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The Future of Medicaid:

A Deeper Dive into the Centers for Medicare and Medicaid Services Administrator Seema Verma's Past Medicaid Waiver Projects

Earlier this year, Seema Verma, a health care consultant from Indiana, was [confirmed](#) as Administrator of the Centers for Medicare and Medicaid Services (CMS). Verma comes into the role familiar with Medicaid, as she has worked behind the scenes for decades on state health strategies and has played an influential role in Medicaid and Medicare programs across numerous states. In her new role, Verma has a great deal of influence over the Medicare and Medicaid programs. The Administrator of CMS “directs the planning, coordination, and implementation of the programs” and “oversees the establishment of program goals and objectives and the development of policies, standards and guidelines . . .” With such a broad mandate that will directly impact the 57.4 million people on Medicare and the 74.2 million people on Medicaid, it is imperative to analyze Verma’s past policies and programs to understand how she will likely work to reshape the health policy landscape.

The Centers for Medicare and Medicaid Services controls quite a large percentage of the country’s GDP. In 2015, national health expenditures (NHE) accounted for 17.8% of GDP. Of these expenditures, Medicare accounted for 20% of NHE and Medicaid accounted for 17% of NHE. In dollars, that means that \$1.19 *trillion* dollars runs through the Medicare and Medicaid programs. CMS also has over 5,000 employees who manage and regulate the Medicare, Medicaid, SCHIP, and ACA programs.

Verma, as Administrator, will play a critical role in implementing legislation and directing CMS as it navigates the health care sector, the public sector, and dynamics between payers and providers. Already she, along with Secretary of the Department of Health and Human Services Tom Price, have issued a [letter](#) encouraging states to submit novel and creative waivers to adjust their Medicaid programs. This letter [suggests](#) that the Trump Administration is likely to approve state Medicaid waivers that the Obama Administration had previously rejected or discouraged. Given the amount of influence that Seema has over Medicaid, it is critical to analyze her past Medicaid work as a predictor of trends to come.

Advocates should:

1. Understand Verma’s fundamental positions on Medicaid benefit design and access, as well as how these positions may affect state Medicaid waivers.
2. Study the Healthy Indiana Plan 2.0 for a better sense of what Medicaid programs under the current Administration are likely to look like.
3. Reviews the research on the impact to access to care that these proposals have had in the past.

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Seema Verma: Background on the New Administrator

Verma had been involved in the design of numerous Medicaid programs before her appointment as CMS Administrator. After graduating from Johns Hopkins with a Master's degree in Public Health, Health Policy & Administration, Verma worked for several health focused organizations before founding [SVC, Inc.](#), a consulting company that specializes in national health policy. Through SVC, Inc., Verma has been integrally involved in redesigning or reforming Medicaid programs in Iowa, Ohio, Kentucky, Tennessee, and, most notably, in Indiana. In many of these states, she has focused on developing and implementing [Section 1115 waiver programs](#) for states looking to circumvent some of the traditional Medicaid requirements.

Verma has written on her approach to novel Medicaid structures for the *Health Affairs Blog*, first in [2008](#) and second in [2016](#). Both posts provide insight into Verma's philosophy when it comes to new Medicaid benefits proposals and, therefore, provide advocates with insight as to what to expect from CMS now that she is at the helm. In 2008, Verma wrote that she viewed the Healthy Indiana Plan (HIP) as a combination of the traditionally "diametrically opposed themes in American society of individualism and a Judeo-Christian ethic." Verma sees HIP as allowing individuals to make their own choices while still taking care of society's most vulnerable populations. She argues that entitlement programs, such as Medicaid, can be successful if the following lessons are kept in mind: 1) inaction exacerbates problems faced by the uninsured; 2) it is possible to choose reforms that increase personal responsibility and take advantage of market incentives; 3) entitlement programs can be fiscally responsible; and 4) that bi-partisan support and compromise are essential to success.

In late 2016, Verma penned a second blog post that described the Healthy Indiana Plan 2.0 (HIP 2.0) as "the most significant departure from traditional Medicaid ever approved by the Center for Medicare and Medicaid Services." HIP 2.0, she explains, focuses on a "consumer-driven approach" in light of the fact that "able-bodied adults need coverage, but not the same set of policy protections" as vulnerable populations like those who are aged, blind, disabled, or who have incomes below the poverty line. Verma describes several key features of HIP 2.0 that, in her view, embody these consumer-driven ideals. For example, Verma argues that a monthly premium payment "respects the dignity of each member by setting a fair expectation of personal investment and engagement in his or her own well-being." Verma believes that an emphasis on continuous care leads to more effective disease management and prevention, and structures her program to incentivize this care with stiff penalties for those without continuous care.

An Overview of the Healthy Indiana Plan

HIP 2.0 was one of Verma's most recent and high profile Medicaid projects as an executive with SVC. Originally, Verma, a long-time resident of Indiana, was the architect in the design and implementation of HIP, which was a notable Medicaid program because it required participants to pay a small monthly fee as a premium. After the outcome in *National Federation of Independent Business (NFIB) v. Sebelius*, which changed Medicaid expansion from a mandatory to a voluntary program, Verma worked with then-Governor Michael Pence to create HIP 2.0. The largest difference between HIP and HIP 2.0 is that HIP 2.0 expanded access to Medicaid to a larger percentage of Indiana residents. Both programs demonstrate a commitment to conservative ideals that emphasize personal responsibility to the point that it may hamper access to care.

HIP 2.0 implements several ideas that have been championed by conservatives as reform to Medicaid. Key elements of HIP 2.0 include:

- **High deductibles paired with health savings accounts.** HIP 2.0 members have a deductible of \$2,500 and are given a "POWER" account with \$2,500 in it. These POWER accounts function similarly to health savings accounts—members pay for their deductible out of these accounts and, after their deductible is met, the plan covers future claims.
- **A requirement that enrollees seeking HIP Plus coverage make monthly premium payments of 2% of their**

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income. HIP Plus is coverage for those between 100 and 138 percent of the poverty line (other people are enrolled in HIP Basic although they can choose to enroll in HIP Plus). The premiums paid by HIP Plus enrollees are viewed as contributions to individuals' POWER accounts and, in Verma's view, incentivizes cost-conscious decisions about health care. An important aspect of this program is the consequences of nonpayment. If individuals do not pay these contributions, they are terminated from the plan and must wait six months to re-enroll. Individuals below the federal poverty level who are terminated from the HIP Plus plan will be transferred to HIP Basic, which excludes vision and dental coverage *and* involves co-payments for services.

- **Incentives to encourage appropriate care use.** Retroactive care for individuals who are sick upon enrollment is not covered under this plan. Further, the plan discourages individuals from using emergency facilities for what the plan calls "inappropriate use" through a co-payment that begins at \$8 and rises to \$35 for subsequent "inappropriate use." HIP 2.0 encourages individuals who are unsure of whether an emergency room visit is appropriate to call a 24-hour hotline to discuss their health situation with a nurse.

When discussing HIP 2.0, Verma states that "while HIP has never touted itself as some sort of national silver bullet, it continues to serve as an example for states having similar interest in re-aligning Medicaid with the broader objective of individual empowerment." This line, if nothing else, illustrates the importance that HIP 2.0 plays in the Medicaid landscape, and why it is important for advocates outside of Indiana to be familiar with it. For example, Kentucky has, over the past year, revamped their Medicaid program by modelling it after HIP 2.0, with Kentucky Governor Bevin saying "[HIP 2.0] is a model that we are going to copy . . . I am not above copying what other people are doing well." Verma has been very consistent in her policy views and the types of programs she designs, and her new role as Administrator will only further burnish the reputation of HIP 2.0 as a Medicaid template for other conservative states to follow.

Implications of the Healthy Indiana Plan

Advocates should make sure they understand the impact on access to care of three aspects of HIP 2.0. First, a combination of a high deductible and health savings account was pioneered for Medicaid in Indiana and is quickly gaining in popularity in other states. Second, charging premiums or asking for contributions for Medicaid or Medicaid-equivalent plans is an innovative strategy, but one that could create barriers to access to care. Third, incentivizing appropriate delivery systems by charging fees for inappropriate uses of emergency rooms is also gaining in popularity but may also form a barrier to access to care.

High Deductibles Coupled with Health Savings Accounts

HIP 2.0 provides all enrollees with HSA accounts, called POWER accounts, along with a matching deductible, under the theory that when people have autonomy over their health care decisions, they make stronger decisions. Theoretically, the POWER accounts offered by the Indiana government would cover the entire deductible since the deductible of \$2,500 is the same as the POWER account ceiling of \$2,500. These accounts are funded by a combination of (mostly) state and (partially in the case of HIP Plus) member contributions. As such, individuals would be incentivized to take ownership of their own health care but would not be paying out-of-pocket for services that they could not afford. This dynamic relies on a key assumption—that individuals are aware of their POWER accounts and are utilizing them appropriately. HIP 2.0 members were asked whether they were aware of their POWER accounts in an [interim report](#) required by CMS. Approximately 60% of members (66% of HIP Plus members and 46% of HIP Basic members) reported that they had heard of POWER accounts. Those who reported hearing of these accounts were then asked if they had POWER accounts—72% of HIP Plus members and 76% of HIP Basic members said that they had accounts.

The implications of these statistics are twofold. First, at an institutional level, individuals are not receiving the information that they need to fully take advantage of this benefit structure. Individuals cannot take ownership of their care if they don't

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realize that there is ownership for them to take. Second, if individuals do not know that they have POWER accounts to offset their deductibles, they may be offsetting their deductibles with other sources of income. These individuals, through their lack of awareness of the POWER accounts, are being made worse off as they are, as a result, putting up to \$2,500 of their own money into their deductibles, lowering their spending power in other areas of their lives.

Additionally, there may be other concerns with enrolling lower income individuals in high deductible health plans. Most [research](#) done on high deductible health plans has determined that individuals use less health care when they have a higher cost-sharing component, with studies measuring the reduction in spending from 2% to 15% depending on the study. Studies have also found that coupling a high deductible health plan with a health savings account (like the POWER accounts) may lead to less of a decrease in spending. For individuals living with chronic illnesses and disabilities, a decrease in health care spending can translate to lower utilization of services needed to appropriately manage their conditions.

As the high deductible health plan with a savings account becomes an increasingly popular structure, advocates should make sure they understand the impact that this benefit design could have on vulnerable individuals. This structure raises some serious access to care concerns regarding individuals who are lower income and living with chronic illnesses and disabilities. Advocates should work to educate their state policy makers on this issue, and closely monitor any upcoming Section 1115 waivers to see if their states are attempting to adopt this structure.

Required Premiums from Enrollees

A second important element of HIP 2.0 is the fact that many enrollees must make at least some sort of financial contribution to their POWER accounts to increase personal responsibility. A study of HIP 2.0 specifically has found that more than 90% of people in the program can make their monthly contributions. The same study found that about half of these individuals worried about their ability to pay their contributions (ranging from \$3–\$25 a month). Verma states that having these premiums increases the dignity of each individual person—however it is unclear whether the premium requirements achieve that goal or require enrollees to find alternate sources of funding. An *Indiana Star* report [claimed](#) in early 2016 that at least some Indiana hospitals were helping HIP 2.0 recipients pay these premiums if there was any indication that the enrollee would have trouble paying the fee themselves.

Outside of HIP 2.0, academics have researched whether contributions of Medicaid users were helpful. Typically, states cannot charge premiums for Medicaid users—Indiana received a partial exemption from this requirement through their Section 1115 Waiver. In 2013, the Kaiser Family Foundation (KFF) put together a [summary](#) of research on premiums and cost-sharing for Medicaid. These observations were made based on analyses done of Medicaid systems in Oregon and Utah, which both increased premiums and cost-sharing for Medicaid recipients in 2003. Overall, according to KFF, premiums act as barriers to obtaining or maintaining coverage. Further, while states may experience short term cost-savings as a result of low-income groups being uninsured, these people will eventually be cared for by higher cost health care safety-net systems. Five studies done on these states and several others found that premiums decreased participation in Medicaid programs. A survey of former enrollees in Oregon found that premiums were a key factor in individual's decisions to drop their coverage. These individuals would typically not find coverage elsewhere and, as a result, would become uninsured. Another [study](#) demonstrated that premiums decreased Medicaid enrollment in eleven states that have experimented with it.

While states have the autonomy to add premiums to their Medicaid programs, the trade-off between “personal responsibility” and access to care is clear. These programs *do* decrease enrollment and those who de-enroll because of this cost barrier end up being uninsured. Advocates should be familiar with these studies, and the experiences in states such as Indiana, Oregon, and Utah. As more states submit Section 1115 waivers that incorporate premiums, it will be important for advocates to educate their policymakers on the negative impact premiums can have on access to care for lower income, vulnerable individuals.

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Incentivized Appropriate Delivery Systems

The third important aspect of HIP is the incentive program, designed to encourage people to use care delivery systems outside of the emergency department by up-charging for these services in the form of a co-payment for unnecessary use. Several studies have been done on this type of incentive scheme, with the overall result being that these schemes present some serious access to care concerns. The first concern is that it is very difficult to determine what is non-urgent care and what services are urgent and appropriate for the emergency department. Without a consistent definition on what type of care is being discouraged, it is difficult to set up an incentive program that encourages appropriate care in the correct settings.

Another concern is that imposing penalties and incentives on emergency department use can decrease utilization of needed services, even in other contexts. One study [found](#) that higher emergency room visit co-payments were correlated with decreases in utilization of emergency room services *for both* urgent and non-urgent needs. The study further found that utilization is significantly affected with co-pays of \$50 or more. On the other hand, a more recent [study](#) found that there was no correlation between co-payments and emergency room utilization for either urgent or non-urgent needs. An earlier [study](#), published in 2010, agreed. This suggests that, at best, incentives do not direct appropriate care, adding only potential administrative barriers.

Advocates should closely monitor the development of any Section 1115 waivers in their states for the inclusion of penalties or other programs intended to incentivize certain types of care. In some situations, use of the emergency department is appropriate. Because it is difficult to determine when that is the case, and because some studies have shown that these incentives decrease care across the board, these types of programs should only be carefully and cautiously implemented to avoid creating barriers to access to care. Advocates should be sure to educate their local policymakers on this issue, stressing that these programs may not work as intended.

What to Expect Moving Forward

Going forward, it is likely that Verma will continue to implement policies at the national level that continue to align with her ideological values of personal responsibility and utilizing market incentives. However, some of the policies and programs implemented in HIP 2.0 may not achieve those goals, instead presenting barriers to care for the most vulnerable. Advocates should understand the impact that these policies have had in Indiana and in other states. While during the Obama Administration CMS could be relied upon to limit the use of these programs, advocates should assume that Administrator Verma will likely support states adopting them. Therefore, it is important for advocates to work with state policymakers *before* any Section 1115 waivers are submitted.

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