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**HEALTH JUSTICE IN THE AGE OF ALTERNATIVE FACTS AND
TAX CUTS: VALUE-BASED CARE, MEDICAID REFORM, AND THE
SOCIAL DETERMINANTS OF HEALTH**

ELIZABETH TOBIN-TYLER*

ABSTRACT

Some provisions of the Patient Protection and Affordable Care Act of 2010 (ACA) as well as regulatory policies under the Obama administration reflected the overwhelming evidence that to reduce health care costs, and to improve quality of care and population health, the social determinants of health (SDOH) must be addressed. These policies included funding for partnerships between public health agencies, community organizations, and health care institutions, promotion of value-based payment models that incentivize integrated health and social care delivery, and support for Medicaid program innovations that directly address social needs as part of health care. The Trump administration, through a series of legislative and regulatory changes, has undermined many of these efforts, reversing the momentum toward a more preventive and integrated health care system. This article traces how the Trump administration's policy approach to investments in value-based and integrated care models, state Medicaid waivers, and funding of the safety net backtrack from Obama administration evidence-based reforms that acknowledged the large role that SDOH play in health inequity, worsening population health outcomes in the U.S., and out of control health care costs.

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I. INTRODUCTION

Following the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, health care reformers have increasingly embraced the growing evidence base demonstrating that social determinants of health (SDOH) are significant drivers of health inequity,¹ as well as health care utilization and costs.² Although primarily focused on expanding access to health insurance, the ACA sought to address the “triple aim”—improving population health, promoting health care quality, and reducing costs.³ During the Obama administration, the Centers for Medicare and Medicaid Services (CMS) and, in particular, the newly created Center for Medicare and Medicaid Innovation (CMMI), adopted policies and initiatives that explicitly supported the integration of health equity and SDOH into health system reforms.⁴ But with the election of Donald Trump in 2016 and the subsequent shift by CMS in its approach to health care reform and to health care for vulnerable populations, many of these Obama administration policies have been under threat.

While the Trump administration has been unsuccessful at fully dismantling the ACA (through failed repeal and replace attempts),⁵ its policy approach threatens the momentum set forth under the Obama administration incorporating strategies to address SDOH as part of health care delivery and policy. In this article, I focus on the Trump administration’s regulatory approach to investments in value-based care (VBC)⁶ and integrated care models that have

1. See Paula Braveman & Laura Gottlieb, *The Social Determinants of Health: It’s Time to Consider the Causes of the Causes*, 129 PUB. HEALTH REP. 19, 20, 27 (2014).

2. Zachary Pruitt et al., *Expenditure Reductions Associated with a Social Service Referral Program*, POPULATION HEALTH MGMT. (forthcoming 2018).

3. TYLER SMITH ET AL., *ACHIEVING THE TRIPLE AIM IN HEALTH CARE REFORM: THE IMPORTANCE OF THE FOOD SYSTEM 1* (2016), https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-a-livable-future/_pdf/research/clf_reports/ACA.pdf; Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 760 (2008).

4. Samantha Artiga & Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, KAISER FAM. FOUND. 4 (2018), <http://files.kff.org/attachment/issue-brief-beyond-health-care>.

5. See Julie Rovner, *Timeline: Despite GOP’s Failure to Repeal Obamacare, the ACA Has Changed*, KAISER HEALTH NEWS (Apr. 5, 2018), <https://khn.org/news/timeline-roadblocks-to-affordable-care-act-enrollment/> (describing a timeline of congressional Republicans’ failure to repeal and replace the Affordable Care Act (ACA)).

6. Value based care is a system by which payers (public and private) and purchasers (employers, government and consumers) hold providers of health care (physicians, hospitals, etc.) accountable for the quality and cost of care that they deliver. *Value-Based Payment*, AM. ACAD. FAM. PHYSICIANS, <https://www.aafp.org/about/policies/all/value-based-payment.html> (last visited Aug. 29, 2018). Often, this involves risk sharing whereby the providers are rewarded for improving quality and reducing costs but may also be penalized if they do not meet certain quality or cost benchmarks. *Payers are Moving Toward Value-Based Reimbursement*, ATHENA HEALTH, <https://www.athenahealth.com/knowledge-hub/payment-reform/what-is-payment-reform> (last visited Sept. 7, 2018). Quality may be measured through the satisfaction of patients, but also is

increasingly included identifying and addressing SDOH as part of health care delivery. Although VBC primarily targets reduction of health care costs and quality improvement and is not necessarily associated with approaches to SDOH, it has facilitated innovations in this area because of the growing recognition among payers, providers, and policymakers that SDOH are critical drivers of health care costs.

Additionally, I explore what the Trump administration's narrative about safety net programs (and the people who need them) and its budget proposals indicate about its understanding of SDOH. The administration's proposed budget cuts to basic supports (food, housing, and income) and its application of 1990s era welfare reform measures to the Medicaid program suggest a retreat from evidence-based policy designed to address the upstream determinants of population health. While the Trump administration has given some lip service to the importance of SDOH, its actions suggest otherwise.

Part II briefly summarizes the evidence pointing to SDOH as upstream drivers of poor population health outcomes, health disparities, and health system costs. Part III describes ACA health reform measures and Obama administration policies that explicitly supported an upstream approach to prevention and reduction of racial and socioeconomic health disparities, as well as incentivized and facilitated health care delivery models addressing SDOH through VBC and Medicaid. Part IV contrasts Obama administration policies with those of the Trump administration and analyzes how its shift in policy is a retreat from an evidence-based upstream approach to population health and health equity.

II. THE EVIDENCE: SOCIAL DETERMINANTS OF HEALTH AS DRIVERS OF HEALTH DISPARITIES AND HEALTH CARE COSTS

In the past decade, there has been a proliferation of evidence demonstrating the significant role of SDOH in adverse health outcomes and health inequity.⁷ The Centers for Disease Control and Prevention (CDC) describes SDOH as “[t]he complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors.”⁸ Roughly twenty percent of a person's health may be attributed to medical care, whereas as much as sixty

often measured by the health outcomes of the patient population served. *What is Value-Based Healthcare?*, NEJM CATALYST (Jan. 1, 2017), <https://catalyst.nejm.org/what-is-value-based-healthcare/>.

7. See Braveman & Gottlieb *supra* note 1, at 20, 22–23, 27.

8. *Social Determinants of Health*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 21, 2014), <https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html> (citing COMM'N ON SOC. DETERMINANTS OF HEALTH, WORLD HEALTH ORG., CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 1 (2008)).

percent may be associated with social, economic, and environmental factors.⁹ Life expectancy at birth in the U.S. can vary by as much as twenty-five years depending on the county in which a person lives.¹⁰ This disparity is attributed to differences in access to basic needs and opportunities, such as high quality education, nutritious food, and health care.¹¹

Furthermore, international comparisons of population health outcomes reveal a striking picture of health in the U.S. Although the U.S. spends significantly more on medical care than any of its peer nations, it has significantly worse health outcomes. It ranks forty-third for life expectancy among member countries of the Organization for Economic Cooperation and Development (OECD).¹² Researchers point to the high burden of chronic disease—such as heart disease, stroke, cancer, type 2 diabetes, and obesity—as a major factor in these poor outcomes and in driving high health care costs.¹³ According to the CDC, half of all adults have a chronic disease, and one in four has two or more chronic health conditions.¹⁴ A recent study comparing the U.S. with other OECD countries showed that the US had the highest percentage of adults who were overweight or obese (70.1%), while the mean for all other countries was 55.6%.¹⁵ Since many of the most prevalent chronic diseases, such as obesity, diabetes, and heart disease are not only preventable but are often strongly correlated with social and behavioral risk factors, public health researchers suggest that attention to SDOH is fundamental.¹⁶ Researchers argue that a focus on individual behavioral change without recognition of the social

9. *County Health Rankings Model*, COUNTY HEALTH RANKINGS & ROADMAPS (Mar. 29, 2016), <http://www.countyhealthrankings.org/county-health-rankings-model>.

10. *Does Where You Live Affect How Long You Live?*, ROBERT WOOD JOHNSON FOUND., <https://www.rwjf.org/en/library/interactives/whereliveaffectshowlongyoulive.html> (last visited Sept. 5, 2018).

11. *Id.*

12. *See Country Comparison: Health Expenditures*, CENT. INTELLIGENCE AGENCY, <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2225rank.html> (last visited Sept. 5, 2018) (stating the ranking of health expenditure by country); *Country Comparison: Life Expectancy at Birth*, CENT. INTELLIGENCE AGENCY, <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html> (last visited Sept. 5, 2018) (stating the ranking of life expectancy at birth by country).

13. *See About Chronic Diseases*, CTRS. FOR DISEASE CONTROL & PREVENTION (Aug. 6, 2018), <https://www.cdc.gov/chronicdisease/about/index.htm>; *Nutrition, Physical Activity, and Obesity*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 13, 2017), <https://www.cdc.gov/chronicdisease/resources/publications/aag/dnpao.htm>.

14. *About Chronic Diseases*, *supra* note 13.

15. Irene Papanicolas et al., *Health Care Spending in the United States and Other High-Income Countries*, 319 J. AM. MED. ASS'N 1024, 1025, 1027 (2018).

16. Jacquelyn H. Flaskerud & Carol Rose DeLilly, *Social Determinants of Health Status*, 33 ISSUES MENTAL HEALTH NURSING 494, 494–95 (2012).

structures and environmental factors that contribute to chronic disease will be ineffective.¹⁷

The burden of chronic disease is borne more heavily by racial and ethnic minorities and individuals of low socioeconomic status (SES), who often have less control over their social environments.¹⁸ Research pointing to the correlation between SES and poor health first came to light in the United Kingdom in the 1970s.¹⁹ More recent studies have highlighted how the overlapping burden of low SES—poor access to education leading to lower lifetime earnings and social status—affects health over the life course.²⁰ Similarly, research showing that adverse childhood experiences²¹ and “toxic stress”²² in childhood are strongly correlated with poor adult health supports the need to address SDOH early in the life course. All people experience stress, but chronic stress can do significant damage to the body.²³ Stressful experiences such as trauma, violence, and the indignity of racial or gender discrimination take a toll on the body’s organ systems and undermine its ability to regulate its

17. See DB Resnik, *Responsibility for Health: Personal, Social, and Environmental*, 33 J. MED. ETHICS 444, 445 (2007).

18. Sonu Sahni et al., *Socioeconomic Status and Its Relationship to Chronic Respiratory Disease*, 85 ADVANCES RESPIRATORY MED. 97, 105 (2017); see LESLEY RUSSELL, FACT SHEET: HEALTH DISPARITIES BY RACE AND ETHNICITY 2–3, 5 (2010), https://cdn.americanprogress.org/wp-content/uploads/issues/2010/12/pdf/disparities_factsheet.pdf (For example, African Americans and Hispanics have nearly twice the rate of diabetes as do whites, “[t]he prevalence of overweight and obesity in American Indian and Alaska Native preschoolers, school-aged children, and adults is higher than that for any other population group.”).

19. See M. G. Marmot et al., *Employment Grade and Coronary Heart Disease in British Civil Servants*, 32 J. EPIDEMIOLOGY & COMMUNITY HEALTH 244, 247 (1978).

20. Paula A. Braveman et al., *Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us*, 100 AM. J. PUB. HEALTH S186, S193–94 (Supp. I 2010).

21. See Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study*, 14 AM. J. PREVENTATIVE MED. 245, 255 (1998); see also *Adverse Childhood Experiences*, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN. (July 9, 2018), <https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences> (explaining that adverse childhood experiences (ACEs) include exposure to childhood emotional, physical, or sexual abuse, household dysfunction (including exposure to intimate partner violence, parental substance abuse, and/or mental illness, and incarceration of a parent), and lack of basic necessities).

22. Jack P. Shonkoff et al., *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*, 129 AM. ACAD. PEDIATRICS e232, e243 (2012) (explaining how toxic stress is defined as stress in childhood that creates “physiologic disruptions or biological memories that undermine the development of the body’s stress response systems and affect the developing brain, cardiovascular system, immune system, and metabolic regulatory controls...”).

23. Bruce S. McEwen & Eliot Stellar, *Stress and the Individual: Mechanisms Leading to Disease*, 153 ARCHIVES OF INTERNAL MED. 2093, 2098 (1993). This “wear and tear” on the body resulting from chronic stress is referred to as “allostatic load.” *Id.* at 2094.

stress response over time.²⁴ There is increasing recognition that experiences of racism and sexism help to explain persistent racial, ethnic, and gender-based health disparities.²⁵ Because experiences of discrimination are internalized over the life course and can induce chronic stress, they may alter multiple body systems, leading to higher rates of chronic disease, mental health problems, and substance abuse.²⁶ The intersection of race and gender discrimination, in relation to poor health outcomes, is most stark in research linking experiences of racism by black women and higher rates of infant mortality in blacks than whites.²⁷ The emerging research on the social drivers of stress among vulnerable populations supports an intersectoral and structural approach to health inequity through policies that address root causes, not just downstream medical treatment.

In addition to contributing to health disparities and poor overall health outcomes, preventable chronic disease plays a large role in high health care costs in the U.S. According to the CDC, an astounding eighty-six percent of health care expenditures in the U.S. are for people suffering from chronic disease and mental health problems.²⁸ It is estimated that the top one percent of spenders account for more than twenty percent of health care spending, while the top five percent account for fifty percent of spending.²⁹ As noted earlier, the U.S. spends upward of eighteen percent of its Gross Domestic Product on health care, twice that of other OECD countries.³⁰ But what is most telling is that the U.S. spends only fifty-five cents for every dollar spent in other wealthy countries on social services and supports.³¹ In other words, the U.S. spends its money downstream

24. See, e.g., Zinzi D. Bailey et al., *Structural Racism and Health Inequities in the USA: Evidence and Interventions*, 389 LANCET 1453, 1457, 1461 (2017).

25. *Id.*; David R. Williams & Selina A. Mohammed, *Racism and Health I: Pathways and Scientific Evidence*, 57 AM. BEHAV. SCIENTIST 1152, 1153 (2013); David F. Warner & Tyson H. Brown, *Understanding How Race/Ethnicity and Gender Define Age-Trajectories of Disability: An Intersectionality Approach*, 72 SOC. SCI. & MED. 1236, 1237 (2011).

26. See Bailey et al., *supra* note 24, at 1457.

27. See Zoë Carpenter, *What's Killing America's Black Infants? Racism is Fueling a National Health Crisis*, THE NATION, Mar. 6, 2017, at 13–14.

28. *Health and Economic Costs of Chronic Disease*, CTRS. FOR DISEASE CONTROL & PREVENTION (Aug. 7, 2018), <https://www.cdc.gov/chronicdisease/about/costs/index.htm>.

29. EMILY M. MITCHELL, CONCENTRATION OF HEALTH EXPENDITURES IN THE U.S. CIVILIAN NONINSTITUTIONALIZED POPULATION, 2014, AGENCY FOR HEALTHCARE RES. & QUALITY 1 (2016), https://www.ncbi.nlm.nih.gov/books/NBK425792/pdf/Bookshelf_NBK425792.pdf.

30. See Papanicolas et al., *supra* note 15, at 1027.

31. See ELIZABETH H. BRADLEY & LAUREN A. TAYLOR, THE AMERICAN HEALTH CARE PARADOX: WHY SPENDING MORE IS GETTING US LESS 17 (2015); Kenneth Davis, *To Lower The Cost of Health Care, Invest in Social Services*, HEALTH AFF. BLOG (July 14, 2015), <https://www.pcc.org/2015/07/14/lower-cost-health-care-invest-social-services>; Stuart M. Butler et al., *Re-balancing Medical and Social Spending to Promote Health: Increasing State Flexibility to Improve Health Through Housing*, USC-BROOKINGS SCHAEFFER HEALTH POLICY (Feb. 15, 2017), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2017/02/15/re-balanc>

to care for the sick, rather than upstream for prevention. In essence, the U.S. medicalizes social needs.

This “paradox”³² has not been lost on some policymakers, health system administrators, or health care providers, who see the effects of these policy failures on their patients’ bodies as well as their checkbooks. Public health officials have long embraced upstream prevention that includes improving the social environment to improve health. Some state governments are embracing intersectoral “health in all policies”³³ out of recognition that structural change requires multiple government players to work together,³⁴ such as agencies focused on housing, transportation, and planning in addition to health. But in order to tackle chronic disease, reduce disparities, and reign in health care expenditures, partnerships and collaboration among public health, health care, and social services are key. The ACA embraced the evidence that health care costs would not be reigned in until there was a shift in strategy toward upstream prevention.³⁵ The next section outlines the ways in which the ACA embraced the evidence about the importance of addressing SDOH to improve health outcomes and reduce health care costs.

III. POLICIES SUPPORTING HEALTH EQUITY AND UPSTREAM PREVENTION UNDER THE ACA AND THE OBAMA ADMINISTRATION

A. *Prevention and Access to Care*

Although the primary goal of the ACA was to expand health insurance coverage to (near) universal levels, several of its provisions focus on upstream prevention. In the realm of health care provision, the ACA requires insurance sold through state and federal exchanges to cover “essential health benefits,” which include a range of preventive screenings and services, including maternity care.³⁶ It also promotes equity by prohibiting insurance companies from

ing-medical-and-social-spending-to-promote-health-increasing-state-flexibility-to-improve-health-through-housing/.

32. BRADLEY & TAYLOR, *supra* note 31, at 2–3.

33. See *Health in All Policies*, CTRS. FOR DISEASE CONTROL & PREVENTION (June 9, 2016), <https://www.cdc.gov/policy/hiap/index.html>.

34. LINDA RUDOLPH ET AL., *HEALTH IN ALL POLICIES: A GUIDE FOR STATE & LOCAL GOVERNMENTS* 18 (2013).

35. John Auerbach, *Creating Incentives to Move Upstream: Developing a Diversified Portfolio of Population Health Measures Within Payment and Health Care Reform*, 105 AM. J. PUB. HEALTH 427, 427 (2015).

36. See Patient Protection and Affordable Care Act, 42 U.S.C. § 18022 (2010) (Benefits are: (1) Ambulatory patient services (outpatient services); (2) Emergency services; (3) Hospitalization; (4) Maternity and newborn care; (5) Mental health and substance use disorder services, including behavioral health treatment; (6) Prescription drugs; (7) Rehabilitative and habilitative services (those that help patients acquire, maintain, or improve skills necessary for daily functioning) and

charging women higher premiums.³⁷ These provisions acknowledge both the potential for discrimination against women in the insurance market, as well as the reality that women have different health care needs, particularly during their reproductive years. Public health investments were made through training primary care providers, supporting community health centers and school-based health centers, promoting smoking cessation programs for pregnant women enrolled in Medicaid, and furthering oral health care prevention services.³⁸

In terms of larger upstream public health prevention initiatives, the ACA called for development of a national prevention plan and created a fifteen billion dollar Prevention and Public Health Trust Fund to invest in community-based initiatives to improve public health.³⁹ In an attempt to better link clinical care with community-based public health prevention, the ACA requires tax-exempt hospitals to develop a community health needs assessment every three years in collaboration with community and public health partners, as well as an implementation strategy for addressing any identified needs.⁴⁰ These hospitals must also demonstrate to the Internal Revenue Service (IRS) how they are investing their community benefit dollars to improve public health.⁴¹ The IRS regulations were quite specific that hospitals needed to do more than provide charity care to meet their obligations; they must take active measures to address SDOH.⁴² Community health needs include “not only the need to address financial and other barriers to care but also the need to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community.”⁴³

The ACA also addresses health inequity by establishing grant programs aimed at reducing disparities, supporting community health workers and community health teams,⁴⁴ and establishing six new offices of minority health

devices; (8) Laboratory services; (9) Preventive and wellness services and chronic disease management; and (10) Pediatric services, including oral and vision care).

37. JESSICA ARONS, *WOMEN AND OBAMACARE: WHAT’S AT STAKE FOR WOMEN IF THE SUPREME COURT STRIKES DOWN THE AFFORDABLE CARE ACT?* 9 (Ctr. For Am. Progress, 2012).

38. Sara Rosenbaum, *The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice*, 126 PUB. HEALTH REP. 130, 133 (2011).

39. *Id.*

40. Additional Requirements for Charitable Hospitals, 79 Fed. Reg. 78954, 78956 (Dec. 31, 2014) (to be codified at 26 C.F.R. pts. 1, 53, 602).

41. Mary Crossley et al., *Tax-Exempt Hospitals and Community Health Under the Affordable Care Act: Identifying and Addressing Unmet Legal Needs as Social Determinants of Health*, 131 PUB. HEALTH REP. 195, 196 (2016).

42. *Id.*

43. Additional Requirements for Charitable Hospitals, 79 Fed. Reg. 78954, 78963 (Dec. 31, 2014) (to be codified at 26 C.F.R. pts. 1, 53, 602); *see also* Crossley et al., *supra* note 41, at 196.

44. The Patient Protection and Affordable Care Act, 42 U.S.C. § 3502(a) (2010) (A Community Health Team is defined in the ACA as a team that “may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers

at federal agencies that are charged with incorporating health equity into new federal regulations.⁴⁵ Critically, the law also explicitly acknowledges the role of discrimination in health care as playing a role in health disparities by expanding protections for clinicians and patients who experience discrimination based on race, ethnicity, gender, sexual orientation, disability, and more.⁴⁶

Thus, the ACA helped to move the conversation about health equity and the social determinants of health forward by connecting the previously uninsured to the health care system and requiring preventive care be covered, affirmatively linking public health and clinical care, and by acknowledging and providing opportunities to address health disparities and SDOH. However, because of strong opposition from Republican lawmakers and states opposing ACA mandates, it suffered major setbacks, including the Supreme Court's decision in *National Federation of Independent Business v. Sebelius* in 2012. There, the Court effectively made Medicaid expansion voluntary for states and seriously undermined the ACA's goal of near universal coverage.⁴⁷ Another setback was the failure by Congress to fully fund the Prevention and Public Health Trust Fund, which disrupted the momentum around community-based prevention efforts.⁴⁸

Nonetheless, the ACA has had an impact, especially on access to care for disadvantaged populations and those with chronic disease. Overall, the ACA has reduced the number of uninsured from forty-four million in 2013 to twenty-eight million in 2016.⁴⁹ For states that expanded Medicaid, uninsured rates for low-

(including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants"); *Community Health Workers*, AM. PUB. HEALTH ASS'N, <https://www.apha.org/apha-communities/member-sections/community-health-workers> (last visited Sept. 5, 2018) (The American Public Health Association defines a community health worker as: "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.").

45. Daniel E. Dawes, *Why Health Equity Matters in an Era of Health Care Transformation*, ASS'N AM. MED. COLLEGES (Dec. 6, 2016), <https://news.aamc.org/patient-care/article/health-equity-matters-health-care-transformation/>.

46. *Id.*

47. James E. Dalen, *Why do so Many Americans Oppose the Affordable Care Act?*, 128 AM. J. MED. 807, 809–10 (2015); Nat'l. Fed'n. of Indep. Bus. v. Sebelius, 567 U.S. 519, 585 (2012); see *A 50-State Look at Medical Expansion*, FAMILIES USA (May 30, 2018), <https://familiesusa.org/product/50-state-look-medicaid-expansion>.

48. Ashley Yeager, *Cuts to Prevention and Public Health Fund Puts CDC Programs at Risk*, THE SCIENTIST (Feb. 9, 2018), <https://www.the-scientist.com/daily-news/cuts-to-prevention-and-public-health-fund-puts-cdc-programs-at-risk-30298>.

49. *Key Facts about the Uninsured Population*, KAISER FAM. FOUND. (Sept. 19, 2017), <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

income adults have declined ten percent since 2010.⁵⁰ From 2013 to 2015, the percentage of uninsured African-Americans dropped from seventeen percent to twelve percent, of Latinos from twenty-five percent to seventeen percent, and of women seventeen percent to eleven percent.⁵¹ It is important to note, however, that there are still significant disparities in insurance coverage between Caucasians and African-Americans. In 2016, twelve percent of blacks were uninsured versus eight percent of whites.⁵² From 2011 to 2015, fewer women reported foregoing care due to cost, dropping by ten percent.⁵³ This may indicate that the no-cost preventive care provided by the essential health benefit provisions in the ACA have increased access to care for these women.⁵⁴ Additionally, a recent study by Karpman, Long, and Bart in *Health Affairs* reports that access to coverage through the ACA marketplaces has been critical for people with chronic disease.⁵⁵ From July 2014 through December 2015, “45 percent of Marketplace enrollees ages 18–64 were treated for chronic conditions, compared with 35 percent of non-Marketplace nongroup enrollees and 38 percent of adults with employer-sponsored insurance.”⁵⁶

In addition to expanding access to care for vulnerable groups, the ACA’s changes to the insurance market have led to important innovations in care delivery to underserved populations. The expansion of Medicaid under the ACA

50. Michelle M. Doty et al., *Coverage Gains Among Lower-Income Blacks and Latinos Highlight ACA’s Successes and Areas for Improvement*, COMMONWEALTH FUND (Aug. 15, 2017), https://www.commonwealthfund.org/blog/2017/coverage-gains-among-lower-income-blacks-and-latinos-highlight-acas-successes-and-areas?redirect_source=/publications/blog/2017/aug/coverage-gains-blacks-and-latinos.

51. Sara R. Collins et al., *New U.S. Census Data Show the Number of Uninsured Americans Dropped by 4 Million, with Young Adults Making Big Gains*, COMMONWEALTH FUND (Sept. 13, 2016), <https://www.commonwealthfund.org/blog/2016/new-us-census-data-show-number-uninsured-americans-dropped-4-million-young-adults-making>; *Health Insurance Coverage of Women 19-64*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/nonelderly-adult-women/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Sept. 5, 2018).

52. *Uninsured Rates for the Nonelderly by Race/Ethnicity*, KAISER FAM. FOUND., <https://www.kff.org/uninsured/state-indicator/rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Sept. 5, 2018).

53. See Munira Z. Gunja et al., *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care*, COMMONWEALTH FUND (Aug. 10, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/aug/how-affordable-care-act-has-helped-women-gain-insurance-and>.

54. Usha Ranjj et al., *Ten Ways That the House American Health Care Act Could Affect Women*, KAISER FAM. FOUND. 2 (2017), <http://files.kff.org/attachment/Issue-Brief-Ten-Ways-That-the-House-American-Health-Care-Act-Could-Affect-Women>.

55. Michael Karpman et al., *The Affordable Care Act’s Marketplaces Expanded Insurance Coverage for Adults with Chronic Health Conditions*, 37 HEALTH AFF. 600, 604 (2018).

56. *Id.* at 600.

not only provided insurance to those who were previously uninsured,⁵⁷ it has spurred investment in community health centers and providers who care for the most vulnerable patients,⁵⁸ while also supporting innovations like integrating behavioral health services into primary care and linking clinical care to social services.⁵⁹ VBC models have been particularly important in stimulating this type of innovation in care delivery for underserved populations, particularly through Medicaid accountable care organizations (ACOs).⁶⁰ Additionally, under the Obama administration, the § 1115 waiver program supported state experiments, particularly in Medicaid managed care to invest in upstream services. These two policy efforts are explored below.

B. Value-Based Care and Health Equity

A critical goal of the ACA was to reduce health care spending by prodding the health care system away from fee-for-service payment structures toward value-based payment linked to quality measurement.⁶¹ Section 3021 of the ACA created the Center for Medicare and Medicaid Innovation (CMMI) within CMS and provided the authority for the Secretary of the U.S. Department of Health and Human Services (HHS) to “test innovative payment and service delivery models to reduce program expenditures,” while not compromising, and preferably improving, the quality of care and health outcomes for the population served.⁶² The goals of this provision are to:

(1) nudge the health-care system into behaving in different ways in terms of how health professionals work in a more clinically integrated fashion, (2) measure the quality of their care and report on their performance, and (3) target for quality improvement serious and chronic health conditions that result in frequent hospital admissions and readmissions.⁶³

57. Larisa Antonisse et al., *The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review*, KAISER FAM. FOUND. 2 (2018), <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review>.

58. U.S. DEP’T. OF HEALTH & HUM. SERVICES ADMIN., THE AFFORDABLE CARE ACT AND HEALTH CENTERS 1, https://www.hrsa.gov/sites/default/files/about/news/2012tables/healthcenter_sacafactsheet.pdf (last visited Sept. 7, 2018).

59. See generally Bevin Croft & Susan L. Parish, *Care Integration in the Patient Protection and Affordable Care Act: Implications for Behavioral Health*, 40 ADMIN. POL’Y MENTAL HEALTH 258 (2012).

60. See *infra* notes 77–86 and accompanying text.

61. Tingyin T. Chee, et al., *Current State of Value-Based Purchasing Programs*, 133 CIRCULATION 2197, 2197–98 (2016).

62. 42 U.S.C. § 1315a (2010).

63. Rosenbaum, *supra* note 38, at 132.

CMMI has supported ACOs,⁶⁴ primary care medical homes,⁶⁵ and bundled payments.⁶⁶ While results have been mixed, some suggest that the early experiments in payment reform have been critical to informing second wave reform initiatives, have accelerated development of ACOs in the private market, and have led to important reforms in health care delivery.⁶⁷

The next generation of CMMI value-based payment initiatives have increasingly targeted specific populations, including the Medicaid population, and have incorporated a focus on addressing SDOH as part of quality care. For example, the Comprehensive Primary Care Plus initiative (CPC+), which builds on a parent program that “organized private insurers and state Medicaid programs to support primary care practices in providing higher-value primary care,” includes as a quality of care metric demonstration of screening for unmet social needs.⁶⁸ Learning from early payment reform initiatives has emphasized that social needs must be addressed as part of health care to not only bend the cost curve but also to provide effective, high quality health care.⁶⁹ A second catalyst for payment reform under the Obama administration that incorporated a population health approach with a recognition of the role of SDOH, was CMMI’s State Innovation Models (SIM) Initiative which awarded \$950 million to more than twenty-five states to test state initiated multi-payer payment and

64. *see* Tricia McGinnis & David Marc Small, *Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design*, CTR. FOR HEALTH CARE STRATEGIES, INC., Feb. 2012, at 1, 5. An Accountable Care Organization is a network of health care providers (e.g. physicians, hospitals) that shares medical and financial responsibility for coordinating care for patients with the goal of improving quality of care and limiting unnecessary spending. *See* ROBERT A. BERENSON ET AL., ACCOUNTABLE CARE ORGANIZATIONS – INTEGRATED DELIVERY SYSTEMS 2 (2016).

65. *See Advanced Primary Care: A Foundational Alternative Payment Model (APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care*, AM. ACAD. FAM. PHYSICIANS 1, 2 (Jan. 2017). A patient-centered medical home is a care delivery model that centralizes coordination of care with the primary care provider, focusing on the whole patient. It usually involves a team approach to meeting the patient and families need. *See* George L. Jackson, et al., *The Patient-Centered Medical Home*, 158 ANNALS INTERNAL MED. 169, 169 (2013).

66. Robert Mechanic, *Medicare’s Bundled Payment Initiatives: Considerations for Providers*, AM. HOSP. ASS’N. 1 (2016), <https://www.aha.org/system/files/content/16/issbrief-bundledpmt.pdf>. CMS introduced five models of payment reform in 2011: “The Pioneer and Advance Payment Accountable Care Organization (ACO) initiatives, the Bundled Payments for Care Improvement initiative, the Comprehensive Primary Care Initiative, the Partnership for Patients initiative, and the HealthCare Innovation Awards.” *Id.* at 214. Bundled payment is payment method by which the provider is reimbursed on the basis of expected costs for clinically-defined episodes of care (such as a hip replacement surgery). *See* Rocco J. Perla et al., *Government As Innovation Catalyst: Lessons From The Early Center For Medicare And Medicaid Innovation Models.*, 37 HEALTH AFF. 213, 214, 216 (2018).

67. Perla et al., *supra* note 66, at 214–15.

68. *Id.* at 217–18.

69. AARON MCKETHAN ET AL., IMPROVING QUALITY AND VALUE IN THE U.S. HEALTH CARE SYSTEM iii (2009).

delivery system reforms.⁷⁰ Many of the states that received a second round of SIM funding are testing innovations that explicitly address SDOH.⁷¹

Interestingly, a recent survey by Change Health Care showed that eight in ten payers are integrating SDOH into their programs by merging medical and demographic data to assess health risk based on social factors, training providers to screen for SDOH, and building partnerships with community-based services and resources.⁷² The promise of VBC models for identifying and addressing SDOH is that it can shift payment from purely medical services focused on downstream illness and disease to upstream services that prevent or reduce the consequences of (especially chronic) illness. One example of this shift is payment for community health workers who spend their time in the community, not in the medical office, working with vulnerable patients to address and prevent SDOH, such as poor housing or food insecurity, to keep them from initiating or exacerbating chronic (and expensive) health conditions.⁷³ As Daniel Dawes points out, investment in equity and addressing SDOH is not simply based on payers' altruism; it helps their bottom line:

Health systems are paying attention to disparities in the quality of their care and seeking remedies as health care costs rise and consumers demand action. They are doing so not just because it is the right thing to do, but because the financial incentives are increasingly aligning, the legal requirements are there, and their bottom lines benefit.⁷⁴

Nonetheless, the real question is whether VBC can be more effective in addressing SDOH and reducing disparities than fee-for-service payment. Some data suggests it is.⁷⁵ The Massachusetts Blue Cross Blue Shield Alternative

70. Samantha Artiga & Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, KAISER FAM. FOUND. 4 (2018), <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>.

71. *Id.*

72. Meg Bryant, *Survey: 80% of Payers Taking Steps to Address Social Determinants of Health*, HEALTH CARE DIVE (Feb. 14, 2018), <https://www.healthcaredive.com/news/survey-80-of-payers-taking-steps-to-address-social-determinants-of-health/516953/>; CHANGE HEALTHCARE, THE 8TH ANNUAL INDUSTRY PULSE REP. 14 (2018).

73. See Ruth C. Browne et al., *The Messenger Also Matters: Value-Based Payment Can Support Outreach to Vulnerable Populations*, HEALTH AFF. BLOG (July 10, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20120170.060981/full/>; see also *Support for Community Health Workers to Increase Health Access and Reduce Health Inequities*, AM. PUB. HEALTH ASS'N (Nov. 10, 2009), <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/14/19/support-for-community-health-workers-to-increase-health-access-and-to-reduce-health-inequities>.

74. Daniel E. Dawes, *Why Health Equity Matters in an Era of Health Care Transformation*, AAMC NEWS (Dec. 6, 2016), <https://news.aamc.org/patpati-care/article/health-equity-matters-health-care-transformation/>.

75. See e.g. Zirui Song et al., *Lower-Versus Higher-Income Populations in the Alternative Quality Contract: Improved Quality and Similar Spending*, 36 HEALTH AFF. 74, 80 (2017); NAT'L

Quality Contract, which uses global payment tied to quality measures, reports that quality has been improved in care for lower SES patients and that disparities have been narrowed.⁷⁶ On the other hand, there is concern that incentives in value-based payment (VBP) structures may motivate providers to avoid high need, high cost patients. In order to ensure vulnerable patients' needs are addressed, financial incentives need to be aligned, because:

The further we move toward APMs [Alternative Payment Models] with financial incentives that encourage providers to innovate, address social needs affecting health, and fundamentally change the way we provide care, the better things will be for our most vulnerable patients. While some organizations may be driven by a moral imperative to address social determinants of health, financial incentives could persuade organizations that might not otherwise do so to focus on their neediest clients.⁷⁷

One way to incorporate equity into payment structures is to reward providers who address SDOH as part of care and for reducing disparities in quality and access to care for vulnerable patients. In addition, health care providers who serve vulnerable populations can be supported through risk adjustment for social risk factors, in which payment is adjusted upward for high need patients.⁷⁸ While social risk adjustment is in its infancy, states such as Massachusetts are testing it as a mechanism to improve medical care for vulnerable populations.⁷⁹

C. Medicaid Reform and Social Determinants of Health

Medicaid programs, which serve the most vulnerable patient populations, are most likely to confront heightened challenges presented by SDOH.⁸⁰ Several states have initiated Medicaid ACO models to test payment reform in delivery of care to vulnerable populations.⁸¹ As of February 2019, twelve states have active Medicaid ACOs and ten additional states are developing them.⁸² Some states are actively using their ACO programs to address SDOH out of

QUALITY FORUM, A ROADMAP FOR PROMOTING HEALTH EQUITY AND ELIMINATING DISPARITIES: THE FOUR I'S FOR HEALTH EQUITY 31, 37 (2017).

76. Song, *supra* note 75, at 81.

77. Karen E. Joynt Maddox, *Financial Incentives and Vulnerable Populations — Will Alternative Payment Models Help or Hurt?*, 378 NEW ENG. J. MED. 977, 979 (2018).

78. NAT'L QUALITY FORUM, *supra* note 75, at 103–04.

79. See ARLENE S. ASH & ERIC MICK, UMASS RISK ADJUSTMENT PROJECT FOR MASSHEALTH PAYMENT AND CARE DELIVERY REFORM: DESCRIBING THE 2017 PAYMENT MODEL 3 (2016).

80. See Maddox, *supra* note 77, at 977–78.

81. CTR. FOR HEALTH CARE STRATEGIES, INC., *Medicaid Accountable Care Organizations: State Update 1* (2018), <https://www.chcs.org/media/ACO-Fact-Sheet-02-27-2018-1.pdf> (explaining that Medicaid Accountable Care Organizations “align provider and payer incentives to focus on value instead of volume, with the goal of keeping patients healthy and costs manageable.”).

82. *Id.*

recognition that to be successful, they must expand their services for high need, high cost patients who often have complex social and behavioral health needs.⁸³ At the end of the Obama administration, CMMI incentivized the approach through its Accountable Health Communities grants, which awarded grants to provider organizations to test models of screening for health-related social needs, associated referrals to community-based services, and support for navigation of those services.⁸⁴

The other mechanism by which state Medicaid programs have innovated around the SDOH is through the § 1115 waiver program. Under federal law, states may apply for a waiver from federal Medicaid program requirements to test and evaluate program innovations.⁸⁵ CMS explains that “Section 1115 demonstration projects present an opportunity for states to institute reforms that go beyond just routine medical care, and focus on evidence-based interventions that drive better health outcomes and quality of life improvements.”⁸⁶

Under the Obama administration, a key feature of the § 1115 waiver program was the Delivery System Reform Incentive Payment, or DSRIP programs, which provided states with funding to hospitals, particularly safety net hospitals, and other providers to experiment with different payment and delivery models.⁸⁷ Some states have used these waivers to focus on providing non-medical social services to Medicaid beneficiaries, such as transportation, housing supports, and food.⁸⁸ For example, through its § 1115 waiver, Oregon created regional Coordinated Care Organizations, which have the authority to fund housing improvements, temporary housing after hospital stays, and moving expenses if they can be shown to be health-related.⁸⁹ Under the Obama administration, CMS embraced addressing SDOH as a core component of health

83. *Addressing Social Determinants of Health Through Medicaid Accountable Care Organizations: Early State Efforts*, CTR. FOR HEALTH CARE STRATEGIES INC. (Feb. 14, 2018), <https://www.chcs.org/resource/addressing-social-determinants-health-medicare-accountable-care-organizations-early-state-efforts/>.

84. *CMS’ Accountable Health Communities Model Selects 32 Participants to Serve as Local “Hubs” Linking Clinical and Community Services*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Apr. 6, 2017), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-04-06.html>.

85. *About Section 1115 Demonstrations*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicare.gov/medicaid/section-1115-demo/about-1115/index.html> (last visited Aug. 23, 2018).

86. *Id.*

87. Jocelyn Guyer et al., *Key Themes from Delivery System Reform Incentive Payment (DSRIP) Waivers in 4 States*, KAISER FAM. FOUND. 1 (2015), <https://www.kff.org/medicaid/issue-brief/key-themes-from-delivery-system-reform-incentive-payment-dsrip-waivers-in-4-states/>.

88. *Id.*

89. Deborah Bachrach et al., *Medicaid Coverage of Social Interventions: A Road Map for States*, MILBANK MEM’L FUND 12 (2016), <https://www.milbank.org/wp-content/uploads/2016/09/MMF-NYS-Health-Issue-Brief-FINAL.pdf>.

care delivery innovation for Medicaid enrollees.⁹⁰ As we will see, CMS' use of the § 1115 waiver program under the Trump administration has shifted from this holistic approach to delivery system innovation to improve the health of the Medicaid population to one that is primarily concerned with ways to reduce the Medicaid rolls.

IV. HEALTH EQUITY AND SDOH UNDER THE TRUMP ADMINISTRATION: A DEPARTURE FROM PREVENTION AND EVIDENCE-BASED POLICY

While the Trump administration and Congressional Republicans failed in their efforts to repeal and replace the ACA, they have effectively undermined some of its core principles and provisions through legislation and administrative rules and actions. For example, the Republican led Congress dismantled the individual mandate penalty through the 2017 tax bill,⁹¹ and the Trump administration has supported short-term health insurance plans that would be exempt from the requirement to cover essential health benefits and protections for individuals with preexisting conditions,⁹² severely cut outreach and enrollment efforts,⁹³ delayed cost sharing reduction payments to help low-income people buy insurance,⁹⁴ frozen payments to insurance companies through the ACA's risk adjustment program,⁹⁵ and used § 1115 waivers to

90. *See id.* at 3–4.

91. *See The GOP Tax Bill Kills Obamacare's Individual Mandate. Here's What That Means*, TIME (Dec. 20, 2017), <http://time.com/money/5067044/gop-tax-plan-individual-mandate-obamacare/>.

92. Julie Appleby, *No Go For Idaho: State Will Have to Rethink Its "Freedom" Health Policies*, NAT'L PUB. RADIO (Mar. 9, 2018), <https://www.npr.org/sections/health-shots/2018/03/09/592475047/no-go-for-idaho-state-will-have-to-rethink-its-freedom-health-policies> (these plans undermine a foundational component of the ACA, which was to bring young, healthy people into health insurance pools. While the Trump administration rejected Idaho's bid to allow insurance products that clearly flaunt federal standards under the ACA, it has given the green light to short term plans as a way to get around the federal law. The Obama administration limited short-term plans to ninety days. The Trump administration has proposed that short-term plans can last up to one year.).

93. Rachana Pradhan, *Trump Administration Slashes Obamacare Outreach*, POLITICO (Aug. 31, 2017), <https://www.politico.com/story/2017/08/31/trump-obamacare-outreach-cuts-242225> (In August 2017, the Trump Administration cut the budget for advertising insurance enrollment under the ACA from \$100 million to \$10 million and the budget for navigator organizations—which assist individuals in identifying plans and signing up for them—from \$63 million to \$37 million.).

94. Danielle Kurtzleben & Scott Neuman, *Trump Administration to End Obamacare Subsidies for the Poor*, NAT'L PUB. RADIO (Oct. 12, 2017), <https://www.npr.org/2017/10/12/540920671/trump-administration-to-end-obamacare-subsidies-for-the-poor>.

95. Jennifer Hansler & Tami Luhby, *Trump Admin Temporarily Halting Some Payments Under Obamacare Program*, CNN (July 7, 2018), <https://www.cnn.com/2012/07/07/politics/wsj-aca-risk-adjustment/index.html> (suggesting these payments were designed to prevent "cherry picking" by insurers and payments are made to insurers who cover sicker patients).

curtail access to Medicaid.⁹⁶ The rollback of core ACA provisions not only threatens the ACA's expansion of access to care for previously uninsured and disenfranchised populations, it also backtracks on the policy supports and incentives initiated under the Obama administration to address SDOH as part of health care. As described earlier, a strong body of evidence illustrates that to reign in health care costs, improve quality of care, and promote population health, upstream preventive approaches that include both easy to access preventive care and strategies for tackling SDOH are critical. In addition to the administration's reversal of policies promoting prevention under the ACA, its proposed budget cuts to safety net programs and its rhetoric about vulnerable populations, inequality, and poverty all suggest a disregard for the evidence pointing to upstream causes of poor population health and health disparities—worsening structural inequality. Policy changes enacted and proposed under the Trump administration and the narrative supporting them are explored in greater detail below with a focus on how they will impact health equity.

A. *Prevention and Access to Care*

It is beyond the scope of this article to fully detail the potential effects of HHS regulatory changes and actions under the Trump administration affecting access to care for vulnerable populations, but it is clear that they are already having a significant effect. In 2016, the uninsured rate for individuals age 19 to 64 increased by 2.8%, meaning that four million people lost coverage. For states that did not expand Medicaid, uninsured rates rose to 21.9% in 2018.⁹⁷ Furthermore, the Trump administration's rejection of evidence-based preventive health care was starkly highlighted in April 2018 when CMS published its final rule restructuring the federal exchanges, which included providing "flexibility for the States to apply the definition of essential health benefits (EHB) to their markets."⁹⁸ As noted earlier, EHB have been particularly important in expanding access to preventive care for women, particularly low-income women. Giving states the green light to reduce preventive care will likely have a significant effect on the strides made under the Obama administration in promoting access to care for women. This action, coupled with the administration's 2017 rule, which allowed religious exemptions for businesses and nonprofits to the ACA's

96. See *infra* notes 77–86 and accompanying text.

97. Sara R. Collins et al., *First Look at Health Insurance Coverage in 2018 Finds ACA Gains Beginning to Reverse*, COMMONWEALTH FUND (May 1, 2018), <http://www.commonwealthfund.org/publications/blog/2018/apr/health-coverage-erosion>.

98. 83 Fed. Reg. 16930 (Apr. 17, 2018) (to be codified at 45 C.F.R. pts. 147, 153–58); Timothy Stoltzfus Jost, *Idaho's Actions Continue Challenges for ACA*, 37 HEALTH AFF. 523, 524 (2018) ("The proposed rule would give states discretion to adopt EHB benchmark plans or benchmark categories from other states. States could also create a new EHB benchmark plan so long as the new plan was equal in scope to a typical employer plan and no more generous than the most generous comparison plan.").

mandate that employers provide contraception in health insurance plans without cost sharing,⁹⁹ will exacerbate gender inequity. Studies suggest the abortion rate is at an all time low.¹⁰⁰ Reducing access to contraception will likely reverse this course.¹⁰¹

Another important indication of the administration's approach to prevention and the evidence base supporting upstream interventions that address SDOH is its appropriations and budget proposals. In the 2017 tax bill, Congress and the administration cut the ACA's Public Health and Prevention Trust Fund by \$750 million, gutting many community-based prevention efforts.¹⁰² President Trump has proposed several additional cuts to safety net programs: a \$1.4 billion cut to the Children's Health Insurance Program (CHIP) over ten years,¹⁰³ a \$17 billion reduction (twenty-two percent of the budget) in 2019 and a \$213 billion dollar cut over ten years to the Supplemental Nutrition Assistance Program (SNAP),¹⁰⁴ a \$3 billion cut to the Education Department,¹⁰⁵ and a \$6.8 billion cut to the federal Department of Housing and Urban Development (HUD), which amounts to a fourteen percent reduction in agency spending for public housing.¹⁰⁶ In the

99. Robert Pear et al., *Trump Administration Rolls Back Birth Control Mandate*, N.Y. TIMES (Oct. 6, 2017), <https://www.nytimes.com/2017/10/06/us/politics/trump-contraception-birth-control.html>; see Nate Raymond, *Judge Rejects Massachusetts Challenge to Trump Birth Control Rules*, REUTERS (Mar. 12, 2018), https://www.reuters.com/article/us-usa-trump-healthcare/judge-rejects-massachusetts-challenge-to-trump-birth-control-rules-idUSKCN1GO2M4?utm_campaign=KHN%3A%20Daily%20Health%20Policy%20Report&utm_source=hs_email&utm_medium=email&utm_content=61312998&_hsenc=p2ANqtz-8QDjRMZ1rL5oc0pn0xckZD1fcyALczUfNUVS7rpe6TRjt_YvzYIGxp5rXikO9si4tHAuiGsOXGtqrn_OB71Ir_MXL0PevdKEaWMVS7EZ_2UPz8KTE&_hsmi=61312998 (explaining that federal courts are split on whether the rule is a violation of federal law).

100. Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107 AM. J. PUB. HEALTH 1904, 1904 (2017).

101. See *id.* at 1907.

102. See Press Release, Am. Pub. Health Ass'n, *New Tax Bill Slashes Essential Funds, Creates Dangerous Conditions for Public Health* (Dec. 20, 2017); Ashley Yeager, *Cuts to Prevention and Public Health Fund Puts CDC Programs at Risk*, SCIENTIST (Feb. 9, 2018), <https://www.the-scientist.com/daily-news/cuts-to-prevention-and-public-health-fund-puts-cdc-programs-at-risk-30298>.

103. Kristina Peterson, *Congress Leery of Trump's Cuts to Children's Health Program*, WALL STREET J. (May 8, 2018), <https://www.wsj.com/articles/congress-leery-of-trumps-cuts-to-childrens-health-program-1525822614>.

104. Tracy Jan et al., *Trump Wants to Overhaul America's Safety Net with Giant Cuts to Housing, Food Stamps and Health Care*, WASH. POST (Feb. 12, 2018), https://www.washingtonpost.com/business/economy/trump-wants-to-overhaul-americas-safety-net-with-giant-cuts-to-housing-food-stamps-and-health-care/2018/02/12/a7cfd03e-102f-11e8-9570-29c9830535e5_story.html?utm_term=.37c456ef1ad7.

105. *What Trump Proposed Cutting in His 2019 Budget*, WASHINGTON POST (Feb. 16, 2018), https://www.washingtonpost.com/graphics/2018/politics/trump-budget-2019/?utm_term=.c1f2ded7b307.

106. Jan et al., *supra* note 104.

case of the reductions to HUD's budget, the administration said they were intended "to encourage the dignity of work and self-sufficiency" and "chart a new course for the future of public housing."¹⁰⁷ The 2017 tax cut which portends a large federal deficit will likely further fuel the administration and Congressional Republicans' argument that entitlement program and safety net cuts are needed. Given the strong evidence that food, education, and housing are critical SDOH, these severe cuts demonstrate the administration's dismissal of the inequities in access to basic needs and services experienced by many Americans, as well as the impact this lack of access has on their health.¹⁰⁸

The administration's depiction of poverty, inequality, and people enrolled in safety net programs embraces Reagan-era welfare reform narratives that were based on the notion that laziness and personal failings are the primary cause of poverty and poor health rather than structural, social, and economic inequality.¹⁰⁹ But perhaps even more striking is the administration's denial that poverty is even a problem in the U.S.¹¹⁰ In response to a United Nations (U.N.) report on extreme poverty and human rights in America, U.S. Ambassador Nikki Haley claimed that poverty "is down by 77 percent since 1980" and that there are "250,000 persons in 'extreme poverty' circumstances [living on less than \$4 a day],"¹¹¹ compared with the forty million people living in poverty and 18.5 million living in extreme poverty as cited by the U.N. report.¹¹² Similarly, a July 2018 report by the administration's Council of Economic Advisors paints an extremely rosy picture of poverty in America, suggesting that using a consumption-based measure of poverty, there are three percent of Americans who live in poverty, not the twelve to thirteen percent typically reported using

107. *Id.*

108. See generally Patricia Illingworth, *Making America Healthy Again: Analyzing Trump's Take on the Social Determinants of Health*, HEALTH AFF. BLOG (Aug. 11, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170811.061517/full/>.

109. See 'Welfare Queen' Becomes Issue in Reagan Campaign, N.Y. TIMES, Feb. 15, 1976, at 51 (Ronald Reagan famously perpetuated the trope of the "welfare queen," an African-American woman who abused the welfare system, as a political tool to criticize the social safety net.); see also Dylan Matthews, "If the Goal Was to Get Rid of Poverty, We Failed": The Legacy of the 1996 Welfare Reform, VOX (June 20, 2016), <https://www.vox.com/2016/6/20/11789988/clintons-welfare-reform>.

110. See Country Concerned Statement in Response to SR Alston's Country Report on the United States, U.S. MISSION GENEVA (June 22, 2018), <https://geneva.usmission.gov/2018/06/22/country-concerned-statement-in-response-to-sr-alstons-country-report-on-the-united-states/> (noting that accusations of the United States showing "contempt and hatred" for the poor, including accusations of a criminal justice system designed to keep low income persons in poverty, are "inaccurate, inflammatory, and irresponsible").

111. *Id.*

112. See Philip Alston, *Statement on Visit to the USA*, OHCHR (Dec. 15, 2017), <https://geneva.usmission.gov/2018/06/22/country-concerned-statement-in-response-to-sr-alstons-country-report-on-the-united-states/>.

an income-based measure (the standard measure of poverty).¹¹³ The report also boldly asserts that “material deprivation has fallen drastically over the past several decades.”¹¹⁴ Interestingly, the report gives credit to safety net programs for reducing poverty to these historic lows, but then proceeds to argue for work requirements to further reduce poverty due to the “decline in self-sufficiency” associated with the people who participate in the programs.¹¹⁵ Using questionable data, the report asserts that half of the people participating on safety net programs do not work even twenty hours per month.¹¹⁶ The clear narrative is that poor individuals who participate in safety net programs do so to avoid work.

As economist Jared Bernstein points out, this argument completely misses the social and structural factors that make full time work challenging for low-income workers:

It is true low-income adults often work less than higher-income ones, but their reduced hours of work are often a function of instability in the low-wage labor market, their weak access to work supports such as affordable child care and steep barriers to work such as discrimination and criminal records. Contrary to CEA’s [the Council of Economic Advisor’s] claims, health, housing and food support do not discourage work — they complement it.¹¹⁷

The Trump administration is clearly building its policies around “alternative facts” that support a depiction of American poverty and material deprivation as an insignificant problem or as a problem that is best dealt with by reducing supports to the poor. Given this narrative of poverty and deprivation, it is not surprising that the administration’s approach to health care delivery system reform as it relates to vulnerable populations has diverged considerably from that of the Obama administration.¹¹⁸ As noted earlier, payment reforms

113. THE COUNCIL OF ECON. ADVISORS, EXPANDING WORK REQUIREMENTS IN NON-CASH WELFARE PROGRAMS 26, 29 (2018).

114. *Id.* at 30.

115. *Id.* at 6.

116. *Id.* at 8.

117. Jared Bernstein, *The Trump Administration’s New Poverty Report Builds a Phony Rationale to Punish the Poor*, WASH. POST (July 16, 2018), https://www.washingtonpost.com/news/posteverything/wp/2018/07/16/the-trump-administrations-new-poverty-report-builds-a-phony-rationale-to-punish-the-poor/?utm_term=.92749dd4e14c.

118. See generally Atul Gawande, *Trumpcare vs. Obamacare*, NEW YORKER (Mar. 6, 2017), <https://www.newyorker.com/magazine/2017/03/06/trumpcare-vs-obamacare>; See Lena H. Sun & Juliet Eilperin, *CDC Gets List of Forbidden Words: Fetus, Transgender, Diversity*, WASH. POST (Dec. 15, 2017), https://www.washingtonpost.com/national/health-science/cdc-gets-list-of-forbidden-words-fetus-transgender-diversity/2017/12/15/f503837a-e1cf-11e7-89e8-edec16379010_story.html?utm_term=.b3a296174502 (Another indicator of the Trump Administration’s disdain for the prior administration’s approach to addressing inequality and to evidence-based policy was its directive to policy analysts at the Centers for Disease Control and Prevention to not use certain

promoting VBC over fee-for-service, while primarily focused on reducing costs and improving care delivery, have increasingly integrated measures to address SDOH for vulnerable patient populations. Below I explore the Trump administration's policies related to VBC and how these policies may affect attention to SDOH and health equity in health care delivery system reform.

B. Value-Based Care and Health Equity

There was a fair amount of speculation surrounding the Trump administration's approach to federally supported value-based payment demonstration projects initiated after passage of the ACA. Concern grew when Tom Price, Secretary of HHS, suggested to a group of physicians that "fee for service may not be the end of the world" and then canceled the federal mandatory bundled payment program for orthopedic and cardiac procedures.¹¹⁹ Price, a physician, was widely seen as favoring physician autonomy over mandating practice changes designed to reign in costs and improve quality, such as VBC. Price criticized mandatory demonstration models as an overreach by the Obama administration.¹²⁰ On the other hand, Price had supported the Medicare Access and CHIP Reauthorization Act (MACRA),¹²¹ which promotes VBC models, paying providers participating in Medicare based on performance and quality metrics through the Merit Based Incentive Payments System (MIPS).¹²² Health economist Gail Wilensky argued at the time that cancelation of the bundled payment programs did not indicate a large scale movement away from VBC, but rather a reasonable response to criticism of the programs.¹²³

Nonetheless, the Trump administration has indicated that its priorities with regard to VBC are essentially threefold: reducing regulatory burden, shifting from mandatory to voluntary demonstrations, and decreasing federal oversight of VBC. Seema Verma, Director of CMS, explained the shift this way: "We will move away from the assumption that Washington can engineer a more efficient

words. These words included, "'vulnerable,' 'entitlement,' 'diversity,' ... 'evidence-based' and 'science-based.'").

119. Abby Goodnough & Kate Zernike, *Trump Health Agency Challenges Consensus on Reducing Costs*, N.Y. TIMES (Nov. 12, 2017), <https://www.nytimes.com/2017/11/12/health/doctor-pay-trump.html>.

120. Gail Wilensky, *CMS, Demonstration Projects, and the Future of Value-Based Payments*, 95 MILBANK Q. 710, 710 (2017).

121. *Id.* at 711. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is bipartisan legislation which repealed the Sustainable Growth Rate Formula used to reimburse providers through Medicare. *What is MACRA*, NETWORK FOR REG'L HEALTHCARE IMPROVEMENT, <http://www.nrhi.org/work/what-is-macra/what-is-macra/>. MACRA uses a value-based payment structure to reward clinicians for value over volume and streamlines quality measurement through the Merit Based Incentive Payments System (MIPS). *Id.*

122. *What is MACRA*, *supra* note 121.

123. *See* Wilensky, *supra* note 120, at 710–11.

health-care system from afar—that we should specify the processes health-care providers are required to follow.”¹²⁴

In October 2017, the administration announced its “patients over paperwork” initiative to address the burden of regulatory requirements on providers in order to help them focus on patients.¹²⁵ In January 2018, the administration announced that it was replacing the mandatory bundled payment model it had canceled with a voluntary program covering thirty-two clinical episodes.¹²⁶ This announcement came after the departure of Price and was a harbinger that the administration was not abandoning VBC, but rather was scaling back the federal pressure exerted by the Obama administration to accelerate the move from fee-for-service to VBC. Then, to the surprise of many, Alex Azar, who was appointed by Trump to replace Price as Secretary of HHS, not only expressed commitment to VBC, but seemed to suggest that HHS would play a large role in promoting it:

There is no turning back to an unsustainable system that pays for procedures rather than value. In fact, the only option is to charge forward — for HHS to take bolder action, and for providers and payers to join with us. This administration and this President are not interested in incremental steps. We are unafraid of disrupting existing arrangements simply because they’re backed by powerful special interests.¹²⁷

What are we to make of the administration’s commitment to VBC and what will it mean for VBC’s role in promoting health equity and addressing SDOH? The administration, while still committed to advancing VBC, has indicated that it will take a much less aggressive approach to using regulation and federal oversight to promote systems change than did the Obama administration. While reductions in regulation may alleviate some of the paperwork pressure on providers (which, no doubt, is a problem), it is not clear that regulations attached to VBC are the predominant cause of provider stress. The shift to electronic medical records, patient volume, and other factors are also leading to provider

124. Seema Verma, *Medicare and Medicaid Need Innovation*, WALL ST. J., Sept. 20, 2017, at A17.

125. Seema Verma, Admin’r, Ctrs. for Medicare & Medicaid Servs., Remarks by Administrator Seema Verma at the Health Care Payment Learning and Action Network (LAN) Fall Summit (Oct. 30, 2017).

126. Shannon Muchmore, *Trump Admin’s New Bundle Bid Shows Value-Based Care’s Staying Power*, HEALTHCARE DIVE (Jan. 12, 2018), <https://www.healthcaredive.com/news/trump-admins-new-bundle-bid-shows-value-based-cares-staying-power/514701/>.

127. Alex M. Azar II, Sec’y, Remarks on Value-Based Transformation to the Federation of American Hospitals, U.S. DEP’T OF HEALTH & HUMAN SERVS., (Mar. 5, 2018), <https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html>.

stress and burnout.¹²⁸ Since many systems are already entrenched in VBC, reducing CMS' presence and oversight may in fact lead to more confusion and less uniformity in approaches.

While the administration does not, at this time, appear to be retreating from VBC, the question of VBC's continuing role in incentivizing payer and provider attention to SDOH and health equity is unclear. Efforts to incorporate identification of and response to SDOH as part of VBC will not go away. But this type of system innovation is challenging and is unlikely to continue without strong federal and state government support. For example, funding for the State Innovation Models (SIM) grants is set to end in 2018 and 2019.¹²⁹ Further federal support for such efforts is not on the horizon from CMMI. Without federal support, it is unclear whether states will continue to have the resources and commitment to maintain pilot projects, many of which have focused on integrated health care delivery models addressing SDOH.¹³⁰

The federally funded Accountable Health Communities Initiative, which incentivizes strategies for identifying and addressing SDOH as part of health care, also has an uncertain future. It does not appear to be an ongoing priority for the Trump administration.¹³¹

C. Medicaid Reform and the Social Determinants of Health

As noted earlier, the Trump administration's rhetoric blaming the poor for their own misfortune has been used to support massive proposed cuts to the social safety net. This welfare reform approach has been particularly stark in the administration's approach to the Medicaid program. Hostile to the expansion of Medicaid under the ACA (and to the expansion of the program in general), the administration and its congressional partners have sought ways to cut funding for and enrollment in Medicaid. Republican ACA repeal and replace proposals sought to turn Medicaid into a block grant program, reducing overall federal funding while giving states greater flexibility in how they spend federal dollars

128. Tait D. Shanafelt et al., *Relationship Between Clerical Burden and Characteristics of the Electronic Environment With Physician Burnout and Professional Satisfaction*, 91 *MAYO CLINIC PROC.* 836, 836, 844 (2016).

129. CTRS. FOR MEDICARE & MEDICAID SERVS., STATE INNOVATION MODELS (SIM) ROUND 2: MODEL TEST ANNUAL REPORT TWO D-8 (2018), <https://downloads.cms.gov/files/cmimi/sim-round2test-secondannrpt.pdf>.

130. See, e.g., Samantha Artiga & Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, Kaiser Fam. Found. (2018), <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>.

131. See *Verma Outlines Vision for Medicaid, Announces Historic Steps Taken to Improve the Program*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Nov. 7, 2017), <https://www.cms.gov/newsroom/press-releases/verma-outlines-vision-medicaid-announces-historic-steps-taken-improve-program>.

(as was done with the TANF program through welfare reform in 1996).¹³² This strategy for reducing Medicaid spending is unlikely to go away despite the failed repeal and replace bills in 2017. In the meantime, however, the administration is doing its best to reduce Medicaid enrollment through welfare reform-like mechanisms using the § 1115 waiver program.¹³³ The waiver program provides authority to CMS to waive certain provisions of the Medicaid law in order to approve state experiments and demonstration projects that “promote the objectives of Medicaid.”¹³⁴

The Trump administration use of § 1115 waivers is a vast departure from the original intent of the program and from past administrations’ use of it. As Medicaid policy expert Sara Rosenbaum describes, “Historically, 1115 demonstrations have been built on a common value of improving care for the most vulnerable and the goal of making the program stronger and more effective. These values and goals shaped Medicaid eligibility expansion demonstrations, as well as demonstrations to strengthen health care.”¹³⁵ In January 2018, CMS issued a solicitation for waiver applications that will “support state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries.”¹³⁶ In a *Washington Post* op-ed, CMS Director Seema Verma cites Medicaid expansion under the ACA as the reason behind the administration’s embrace of work requirements, saying that the law “fundamentally changed Medicaid by shifting predominantly low-income adults — often without children, healthy and working-age — into a program that wasn’t designed for them.” She argues that the goal of such work requirements is “to help the new able-bodied, working-age Medicaid population unlock their fullest potential.”¹³⁷ Further, she suggests that work requirements are the

132. See, e.g., Rachel Garfield et al., *State-by-State Estimates of Changes in Federal Spending on Health Care Under the Graham Cassidy Bill*, KAISER FAM. FOUND. 1 (Sept. 2017), <http://files.kff.org/attachment/Issue-Brief-State-by-State-Estimates-of-Changes-in-Federal-Spending-on-Health-Care-Under-the-Graham-Cassidy-Bill>; R. Kent Weaver, *The Structure of the TANF Block Grant*, BROOKINGS INST. 1 (Apr. 2011), <https://www.brookings.edu/wp-content/uploads/2016/06/pb22.pdf>.

133. See Sara Rosenbaum, *Weakening Medicaid from Within*, AM. PROSPECT (Oct. 19, 2017), <http://prospect.org/article/weakening-medicaid-within>.

134. See CTRS. FOR MEDICARE & MEDICAID SERVS., *Section 1115 Demonstrations*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/section-1115-demo/index.html> (last visited Aug. 28, 2018); see also Verma *Outlines Vision for Medicaid, Announces Historic Steps Taken to Improve the Program*, *supra* note 131.

135. Rosenbaum, *supra* note 133.

136. See Ctrs. for Medicare & Medicaid Servs., RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries (Jan. 11, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>.

137. Seema Verma, *Making Medicaid a Pathway Out of Poverty*, WASH. POST (Feb. 4, 2018), <https://www.washingtonpost.com/opinions/making-medicaid-a-pathway-out-of-poverty/2018/>

“compassionate” policy, since they make Medicaid “a path out of poverty” by helping people to “achieve the dignity and self-sufficiency they deserve.”¹³⁸

Verma’s arguments in support of work requirements for Medicaid eligibility are flawed in several ways. First, she builds on a long history of efforts to distinguish between the deserving and the undeserving poor; in this case, she presumes that “able-bodied” adults would not be poor and would have access to health insurance if they simply worked harder.¹³⁹ Second, work requirements are a solution without a problem. As the Kaiser Family Foundation has reported, the majority of adults on Medicaid work or have a reason for not working, such as disability, being enrolled in school, or being a caretaker.¹⁴⁰ Kaiser estimates that only about seven percent of the Medicaid population does not work at all or would otherwise not be exempt from work requirements.¹⁴¹ Third, the evidence that being enrolled in Medicaid somehow makes people less likely to work is one-sided and misleading. While it is true that work can be a positive social determinant of health,¹⁴² it is also true that health is critical to a person’s ability to work. Living in poverty and the SDOH associated with it—including food insecurity, unsafe housing, lack of access to quality education, and neighborhood and environmental exposures—are highly correlated to bad

02/04/4570736a-0857-11e8-94e8-e8b8600ade23_story.html?utm_term=.a81492efa440. The specifics of work requirements vary by state, but generally they require that Medicaid recipients demonstrate that they are working or in some cases, engaged in community service in order to maintain insurance coverage. MaryBeth Musumeci et al., *Medicaid and Work Requirements: New Guidance, State Waiver Details and Key Issues*, KAISER FAM. FOUND. (Jan. 16, 2018), <https://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements-new-guidance-state-waiver-details-and-key-issues/>. States generally exempt those who can prove that they are disabled or are caregivers. *See id.*

138. Verma, *supra* note 137.

139. *See* Emily Badger & Margot Sanger-Katz, *Who’s Able-Bodied Anyway?* N. Y. TIMES (Feb. 3, 2018), https://www.nytimes.com/2018/02/03/upshot/medicaid-able-bodied-poor-politics.html?utm_campaign=KHN:%20Daily%20Health%20Policy%20Report&utm_source=hs_email&utm_medium=email&utm_content=60442703&_hsenc=p2ANqtz—BwwKu6Dyb2kJCTuqZv2klMzFYsOkeDzZKyrAjquXcp_HjMqO5nl-jFst4f44qJDRo3wh_lpFhQg4vD5y5nA81mifXXGRgyAaPnL0ghMwEjfkf5RY&_hsmi=60442703.

140. Musumeci et al., *supra* note 137.

141. *Id.* (explaining “[s]ix in ten Medicaid adults are already working [graph omitted]. Among those who are not working, most report illness or disability, caregiving responsibilities, or going to school as reasons for not working. Many of these reasons would likely qualify as exemptions from work requirement policies. This would leave 7% of the population to whom work requirement policies could be directed, including those who report they are not working because they are looking for work and unable to find a job.”).

142. *See, e.g.*, GORDON WADDELL & A. KIM BURTON, *IS WORK GOOD FOR YOUR HEALTH AND WELL-BEING?* 35–36 (2006), <https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being>.

health.¹⁴³ As described in Part II, the working poor have worse health outcomes than those from higher income groups and are more likely to suffer from chronic disease.¹⁴⁴ Restricting access to regular preventive care and chronic disease management will make it *less* likely that the Medicaid population will be able to work, not *more*. In fact, research indicates that Medicaid has been critical in reducing poverty.¹⁴⁵ Fourth, work requirements ignore the reality of work for low-wage workers. They are much more likely to work in unstable jobs without health benefits that have shifting work schedules.¹⁴⁶ Low wage workers who are eligible for Medicaid are likely to have difficulty meeting the hourly work requirements, not because they do not work, but because their work may not fit into the confines of the rules.¹⁴⁷ Finally, the work requirements, though ostensibly about helping people become self-sufficient, seem clearly designed to cull the rolls in order to save money.¹⁴⁸ Given the evidence that most Medicaid recipients are either working or will qualify for an exemption, it is difficult not to conclude that the requirements are simply being erected as an obstacle course to make it more difficult for vulnerable people to stay enrolled in Medicaid.

While CMS has granted waivers to Kentucky, Indiana, New Hampshire, and Arkansas to impose work requirements as part of their Medicaid programs, Kentucky's "HEALTH" program has received the most attention, both because it was the first to be approved by CMS and because it has been challenged in

143. See Monica Peek, *Poverty's Association with Poor Health Outcomes and Health Disparities*, HEALTH AFF. BLOG (Oct. 30, 2014), <https://www.healthaffairs.org/doi/10.1377/hblog.20141030.041986/full/>.

144. Kate M. Shaw et al., *Chronic Disease Disparities by County Economic Status and Metropolitan Classification, Behavioral Risk Factor Surveillance System, 2013*, 13 PREVENTING CHRONIC DISEASE: PUB. HEALTH RES., PRAC., & POL'Y, 1, 1, 3, 5 (2016).

145. Dahlia K. Remler et al., *Estimating the Effects of Health Insurance and Other Social Programs on Poverty Under the Affordable Care Act*, 36 HEALTH AFF. 1828, 1834 (2017).

146. SARA R. COLLINS ET AL., WAGES, HEALTH BENEFITS, AND WORKERS' HEALTH, COMMONWEALTH FUND 2 (2004), <https://pdfs.semanticscholar.org/cab7/8e7c5a22e2e4b74b5840097afd9c4d0388e3.pdf>; KRISTIN F. BUTCHER & DIANE WHITMORE SCHANZENBACH, MOST WORKERS IN LOW-WAGE LABOR MARKET WORK SUBSTANTIAL HOURS, IN VOLATILE JOBS, CTR. BUDGET POL'Y PRIORITIES 4 (2018), <https://www.cbpp.org/sites/default/files/atoms/files/7-24-18pov.pdf>.

147. ADAM SEARING, STATE MEDICAID WORK RULES IGNORE THE REALITY OF WORKING LIFE FOR AMERICANS IN LOW WAGE JOBS (2018), <https://ccf.georgetown.edu/2018/03/16/state-medicaid-work-rules-ignore-the-reality-of-working-life-for-americans-in-low-wage-jobs/>.

148. Ashley Kirzinger et al., *Kaiser Health Tracking Poll—February 2018: Health Care and the 2018 Midterms, Attitudes Towards Proposed Changes to Medicaid*, KAISER FAM. FOUND. (Mar. 1, 2018), <https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2018-health-care-2018-midterms-proposed-changes-to-medicaid/> (Public opinion polls show that more Americans believe the work requirements are aimed at reducing spending than believe they are aimed at lifting people out of poverty.).

court.¹⁴⁹ Several additional states have submitted applications to CMS for waivers to impose work requirements.¹⁵⁰ Kentucky's HEALTH would have required that non-disabled adults demonstrate that they have participated in eighty hours of work, education, job training, or other community service each month in order to maintain coverage.¹⁵¹ It also would have levied cost sharing for recipients.¹⁵²

In January 2018, fifteen Medicaid enrollees filed a class action law suit, *Stewart v. Azar* against the Secretary of HHS in the U.S. District Court for the District of Columbia.¹⁵³ Enrollees alleged that the Secretary's use of the § 1115 waiver to allow Kentucky to impose work requirements overstepped the bounds of his authority, which can be invoked only for experiments that further program objectives.¹⁵⁴ On June 29, 2018, a federal judge from the U.S. District Court for the District of Columbia enjoined Kentucky from implementing the requirement ruling that:

The Secretary [of the U.S. Department of Health and Human Services] never adequately considered whether [the work requirement] would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid. This signal omission renders his determination arbitrary and capricious ... The Secretary never provided a bottom-line estimate of how many people would lose Medicaid with Kentucky HEALTH in place. This oversight is glaring, especially given that the risk of lost coverage was "factually substantiated in the record."¹⁵⁵

The plaintiffs argued, and the court agreed, that while the Secretary has the authority to grant waivers to states to conduct experiments or pilot demonstration projects in their Medicaid programs, he must assess if the plan is "likely to assist in promoting the objectives" of the Medicaid Act.¹⁵⁶ If the state's program makes it harder for eligible recipients to obtain medical coverage, they argued, then it is not promoting the objectives of the Act.¹⁵⁷ The Secretary also "must consider adequately" the impact of the state's plan on Medicaid coverage.¹⁵⁸ The Secretary's failure to do so in granting Kentucky's waiver was

149. Phil Galewitz, *Judge Blocks Kentucky Medicaid Work Requirement*, KAISER HEALTH NEWS (June 29, 2018), <https://khn.org/news/judge-blocks-kentucky-medicaid-work-requirement/>.

150. *Id.* (explaining Arizona, Kansas, Maine, Mississippi, Ohio, Utah and Wisconsin have applications pending with the federal government).

151. *FAQ- KentuckyHealth*, KY.GOV, <https://kentuckyhealth.ky.gov/Pages/FAQ.aspx> (last visited Nov. 18, 2018).

152. *Id.*

153. *Stewart v. Azar*, 313 F. Supp. 3d 237, 243 (D.D.C. 2018).

154. *Id.* For a description of the specific claims made in the complaint, see Sara Rosenbaum, *Experimenting on the Health of the Poor: Inside Stewart v. Azar*, HEALTH AFF. BLOG (Feb. 5, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180204.524941/full/>.

155. *Stewart*, 313 F. Supp. 3d at 262.

156. *Id.* at 254.

157. *Id.* at 250, 265.

158. *Id.* at 260.

therefore arbitrary and capricious.¹⁵⁹ Kentucky Governor, Matt Bevin, had boasted that, with the new work requirement, the state would likely reduce its Medicaid rolls by 90,000 to 95,000 people and accrue projected savings of \$2.4 billion over five years.¹⁶⁰

Kentucky officials have interpreted the ruling narrowly, suggesting that they will work with CMS to remedy “the single issue” (presumably the Secretary’s failure to consider loss of coverage for Medicaid recipients in the state) raised by the court.¹⁶¹ Republican governors in states that have not expanded Medicaid have suggested that without the ability to impose work requirements, they will not entertain expansion to low-income adults.¹⁶² Governor Bevin in Kentucky responded to the court ruling by saying that he will seek further cuts to benefits to save the state money.¹⁶³ As of July 18, 2018, CMS announced that it would open a new public comment period on Kentucky’s waiver in order to abide by the court decision.¹⁶⁴ Secretary of HHS, Alex Azar, stated that he is undeterred by the court’s decision.¹⁶⁵ “We’re fully committed to work requirements and community participation in the Medicaid program ... we will continue to litigate, we will continue to approve plans, we will continue to work with states. We are moving forward.”¹⁶⁶ It remains to be seen how the administration will address the court’s requirement that it address the evidence demonstrating that work requirements, as imposed in Kentucky, will leave nearly 100,000 otherwise eligible people without health coverage.

The administration’s approach to Medicaid reform flies in the face of the large body of empirical evidence that demonstrates the burden of a whole host of SDOH that disproportionately harm the health of low-income and vulnerable people. Rather than using the Medicaid program to test system delivery reforms that support recipients to live healthier lives by addressing SDOH, as many § 1115 waiver demonstration projects did during the Obama administration, the Trump administration is taking a punitive approach to poverty and disadvantage,

159. *Id.*

160. Tami Luhby, *Kentucky is First State Ever to Require Medicaid Recipients to Work*, CNN MONEY (Jan. 12, 2018), http://money.cnn.com/2018/01/12/news/economy/kentucky-medicaid-work-requirements/index.html?wpisrc=nl_health202&wpm=1.

161. Galewitz, *supra* note 149.

162. *See id.*

163. Galewitz, *supra* note 149.

164. Harris Meyer, *CMS to Open New Comment Period on Kentucky Medicaid Waiver*, MOD. HEALTHCARE (July 18, 2018), <http://www.modernhealthcare.com/article/20180718/NEWS/180719901>.

165. Colby Itkowitz, *The Health 202: Trump Administration ‘Undeterred’ by Court Ruling Against Medicaid Work Requirements*, WASHINGTON POST (July 27, 2017), <https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/07/27/the-health-202-trump-administration-undeterred-by-court-ruling-against-medicaid-work-requirements/5b5a10bb1b326b1e64695577/>.

166. *Id.*

using the program to deny health insurance to the most needy. Treating health care, in particular preventive health care, as a privilege that must be earned by jumping through state administered hoops will only increase health disparities, raise health care costs, and reverse what has been critical momentum toward improving population health.

V. CONCLUSION

The shift in policy under the Trump administration belies not only an indifference to the compelling evidence that SDOH are significant drivers of poor health, health disparities and health care costs, but also a fundamental rejection of the goals and values of public health and public health law. At its core, public health seeks ways to improve the health of populations through equitable distribution of resources. Evidence-based public health laws promote strategies that move society toward more just and equitable opportunities for people to be healthy. The Trump administration's denial of structural inequality as a root cause of health disparities and its punitive policies toward the poor will only exacerbate worsening population health in the U.S. Despite some support for VBC, the administration's focus on dismantling the social safety net will undermine efforts to better integrate social services with health care. By reducing access to Medicaid through work requirements and funding cuts, efforts to use Medicaid programs as a way to engage vulnerable populations in holistic systems of care are also being threatened. While states, payors, and providers will likely continue to focus on and innovate around approaches to SDOH, their efforts may ultimately be in spite of Trump administration policies, not because of them.

