants to improve these requirements, that's really outside the scope of the Secretary's legal authority to do so under standard administrative law principles.

If Congress wants to make this change, it can do so. It can do so. And, perhaps it ought to, perhaps it ought not to. That's a matter of policy. Right now, this is outside the scope of the law. There are couple other problems – and by the way, again, that problem is not

²² Medicaid.gov, Index Page, <https://www.medicaid.gov/medicaid/index.html> (last visited July 30, 2019).

²³ Medicaid.gov, About Us Page, <https://www.medicaid.gov/about-us/program-history/index.html> (last visited July 30, 2019).

²⁴ Office of Family Assistance, About TANF Page, <https://www.acf.hhs.gov/ofa/programs/tanf/about> (Last visited July 30, 2019).

²⁵ *Id.*

²⁶ CONGRESSIONAL RESEARCH SERVICE, TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) BLOCK GRANT: A LEGISLATIVE HISTORY, <https://crsreports.congress.gov/product/pdf/R/R44668> (Updated April 2, 2019).

specific to Tennessee's waiver. This is problems that all of them have. Tennessee's waiver also fails to provide that estimate of the number of individuals who would be impacted.²⁷ There is specific federal regulation on this particular topic, and it hasn't met this, and it shouldn't be considered until TennCare provides this estimate. But then it also provides no information about how the proposal's going to be implemented – and this is really problematic.²⁸

So, we think again about Arkansas. So, Arkansas is really the only state from which we have any data at this point. Arkansas implemented these work requirements in, I think, June of 2018. So, it's been around for a little bit over six months at this point. So, in the Arkansas works program, over 18,000 beneficiaries have lost their benefits since the program was instituted. And, you can see it goes, you know, the number who have lost benefits goes up here by about 4,000 per month. And then there is less of a jump here between November and December. And, part of the problem here, you know, we don't know whether these people are finding jobs and getting private coverage and getting out of the program – we have no idea because that data is not being collected. That is not how this program is being implemented. Okay. And this is not how any of them are proposed to be implemented to the best of my knowledge.

But another problem with Arkansas' program is that the reporting could only be done online. So, the Arkansas work recipients had to report their hours online every month. And a large number of people in the Arkansas Medicaid program had no access to the Internet. They have no Internet access. And so, they're dropping out. We find that the vast majority of people who are dropping out here, in the yellow for example – and this is from December of last year. A large majority of these people, it's not that they didn't report enough hours, it's that they didn't report at all. But again, we don't know if that's because they thought, oh, nuts, this is just too hard, and it's just not important to me because I don't use much healthcare. Or, if they said, you know, nuts to this, I'm going out and getting a job and I'm going to get private coverage and, you know, goodbye Medicaid.

²⁷ MEDICAID, AMENDMENT 38, December 28, 2018, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenn-care-ii-pa6.pdf>.

²⁸ *Id.*

Or, if they just didn't have the materials to do the reporting. So, in December, last year, in the middle of December, the state of Arkansas said, okay, we know we've got a problem with this, so we're going to let people report also by telephone. You know, maybe that's what's going on here. But we don't know, and I don't know that they're collecting that data to satisfy that question or to answer that question.

So, you can also see here that the vast number of people are exempt from reporting. So, this is out of about 61,000 beneficiaries who are subject to the work requirements. And that's kind of been the average since this program has started. So, 90% of them are exempt from reporting. Tennessee's numbers from the Financial Review Committee are somewhat similar, by the way, not exempt from reporting about 6,000. So, the number of people from whom they got new information. And then part of the reason why some of these are exempt from reporting this because they're already meeting the work requirements under either TANF or under the food stamp program, under SNAPS. So, the state already knows they're meeting these requirements. They don't have to double report. Okay. So, they will be getting new information from 1,311 people in the month of December. This is a huge amount of "hoo ha" that the state is having to go through in order to get new information from 1,311 people. That's it. Okay. So, if we go back and think about, umm, I'm sorry, let me just, um, okay. Let me just talk about this one little bit.

Now, when you look at the administrative costs to the state, the administrative costs to the state, your Financial Review Board estimated that it would end up costing the state, net. Now, this is after we subtract out all the money that the state's going to be saving from the beneficiaries who get kicked out of the program. You all are still going to be spending nineteen million dollars per year, just on being counted for these administrative costs. So, keeping track of these people and their work requirements and their exemptions and all the rest of that. And, you all are not alone. Okay? So, Minnesota was considering doing this, I'm from Minnesota, and in the last legislative session – well, it was going to be massively expensive to institute these work requirements. And so, we had Republican legislators who were saying, look, I totally, I totally agree with the principle of this, but this is nuts. This is fiscally crazy

to do this. Why would we ever do this? And you know, we ended up not passing that legislation.

So, let's just go back to a moment, to this slide on low SES. So, it's unhealthy to be poor. Why is it, why is poverty, low SES in itself, a risk factor that diminishes a person's lifespan on average? There is research out there – a lot of it done, or at least instituted by a Sir Michael Marmot, through the Whitehall study, looking at the role of stress. And Larry talked at the beginning of the day about stress. So, it is stressful to be impoverished. When the Whitehall study was done, they expected to find that there would be a huge amount of stress in the upper class. Lots of people dropping dead from heart disease because they were stressed out as titans of industry or what have you, you know with their mergers and so forth, and found that actually it's really stressful to be poor.

Why is it stressful to be poor? Well, you know, you're worried about keeping your job. You know that you don't have many skills. You're working in a low wage job, you're easily replaceable, and you could be one sickness away from losing your job. If you lose your job, you might lose the roof over your head. You might not be able to pay your utilities. You've got all these other problems going on. It is super stressful to be poor. If you're poor, you're more likely, you know people of color are more likely to be poor. You have to deal with daily microaggressions from discrimination. It is really stressful.

So, what role would having to report work requirements to prove to the state that you are worthy of your health coverage? You know, if you are a diabetic, you need your health care. You need your insulin, or whatever drugs you're taking to try to keep your diabetes under control so you can work. And, if you then have to report these requirements, particularly if you have to do it through modalities that you might not have access to, what is this – what impact is this going to have on your stress? Is this really going to be doing a lot of good for anyone? And that's the question. What is this really about? What's going on?

So, it increases the state administrative costs – right? It demeans and hassles TennCare members, it treats them like children, and they have to go and report these requirements all the time. Those of you

who work in law firms, you know, you have to do your billable hours, you have to do your billing and you know you all understand that. But you're doing that so that you can get paid – so that you make sure that your clients pay you. You know, this is for health care, and it doesn't improve health. This is not something that is going to improve health. And what's more, these work requirements, you know, the state says, you know, we're going to help connect people up with jobs who don't have employment. That's great! Please, help connect people who are unemployed to work. That's great! Are they doing anything new? Do these programs? No. They are connecting them up with already existing state services that these individuals could take advantage of anyway and probably should be connected with if they're not employed. Okay? So, this really doesn't improve how, and it ultimately applies to this tiny little fraction of members.

So, what really is going on here? That is the question. So, there are better ways of doing this. There are better ways of helping individuals who are low income, get the skills that they need in order to move forward with their lives and their careers. It is great for people to be employed. But you need health care in order to be employed in the first place. If you are not already healthy, you need to get into better health to do this. So, there are ways that we can try to fix this problem. But these solutions are ones that are going to need to come from the community. if you don't have any bootstraps to pull yourself up by, you're going to be in trouble.

So, we all need to work together to help improve these community health efforts, rather the imposing these requirements just on these individuals who are already struggling. Thank you very much. [Applause]

Okay. Any questions? You all desperately want your lunch. Yes?

Audience Member: So, I assume there haven't been any studies on increased morbidity in Arkansas?

Prof. Hermer: It is way too early to get that data. And what's more, to the best of my knowledge, no one knows what has happened to the individuals who have left – who no longer have coverage. So,

we don't know whether the individuals who are remaining are healthier or less healthy. But we also don't know what's happening to the people who are leaving here.

I'd be happy to talk to people afterwards if you all are just desperate to get to lunch. But, thank you all very much. [Applause]

Phillip Fitzgerald: Thank you, Professor Hermer. There is one last thing before lunch, and that is me. I'm Phillip Fitzgerald. I'm the editor-in-chief of the health law journal. It's my pleasure to have had you all here today. The lunch today is sponsored by Waller Lansden Dortch and Davis, and I can't wait to let you go eat it. But I have two points I'd like to make.

The first is, we have a website up: belmonthealthlaw.com, and on that website you can find our previous publications or transcripts from our prior symposiums. We have a blog post on there that does current updates on developments in health law. And, we also accept rolling submissions for articles for publication. So, if you have an article idea – if you have something you'd like to submit for publication, please do so. That's at: belmonthealthlaw.com.

Lastly, I'd like to say that the best thing about the health law journal is that it can act as a conduit for professionals in the education world, the legal world, and the healthcare world. And, it's been great to host this event today. As we all know, Nashville is a hub for publicly traded private healthcare companies not withholding all of the country, and all over the world. And so, the conversations we have here today and the dialogue we have can have an effect beyond these walls and beyond our city. And I want to thank all of you for being here today and being a part of that dialogue. So, thank you very much. And with that, lunch is served!