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Balancing Personal Responsibility with Access to Care; Confirmation Proceedings Begin for Seema Verma, Architect of Indiana's Medicaid Program

President Donald Trump's nominee for the Administrator of the Centers for Medicare & Medicaid Services (CMS), Seema Verma, will begin her confirmation process this week. The Senate Committee on Finance is expected to hold a confirmation hearing to consider her nomination on Thursday, February 16, 2017. As CMS Administrator, Verma would be able to shape Medicaid, particularly through granting waivers to state programs. These hearings are an opportunity for advocates to better understand how Verma's leadership will change the direction of Medicaid, an important program for vulnerable individuals.

Ms. Verma, a [health care consultant](#) has worked on several high profile Medicaid expansion proposals that encompass controversial provisions, such as work requirements and lockout periods. Her work reflects her [belief](#) that the "Medicaid program has not kept up with the modern healthcare market [because] its rigid complex rules designed to protect enrollees have also created an intractable program that does not foster efficiency, quality of personal responsibility." For the past eight years, the Obama Administration has opposed or had serious reservations about many incentives, penalties, and other tools often espoused by Verma. Verma's tenure as CMS Administrator may be a period in which states are given greater flexibility to experiment with these types of Medicaid requirements in the interest of encouraging personal responsibility among enrollees. Unfortunately, some of these provisions, when incorporated without care to the realities of many low income individuals, may prevent vulnerable people, such as those living with chronic illnesses and disabilities, from accessing appropriate care when needed.

Advocates Should:

1. Advocates should reach out to Senators serving on the [Finance Committee](#) and encourage them to ask Verma to clarify her position on certain provisions, such as premium requirements, and to commit to protecting access to care for Medicaid enrollees.
2. Advocates should closely monitor the confirmation hearings to gain visibility into the Trump Administration's priorities and intentions for Medicaid.
3. Advocates should review the Medicaid expansion proposals that Seema Verma has helped develop, including Indiana and Kentucky, for a better sense of the flexibility Verma may promote with respect to state Medicaid programs.

Advice and Consent; The Process for Appointing the CMS Administrator

The Constitution divides responsibility for appointing high-level positions within the executive branch between the President and the Senate. These appointments are often referred to as "advice and consent positions" or "PAS positions". CMS Administrator, although not a Cabinet position, is considered high-level enough to require Senate confirmation of the

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Presidential nominee for this position. The Senate confirms a nominee by holding a hearing with the candidate and then taking a vote on whether or not to confirm the nomination. The hearings, which are held by the relevant Senate Committee, are an opportunity to probe the nominee's policy perspectives and force him or her to articulate positions on relevant issues "on the record."

The [Senate Committee on Finance](#) has jurisdiction to hold the confirmation hearings for CMS Administrator. The Finance Committee's hearing for Verma will happen on February 16, 2017. The final confirmation vote, taken by the entire Senate, will likely occur in later in February. Historically, the Senate has confirmed the vast majority of all executive branch nominations. Because health policy issues have become so contentious, however, the position of CMS Administrator has become more politicized in recent years. The Obama Administration saw several occasions when the agency was headed by an acting administrator for an extended period of time due to Congressional opposition.

A Short Dive into Healthy Indiana Plan 2.0, An Example of Seema Verma's Approach to Medicaid

Ms. Verma's highest profile Medicaid project was shaping then Governor Michael Pence's Healthy Indiana Plan 2.0 (HIP 2.0), a Medicaid expansion proposal implemented in 2015. This is also likely the project that brought her to the attention of the current Administration. As such, advocates should review HIP 2.0 as well as the available data on its outcomes to better understand the direction in which Verma may take CMS as Administrator. The key takeaways from HIP 2.0 are its emphasis on personal responsibility, including incentives not often used in Medicaid such as health savings accounts, as well as access to care concerns stemming from the complexity of the program and the potential deterrence effect of premiums requirements.

HIP 2.0 is designed to encourage personal responsibility regarding medical spending by utilizing health savings accounts, high deductible health plans, premiums, and co-payments. HIP 2.0 includes two types of coverage, HIP Plus and HIP Basic. Approximately 65% of enrollees are in HIP Plus with 35% enrolled in HIP Basic. HIP Plus has significantly expanded benefit coverage as compared to HIP Basic, including both dental and vision. HIP Basic requires co-payments for services, while HIP Plus only requires co-payments for non-emergency use of the emergency room. People with incomes between 100-138 percent of FPL are enrolled in HIP Plus and are required to pay premiums ranging from \$1-27 per month. Failure to pay premiums at this level of income can result in loss of coverage and being barred from reenrolling in either HIP program for six months. People with incomes below 100 of FPL have the choice to either pay premiums and enroll in HIP Plus or forgo premiums and enroll in HIP Basic. Enrollees in both HIP Plus and HIP Basic are given a Personal Wellness and Responsibility (POWER) account, which operates very similarly to a health savings account. All enrollees have \$2,500 in their POWER accounts, which are funded by state contributions and premiums paid by the enrollees. The POWER accounts are complimented by a high-deductible health plan that covers costs when the POWER account is fully spent. To provide an incentive to spend wisely, a portion of the funds left in the POWER accounts at the end of the year for HIP Plus enrollees may be rolled over to reduce premiums for the following year. To provide an incentive to obtain preventive care, HIP Plus enrollees can roll over a larger amount of left over POWER account funds if they obtain adequate preventive care. HIP Basic enrollees are required to obtain preventive care and are only allowed to roll over funds if they do so.

The impact that HIP 2.0 has had on access to care is still being studied. However, [research](#) from other Medicaid demonstration projects demonstrates that premiums, even nominal ones, significantly reduce low-income participation in health coverage programs. Enrollment in HIP 2.0 has also been significantly lower than predicted. Indiana estimated that HIP 2.0 would cover 350,000 then-uninsured individuals, but only 207,000 enrolled. The discrepancy in enrollment may be due to the complexity of the program, or the deterrence effect of the premium requirements. About one-third of individuals who apply to HIP 2.0 are found eligible but do not enroll because they fail to make the required premium payment. Additionally, in a [survey](#) of HIP 2.0 enrollees who were moved from Plus to the more limited Basic due to non-payment of premiums, the most frequently cited reason was confusion about the payment process and understanding which HIP 2.0 plan they were enrolled in. There

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are also concerns regarding the effectiveness of HIP 2.0's incentives for preventive care and access to care for HIP Basic enrollees.

Verma's Previous Medicaid Work Suggests Emphasis on Personal Responsibility But Also Some Access to Care Concerns

Ms. Verma has worked on several Medicaid 1115 waivers¹ beyond HIP 2.0, including proposals for Iowa, Kentucky, Tennessee, and Ohio. She also helped develop a [position paper](#) on Medicaid reform for the Republican Governors Public Policy Committee. Her guiding principles have often been personal responsibility for Medicaid enrollees as well as greater flexibility for the states to experiment with various structures, including shaping Medicaid to look more similar to the private insurance markets. Although each proposal was tailored to reflect the needs of that particular state, the proposals Ms. Verma has been involved with often have similar hallmarks, including:

- **Monthly Premiums:** Several of the Medicaid proposals that Verma has shaped include requirements for Medicaid enrollees to make monthly payments. The purpose of these premiums as well as the health savings accounts they fund is to emphasize personal responsibility for healthcare choices, even for lower income individuals. Unfortunately, premiums may present a challenge for vulnerable individuals, such as those living with chronic illnesses and disabilities. Individuals already struggling to manage their conditions on limited budgets may find paying the monthly premiums difficult. They may also be living in unstable situations in which remembering to pay the premium could be challenging.
- **Work Requirements:** Verma has espoused proposals, such as in Kentucky, that would require Medicaid enrollees to either pay premiums, be employed, or volunteer for a charity in order to maintain certain funding and financial support. Work requirements for Medicaid enrollees have been controversial in the past, with the Obama-era CMS rejecting almost all proposals for such requirements. Employment can be challenging for individuals managing chronic illnesses and disabilities, so work requirements, if not reflective of the realities these individuals face, can pose a challenge to access to care.
- **Health Savings Accounts Coupled with High Deductible Health Plans:** Traditionally, Medicaid has covered all health care costs from the "first dollar" spent. Verma's projects, however, seek to modify Medicaid's structure to resemble more closely the private insurance markets by introducing health savings accounts coupled with high deductible coverage. For most of her proposals, individuals are provided some sort of savings account, funded in part by the state and in part by enrollee premiums, that is supposed to fund initial health care spending. For example, the Kentucky proposal enrolls all individuals in a health plan that carries a \$1,000 deductible and enrollees are given an account with \$1,000 to fund the initial spending. In theory, this should make enrollees more thoughtful about the health care they consume because money left over in the savings accounts can be rolled over to help with premiums or other services in the following year. Unfortunately, [research](#) demonstrates that enrollees often do not know about their accounts or do not find these incentives compelling. Additionally, this financing structure could form a major barrier to care if states decide not to fully fund the individual accounts to cover the full amount of the deductible. Advocates should make sure they understand how health savings accounts and high deductible health plans interact and closely monitor the funding proposals for these accounts.

¹ States can request permission to run experimental, pilot, or demonstration projects to promote the objectives of Medicaid by submitting what is called an 1115 waiver to CMS for approval. Generally, 1115 waivers are only approved when they will increase or strengthen overall coverage of low income individuals in the state; increase access to, stabilize, or strengthen provider and provider networks for Medicaid; improve health outcomes; or increase the efficiency and quality of care provided. These projects must also be budget neutral for the federal government. 1115 waivers are generally approved for five years, with three year extensions possible. For more on 1115 waivers, please see the Kaiser Family Foundation's fact sheet [here](#).

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- **Lockout Periods:** A recurring component in the Medicaid proposals generated by Verma is penalties for failing to pay premiums, including lockout periods. In both Indiana and Kentucky, Verma proposed that individuals with incomes above the poverty line who fall behind on their premium payments by over 60 days would be locked out of coverage for six months. This penalty is alarming from an access to care perspective, because many individuals have conditions that could rapidly deteriorate if left unmanaged for such a long period of time.

In the past, CMS has been reluctant to approve waivers that incorporate many of these structures. For example, HIP 2.0 took many rounds of careful negotiation between CMS and Pence, Verma, and Indiana. Previously, advocates could be confident that CMS would act as a safety brake for proposals that pursued personal responsibility to the detriment of comprehensive access to care. Moving into this new era, advocates should not rely on CMS to carry out that same role. Instead, advocates should understand the impact that these personal responsibility requirements can have, if not implemented thoughtfully, on access to care. Advocates should also focus their participation in the waiver process on the state drafting level, before these proposals are submitted to CMS for federal approval.

Advocates Should Urge Senators to Question Ms. Verma on Key Access to Care Issues

CMS Administrator is a position that can dramatically impact access to care for the 70 million Americans enrolled in Medicaid, including many living with chronic illnesses and disabilities. **Advocates should ask their Senators to have Ms. Verma clarify how she would protect access to care for vulnerable individuals and how she intends to change the Medicaid program to focus more on personal responsibility and state flexibility.** This is an opportunity to require Ms. Verma to go “on the record” about issues that affect our communities, and better prepare advocates for what types of state Medicaid proposals will be approved in the future. Advocates should highlight any problematic answers given by Verma during the hearings to their Senators and explain the importance of strong access to care in the Medicaid program.

Advocates should also understand the changing nature of CMS, as compared to the Obama era. In the past, CMS was reluctant to approve state proposals that involved certain components such as work requirements or lockouts. A CMS guided by the principles articulated by Verma in her past work, however, would be more accommodating to states’ desire for flexibility. Advocates should closely review the proposals Verma was involved with in the past to gain a better sense of how they would impact access to care for their communities. Advocates should also focus on influencing the waiver process earlier, when the states are drafting these proposals, knowing that CMS will be more likely to approve the waivers once they are submitted.

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