

PUTTING THE BRAKES ON CONSUMER DRIVEN MEDICAID: THE FAILURES AND HARMS OF HEALTHY INDIANA PLAN (HIP) 2.0

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ABSTRACT

In January 2015, the U.S. Department of Health and Human Services (HHS) granted Indiana a Section 1115 Demonstration Waiver to experiment with consumer driven Medicaid. The Healthy Indiana Plan (HIP) 2.0 combines a \$2,500 high deductible with a Personal Responsibility and Wellness (POWER) Account, premiums, and copays. Described as “the most significant departure from traditional Medicaid ever approved,” Indiana claims that the POWER Account, the signature feature of HIP 2.0, is “similar to a health savings account (HSA)” and encourages members to be more cost-conscious consumers, helps familiarize members with how commercial health insurance works, and encourages continuous Medicaid enrollment.

This article explains how and why POWER Accounts and HIP 2.0 fail on all counts: The POWER Account does not encourage members to comparison shop and be more cost-conscious consumers. Neither does it help educate Medicaid enrollees about how commercial insurance works because the POWER Account is nothing like a commercial HSA. Most troubling, though, POWER Account premiums create significant barriers to Medicaid coverage. Nearly 60,000 Hoosiers have lost Medicaid coverage because of missed POWER Account premiums and another 300,000 have been moved to more costly, less comprehensive Medicaid plans because of their inability to meet the POWER Account premium requirement.

HHS used its authority under Section 1115 of the Social Security Act to grant Indiana a waiver to conduct HIP 2.0 as an “experimental, pilot, or demonstration” project likely to promote the objectives of the Medicaid Act. HHS was wrong. Consumer driven Medicaid does not promote the objectives of the Medicaid Act. Indiana’s HIP 2.0 waiver experiment proves that consumer

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driven Medicaid suppresses enrollment by creating administrative and financial barriers to coverage.

I. INTRODUCTION

In January 2015, the U.S. Department of Health and Human Services (HHS) granted Indiana a Section 1115 Demonstration Waiver to experiment with consumer driven Medicaid.¹ The experimental Healthy Indiana Plan (HIP) 2.0 combines a \$2,500 high deductible with a Personal Responsibility and Wellness (POWER) Account, premiums, and copays. Described as “the most significant departure from traditional Medicaid ever approved,”² Indiana claims that the POWER Account, the signature feature of HIP 2.0, is “similar to a health savings account (HSA)” and encourages members to be more cost-conscious consumers, helps familiarize members with how commercial health insurance works, and encourages continuous Medicaid enrollment.³

This article explains how and why POWER Accounts and HIP 2.0 fail on all counts: The POWER Account does not encourage members to comparison shop and be more cost-conscious consumers.⁴ Neither does it help educate Medicaid enrollees about how commercial insurance works because the POWER Account is nothing like a commercial HSA.⁵ Most troubling, though, POWER Account premiums create significant barriers to Medicaid coverage. Nearly 60,000 Hoosiers have lost Medicaid coverage because of missed POWER Account premiums and another 300,000 have been moved to more costly, less comprehensive Medicaid plans because of their inability to meet the POWER Account premium requirement.⁶

Section II of this article discusses the theory and research on consumer driven health care and consumer driven health plans. In theory, consumer driven health care shifts costs away from insurance and onto patients so they will be more careful and prudent users of health services and reduce health care spending. Section II explains the challenges of moving consumer driven health care theory into practice. It ends with a discussion of the concerns that arise about trying to import consumer driven health care into Medicaid.

Section III describes the POWER Accounts, premiums and other components of HIP 2.0 intended to transform Indiana’s Medicaid coverage into consumer driven health care. Section IV shows why POWER Accounts are

1. CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY INDIANA PLAN (HIP) 2.0-SPECIAL TERMS & CONDITIONS NO. 11-W- 00296/5 1 (2015). For a complete chronology of the HIP 2.0 waivers, see *Medicaid Expansion in Indiana*, KAISER FAM. FOUND. 1 (Feb. 3, 2015), <https://www.kff.org/medicaid/fact-sheet/medicaid-expansion-in-indiana/>.

2. Seema Verma & Brian Neale, *Healthy Indiana 2.0 Is Challenging Medicaid Norms*, HEALTH AFF.: BLOG (Aug. 29, 2016), <https://www.healthaffairs.org/doi/10.1377/hblog20160829.056228/full/> (last visited Mar. 3, 2018).

3. *Id.*; see IND. FAMILY & SOC. SERVS. ADMIN., HIP 2.0 1115 WAIVER APPLICATION 4 (July 2, 2014), [https://www.in.gov/fssa/hip/files/HIP_2_0_Waiver_\(Final\).pdf](https://www.in.gov/fssa/hip/files/HIP_2_0_Waiver_(Final).pdf).

4. See *infra* note 149 and accompanying text.

5. See discussion *infra* notes 93–97 and accompanying text.

6. See *infra* text accompanying notes 160–165.

unlike anything offered in the commercial market and more likely to confuse consumers than help them make the transition to private insurance coverage. It explains why POWER Accounts are a pale imitation of consumer driven health care that are highly unlikely to encourage patients to be more cost-conscious consumers.

Section V reviews the available data evaluating Indiana's HIP 2.0 waiver experiment. While data is limited, it appears that HIP 2.0 is creating more confusion than consumer empowerment. Most troubling are the barriers that POWER Account premiums have created. HIP 2.0 has not only failed to "encourage[] continuous Medicaid enrollment,"⁷ it has resulted in disruptions in coverage far beyond anything reported in traditional Medicaid.

HHS used its authority under Section 1115 of the Social Security Act to grant Indiana a waiver to conduct HIP 2.0 as an "experimental, pilot, or demonstration" project likely to promote the objectives of the Medicaid Act.⁸ HHS was wrong. Consumer driven Medicaid does not promote the objectives of the Medicaid Act. Indiana's HIP 2.0 waiver experiment proves that consumer driven Medicaid suppresses enrollment by creating administrative and financial barriers to coverage.⁹

II. CONSUMER DRIVEN HEALTH CARE & CONSUMER DRIVEN HEALTH PLANS: THEORY & RESEARCH

Consumer driven health care is animated by the concern that health insurance shelters patients from the true cost of health care resulting in them using more care than is necessary and increasing the cost of health care and health insurance.¹⁰ Consumer driven health care posits that making patients bear more of the cost of health care should prompt them to turn down high cost, low value care, and encourage providers to compete by offering both lower cost and

7. Verma & Neale, *supra* note 2. Indiana's waiver applications and other descriptions of HIP 2.0 and the POWER Account all described it as "like an HSA" or "similar to a[n] HSA." See IND. FAMILY & SOC. SERVS. ADMIN., *supra* note 3, at 4. The waiver application claims these programs engage participants in their health care decisions, provide new coverage pathways, and support transition to commercial health insurance. See *id.*

8. 42 U.S.C. § 1315(a) (2016).

9. Elsewhere, I have argued that HHS does not have authority under Section 1115 to impose premium requirements like the POWER Account fees. See Sidney D. Watson, *Premiums and Section 1115 Waivers: What Cost Medicaid Expansion?*, 9 ST. LOUIS UNIV. J. HEALTH L. & POL'Y 265, 269 (2016). This article focuses on a separate issue of whether HIP 2.0 waivers further the objective of the Medicaid Act.

10. Mark A. Hall, *The Legal and Historical Foundations of Patients as Medical Consumers*, 96 GEO. L.J. 583, 586 (2008); James C. Robinson & Paul B. Ginsberg, *Consumer-Driven Health Care: Promise and Performance*, 28 HEALTH AFF. 272, 272 (2009). This phenomenon is often referred to as a "moral hazard." See Christopher Robertson, *The Split Benefit: The Painless Way to Put Skin Back in the Health Care Game*, 98 CORNELL L. REV. 921, 939 (2013).

higher quality care.¹¹ As Wendy Epstein puts it, “The premise is basic economics: a patient who must spend more of his or her own money (rather than the insurance company’s money) should consume less care, particularly if it is unnecessary care.”¹²

Consumer driven health care uses a variety of cost sharing approaches to make consumers pay more out of their own pockets and thus have more “skin in the game.”¹³ Raising copays or coinsurance to increase the patient’s costs at the point of service is one option. Higher deductibles that should make the patient act more like an uninsured patient until the deductible is met is another. Consumer driven health plans, both HSAs and Health Reimbursement Accounts (HRAs), are another variant that combine high deductibles, tax benefits and savings accounts.¹⁴

HSAs couple a high deductible health insurance plan with a tax-sheltered interest-bearing savings account that can be used to pay for medical and non-medical expenses.¹⁵ HSAs are owned by the patient and unused balances can be carried over from year to year without limit.¹⁶ Both patients and their employers can contribute to the HSA with pre-tax dollars. The high deductible is intended to expose patients to the costs of care and incentivize them to use medical

11. See Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 645 (2008); see also William M. Sage, *Assembled Products: The Key to More Effective Competition and Antitrust Oversight in Health Care*, 101 CORNELL L. REV. 609, 635 n.108, 690 (2016); Srishti Miglani, *Reference Pricing: A Small and Mighty Solution to Bend the Health Care Cost Curve*, 22 CONN. INS. L.J. 47, 52 (2016) (explaining both the theory and the role the RAND Health Insurance Experiment played in the development of the theory).

12. Wendy N. Epstein, *Price Transparency and Incomplete Contracts in Health Care*, 67 EMORY L.J. 1, 27 (2017).

13. See *id.* (cataloguing approaches that fall under the term “consumer-driven health care” or “consumerism”).

14. CAROL RAPAPORT, CONG. RESEARCH SERV., RS21573, TAX-ADVANTAGED ACCOUNTS FOR HEALTH CARE EXPENSES: SIDE-BY-SIDE COMPARISON 1, 4–5 (2013). Medical Savings Accounts are another form of CDHP plan that pre-dated HSAs, but new MSAs may not be set up after December 2007. *Id.* at 5.

15. 26 U.S.C. § 223 (2016) (defining an HSA); *Id.* § 223(c)(2)(A) (providing the Internal Revenue Service’s definition of “high-deductible plan”); Medicare Prescription Drug Improvement and Modernization Act, Pub. L. No. 108–173, tit. XII, § 223, 117 Stat. 2066 (2003) (to be codified at 42 U.S.C. § 1305) (authorizing HSAs). In 2017, the deductible must be at least \$1,300 for self-only coverage and \$2,600 for family coverage. Norton Francis et al., *The Tax Policy Briefing Book: A Citizens’ Guide to the Tax System and Tax Policy* 1257 (Apr. 14, 2017), http://www.taxpolicycenter.org/sites/default/files/briefing-book/tpc-briefing-book_0.pdf. In 2017, “HSA contributions are limited to \$3,400 for self-only coverage and \$6,750 for a family.” *Id.* Additionally, “[a]ccount holders age 55 or older can contribute an additional \$1,000.” *Id.* Both the deductible amount and HSA contribution limit are indexed annually, growing for inflation. *Id.*

16. *Id.*

services more appropriately.¹⁷ The savings account is designed to encourage patients to spend less on health expenses by allowing patients to retain unused money in the HSA from year-to-year to use as they see fit, for either medical or non-medical purposes.¹⁸ HSA plans are available in both the employer and individual markets, although ninety percent of people with HSAs have employer sponsored coverage.¹⁹

HRAs are employer-established tax-sheltered accounts that are attached to an employer health plan.²⁰ Unlike an HSA, the employer owns and controls the HRA.²¹ The employer funds the HRA and employee contributions are not permitted. The employer determines which medical expenses can be reimbursed from the HRA and can limit the amount of unused funds that can be carried over from year-to-year.²² In actuality, HRAs are really “arrangements” rather than accounts. The employer only moves money into an account to pay claims as they come due. No account is pre-funded as is the case with HSAs.²³

Most employers do not allow employees to take unused HRA money when they change jobs or retire.²⁴ HRAs typically use a high deductible to expose patients to the costs of care to incentivize them to use medical services more appropriately.²⁵ However, HRAs do not create as strong a spend-less-to-save-more incentive as HSAs do because employers limit how much HRA money can

17. See Lindsey F. Wiley, *From Patient Rights to Health Justice: Securing the Public's Interest in Affordable, High-Quality Health Care*, 37 CARDOZO L. REV. 833, 851–52 (2016).

18. Francis et al. *supra* note 15, at 257. Withdrawals for non-qualifying medical expenses are subject to income tax and a twenty percent penalty, but the penalty is waived for individuals who are disabled, age sixty-five or older, or deceased. *Id.* HSAs are particularly attractive to high-wage workers who max out on their IRA contributions and use HSAs as an additional means of tax-preferred saving. *Id.*

19. See 2016 Survey of Health Savings Accounts-High Deductible Plans, AM.'S HEALTH INS. PLANS 4 fig. 2 (2016), https://www.ahip.org/wp-content/uploads/2017/02/2016_HSASurvey_Draft_2.14.17.pdf.

20. RAPAPORT, *supra* note 14, at 3. HRAs began as stand-alone accounts that offered an alternative to traditional health insurance coverage, making the patient responsible for medical costs beyond the HRA. See *id.* at 4. Now that the Affordable Care Act prohibits an annual cap on health insurance benefits and imposes an annual limit on patient out-of-pocket liability, HRAs must be coupled with employer sponsored health insurance for medical costs above the HRA amount. *Id.* at 5.

21. Francis et al., *supra* note 15, at 264.

22. RAPAPORT, *supra* note 14, at 3–4.

23. Francis et al. *supra* note 15, at 264.

24. See Paul Fronstin & M. Christopher Roebuck, *Health Care Spending after Adopting a Full-Replacement, High-Deductible Health Plan with a Health Savings Account: A Five-Year Study*, EMP. BENEFIT RES. INST. 1, 3–4 (2013), https://www.ebri.org/pdf/briefspdf/EBRI_IB_07-13.No388.HSAs.pdf; RAPAPORT, *supra* note 14, at 4 (explaining employers may, but are not required to, allow employees to keep unused HRA money when they leave employment).

25. Paul Fronstin, *Health Savings Accounts and Other Account-Based Health Plans*, EMP. BENEFIT RES. INST. 4, 8 (2004), <https://ssrn.com/abstract=599942> (explaining that HRAs are usually partnered with a high deductible plan but can be offered with lower deductible plans, too).

be carried over, the purposes for which it can be used, and typically do not allow employees to keep money when they leave the employer.

Although enrollment in HSAs and HRAs has increased since they were introduced in 2005, they are not the predominate form of commercial insurance in either the employer or individual health insurance markets. Less than one quarter of employees are enrolled in plans with HSAs or HRAs.²⁶ Only six percent of employers offer HSAs or HRAs as the only option for coverage.²⁷ In the individual market, high deductible plans have exploded but relatively few people combine them with an HSA.²⁸

HSAs have become a savings mechanism as much as, or maybe even more than, a health care financing tool. The people most likely to have HSAs are high income earners, those with incomes over \$200,000 a year, who favor them because they offer tax-sheltered savings.²⁹

Critics of consumer directed health plans point out that while the linchpin of consumer directed health plans is encouraging patients to comparison shop, find less expensive care and forgo unnecessary care, patients find this virtually impossible to do.³⁰ Medical prices are not transparent.³¹ Patients' treatment decisions are highly influenced by physician treatment recommendations.³² Many, if not most, treatment decisions are made under urgent and emotionally-

26. Paul Fronstin, *What Do We Really Know About Consumer-Driven Health Plans?*, EMP. BENEFIT RES. INST. 1, 23 (2010), https://www.ebri.org/pdf/briefspdf/EBRI_IB_08-2010_No345_CDHP.pdf.

27. Gary Claxton et al., *Employer Health Benefits 2017 Annual Survey*, KAISER FAM. FOUND. 3, 7 (2017), <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017>.

28. AM.'S HEALTH INS. PLANS, *supra* note 19, at 4.

29. HSAs are most attractive to higher income people because of their tax advantages. Francis et al. *supra* note 15, at 257–58. Both employees and employers can contribute to the HSA. *Id.* Contributions made by the account owner can be deducted from their adjusted gross income. *Id.* Contributions by the employer are exempt for income and payroll taxes. *Id.* Interest earned on the HSA funds accrue tax-free, and withdrawals for qualifying medical expenses are not taxed. *Id.* Withdrawals for non-qualifying expenses are subject to income tax and a twenty percent penalty, but the penalty is waived for individuals who are disabled, age sixty-five or older, or who have died. *Id.* HSAs are particularly attractive to high-wage workers who max out on their IRA contributions and use HSAs as an additional means of tax-preferred savings. *Id.*

30. See Ateev Mehrotra et al., *Americans Support Price Shopping for Health Care, But Few Actually Seek Out Price Information*, 36 HEALTH AFF. 1392, 1399 (2017) (finding in a national survey of patients little evidence of price shopping because of the difficulty of finding price information and the desire not to disrupt existing provider-patient relationships); Erin C. Fuse Brown, *Resurrecting Health Care Rate Regulation*, 67 HASTINGS L.J. 85, 107–08 (2015) (synopsizing the literature that identifies barriers that prevent patients from engaging in the consumer behavior that consumer-driven health plans seek to promote); Wiley, *supra* note 17, at 851–53 (discussing these and other criticisms of consumer-directed health plans).

31. Epstein, *supra* note 12, at 3, 4.

32. Hall & Schneider, *supra* note 11, at 652.

charged conditions which are not conducive to price shopping.³³ The line between necessary and unnecessary care is often blurred, particularly when it comes to medical testing.³⁴

Studies show that most consumers simply do not understand how their consumer directed health plans operate or the economic incentives they are intended to create. In general, consumers have high levels of health insurance illiteracy and fail to understand how deductibles, HSAs, coinsurance and copayments work.³⁵ HSAs in particular tend to have complicated designs where some services require a deductible or coinsurance payment from the HSA while others do not, creating widespread consumer confusion about which services they are encouraged to use and which they should approach more cautiously.³⁶

Research confirms skepticism that HSAs will not dramatically reduce health care spending. While a number of studies report striking savings the first year an employer offers an HSA, savings erode quickly and decline to the six to seven percent range by year three.³⁷

Research also confirms that cost savings from consumer directed health plans result from patients reducing spending on necessary and appropriate care—specifically medication for chronic diseases, physician office visits and

33. See *id.* at 658; see also Ani B. Satz, *Fragmentation After Health Care Reform*, 15 HOUS. J. HEALTH L. & POL'Y 173, 193–95 (2015) (discussing the overall difficulty patients have when making complex medical choices).

34. Mary Reed et al., *High-Deductible Health Insurance Plans: Efforts to Sharpen a Blunt Instrument*, 28 HEALTH AFF. 1145, 1145, 1150 (2009).

35. *Id.* at 1145.

36. See Jeffrey T. Kullgren et al., *Health Care Use and Decision Making Among Lower-Income Families in High-Deductible Health Plans*, 170 JAMA 1918, 1918 (2010); Mary E. Reed et al., *In Consumer-Directed Health Plans, A Majority of Patients Were Unaware of Free or Low-Cost Preventive Care*, 31 HEALTH AFF. 2641, 2641-42 (2012); Reed et al., *supra* note 34, at 1145.

37. See Amelia M. Haviland et al., *Do “Consumer-Directed” Health Plans Bend the Cost Curve Over Time?*, 46 J. HEALTH ECON. 33, 42 (2016). Introduction of the HSA reduced total spending by twenty-five percent in the first year, but HSA spending rebounded in later years showing only a six percent decrease over three years. Fronstin & Roebuck, *supra* note 24, at 5, 8. Moreover, the comparison group, which was composed of workers covered by traditional health insurance, had an increase in spending of twenty-nine percent in the first year, which may have caused the study to overstate the savings from the adoption of the HSA. *Id.* at 5, 12; see Stephen T. Parente et al., *Evaluation of the Effect of a Consumer-Driven Health Plan on Medical Care Expenditures and Utilization*, 39 HEALTH SERVS. RES. 1189, 1201, 1205–06 (2004) (stating that CDHP enrollees had lower total expenditures than enrollees in PPO, but higher than HMO enrollees after a two-year period, controlling for a variety of enrollee characteristics. HRA resulted in higher spending for hospital and physician services but had no impact on prescription drug spending); Anthony T. Lo Sasso et al., *Health Savings Accounts and Health Care Spending*, 45 HEALTH SERVS. RES. 1041, 1056 (2010) (stating that enrollees in HSAs spent approximately five to seven percent less than the enrollees in traditional health plan, with most spending reduction occurring in the first year).

preventive care.³⁸ In fact, one recent study found that consumer directed health plans produce no change in spending on unnecessary care, services that have unclear or no clinical benefit to the patient.³⁹

Studies substantiate that the consumer driven health plans that produce the greatest cost savings are those with the highest deductibles and lowest HSA or HRA contribution from employers.⁴⁰ In short, consumer directed health plans that put the most consumer “skin in the game” produce the greatest savings.⁴¹ As one employer warns, “Should you get sick or injured and need significant medical care, you’ll pay a lot more out of pocket [with our HSA plan] than you would with a traditional plan.”⁴² These high deductible plans also shift more costs of medical care to the patients, and leave patients with medical debt and the threat of a medical bankruptcy when they get sicker and do not have their own funds to cover the deductible amounts through the HSA account or otherwise.⁴³

38. Rajender Agarwal et al., *High-Deductible Health Plans Reduce Health Care Cost and Utilization, Including Use of Needed Preventive Services*, 36 HEALTH AFF. 1762, 1762 (2017); see also M. Kate Bundorf, *Consumer-Directed Health Plans: A Review of the Evidence*, 83 J. RISK INS. 9, 27 (2016) (discussing studies that show consumer-directed health plans prompt worrisome reductions in drug adherence among patients with chronic conditions, particularly those who have asymptomatic conditions like hypertension and high cholesterol).

39. Rachel O. Reid et al., *Impact of Consumer-Directed Health Plans on Low-Value Healthcare*, 23 AM. J. MANAGED CARE 741, 741 (2017) (while consumer-directed health plans do reduce overall health care spending, they do not reduce spending on low-value services that provide unclear or no benefit to patients).

40. *Id.* at 29.

41. *Skin in the Game: How Consumer-Directed Plans Affect the Cost and Use of Health Care*, RAND HEALTH 1 (June 28, 2012), file:///Users/Owner/Downloads/RAND_RB9672.pdf; Karen Davis, *Consumer-Directed Health Care: Will It Improve Health System Performance?*, 39 HEALTH SERVS. RES. 1219, 1219 (2004); Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 119–20 (2005).

42. *How Consumer-Directed Health Plans Work*, UNIV. WASH. HUMAN RES., <http://hr.uw.edu/benefits/insurance/health/compare-plans/how-consumer-directed-health-plans-work/> (last visited Apr. 16, 2018).

43. In 2017, the average deductible for single coverage was \$2,433 for an employer-sponsored HSA and \$2,129 for an HRA plan, and one out of four workers had a deductible of \$3,000 or more. GARY CLAXTON ET AL., KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 2017 ANNUAL SURVEY: HIGH-DEDUCTIBLE HEALTH PLANS WITH SAVINGS OPTION 139 (2017), <https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/>. HSA plans must have a deductible of at least \$1,300 for self-only coverage and \$2,600 for family coverage. Francis et al. *supra* note 15, at 2. Almost half of firms offering HSAs do not contribute to the HSA. CLAXTON ET AL., *supra*, at fig. 8.8. Only two percent of workers with a HSA and twenty-one percent of workers with a HRA received an account contribution from their employer at least equal to their deductible. Another thirty percent of workers with a HSA and thirty percent of workers with a HRA received employer account contributions that, if applied to their deductible, would reduce it to less than \$1,000. *Id.* at 139.

High deductibles and high cost sharing carry health risks for Medicaid patients.⁴⁴ The 1982 RAND Health Insurance Experiment provided early support for consumer driven health care theory by showing that increasing patient cost sharing for moderate and higher income patients reduces health care spending but results in similar health outcomes.⁴⁵ However, that study also found that cost sharing for low income patients created barriers to care, causing poor patients to forgo needed and necessary medical care.⁴⁶

Decades of research confirms that for patients living at or near the poverty level even a small amount of “skin in the game,” cost sharing in the range between one and five dollars, reduces the use of necessary and essential services.⁴⁷ Cost sharing has been shown to create barriers to a wide assortment of medically necessary care including vaccinations, prescription drugs, mental health visits, preventive care, primary care, and inpatient and outpatient care.⁴⁸ Premiums, too have been shown to create substantial barriers to obtaining and maintaining Medicaid enrollment for low-income adults and children.⁴⁹

Thus, Congress has limited states’ ability to impose consumer driven health driven plans on Medicaid patients. Federal Medicaid law provides that Medicaid

44. They also carry financial risks. See Gery P. Guy Jr., *The Effects of Cost Sharing on Access to Care among Childless Adults*, 45 HEALTH SERVS. RES. 1720, 1722 (2010). Most patients do not have savings to cover the costs of a high deductible. Reed Abelson, *Is High-Deductible Health Insurance Worth the Risk?*, N.Y. TIMES (Oct. 31, 2016), <https://www.nytimes.com/2016/11/01/business/is-high-deductible-health-insurance-worth-the-risk.html> (last visited Apr. 16, 2018). Thus, employers who do not fully fund an HSA or an HRA leave employees at risk of medical debt and even bankruptcy. NAT’L CONFERENCE OF STATE LEGISLATURES, HEALTH SAVINGS ACCOUNTS AND THE STATES 4 (Oct. 10, 2017).

45. See Michael E. Chernew & Joseph P. Newhouse, Commentary, *What Does the RAND Health Insurance Experiment Tell Us About the Impact of Patient Cost Sharing on Health Outcomes?*, 14 AM. J. MANAGED CARE 412, 412 (July 2008); see also Robert H. Brook et al., *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate* RAND HEALTH 1, 3 (2006), https://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB9174.pdf. The original RAND Study found that high deductible plans with high cost sharing led to much lower average spending—on average twenty-five to thirty percent less—than plans with no out-of-pocket expenses aside from the premiums. *Id.* at 2. Later studies have found that these kinds of savings cannot be sustained over time. See *infra* notes 48–50 and accompanying text.

46. JOSEPH P. NEWHOUSE & INS. EXPERIMENT GROUP, FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 246 (1996).

47. Samantha Artiga et al., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings*, KAISER FAM. FOUND. 4 (2017), <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations>.

48. *Id.*

49. *Id.* at 5; see also David Machledt & Jane Perkins, *Medicaid Premiums and Cost Sharing*, NAT’L HEALTH LAW PROGRAM 1, 15 (Mar. 26, 2014), file:///Users/Owner/Downloads/NHeLP_IssueBriefMedicaidCostSharing_03262014.pdf (reviewing research literature on cost sharing and premiums for low income populations).

enrollees with incomes below 150% of the Federal Poverty Level (FPL) cannot be charged premiums or deductibles, and copays or co-insurance must be within limits prescribed by statute and implementing regulations.⁵⁰ Copays and co-insurance are prohibited for pregnant women, children, and most emergency room use.⁵¹ Where copays are permissible, those with incomes under 100% FPL can only be charged “nominal” copays of no more than four dollars for most outpatient services, seventy-five dollars for inpatient care.⁵² Those with incomes between 100–150% FPL can be charged up to ten percent of the cost of both inpatient and outpatient services.⁵³ Both groups can be charged up to eight dollars for non-preferred drugs and non-emergency use of the emergency room.⁵⁴ Federal rules cap combined costs for premiums and cost sharing at five percent household income, calculated on a monthly or quarterly basis, at state option.⁵⁵

Indiana’s Healthy Indiana Plan 2.0 waiver allows the state to ignore these federal limits on premiums and deductibles so it can experiment with consumer directed Medicaid. What does Indiana’s consumer directed Medicaid look like?

III. CONSUMER DRIVEN MEDICAID IN INDIANA: HIP 2.0, POWER ACCOUNTS AND PREMIUMS

Consumer directed Medicaid is not new in Indiana. In 2007, the Bush Administration approved a Section 1115 demonstration waiver for the first version of HIP that allowed Indiana to use federal Medicaid funds to pay for a limited benefit package for a capped number of working adults earning up to 100% FPL.⁵⁶ HIP was touted as a model of consumer directed health care because coverage included a \$1,100 deductible coupled with a \$1,100 POWER Account.⁵⁷ Indiana claimed the experiment was a success, but costs were significantly higher than anticipated, and the state never released either their own data or outside evaluations by which the experiment could be appraised.⁵⁸

50. See 42 U.S.C. § 1396o-1 (b)(1)(B)(ii) (2010). Regulations are codified at 42 C.F.R. 447.52–447.56 (2018).

51. 42 C.F.R. § 447.56(a) (2018).

52. *Id.* § 447.52.

53. *Id.* §§ 447.52, 447.54.

54. *Id.* § 447.53.

55. *Id.* § 447.56(f).

56. *Healthy Indiana Plan: Key Facts and Issues*, KAISER FAM. FOUND. 1 (2008), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7786.pdf>.

57. *See Id.*

58. Laura D. Hermer & Merle Lenihan, *The Future of Medicaid Supplemental Payments: Can They Promote Patient-Centered Care?*, 102 KY. L.J. 287, 309–11 (2014).

In January 2015, after more than a year of negotiation, the Obama administration granted Indiana a Section 1115 waiver for HIP 2.0.⁵⁹ Indiana expanded its Medicaid program to cover the Affordable Care Act's (ACA) expansion group, working age adults ages nineteen through sixty-four with incomes up to 133% of the federal poverty level, or \$16,040 for a single person.⁶⁰ Under the terms of the demonstration waiver, the Centers for Medicaid and Medicare Services (CMS) waived federal Medicaid rules limiting cost sharing, deductibles and premiums to allow Indiana to enroll new ACA eligible adults, low-income parents and pregnant women in HIP 2.0, a suite of consumer driven health plans that combine a \$2,500 high deductible with a POWER Account.⁶¹ The original HIP 2.0 waiver was for three years, through January 2018.⁶² In February 2018 CMS granted Indiana a waiver extension continuing most components of HIP 2.0 through December 2020, adding some new premium provisions and a controversial new work requirement.⁶³ This article describes HIP 2.0 as it exists in early 2018.

HIP 2.0 offers two types of consumer directed health plans, PLUS and BASIC, both of which have a \$2,500 deductible combined with a \$2,500 POWER Account.⁶⁴ PLUS plans cover more benefits and require a monthly

59. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 1, at 1; Letter from Eric J. Holcomb, Governor of Indiana, to the Honorable Norris Cochran, Acting Secretary of the Department of Health and Human Services, Healthy Indiana Plan § 1115 Waiver Extension 1 (Jan. 31, 2017), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-demo-app-02152-017.pdf>. The formal waiver application was filed with CMS on February 14, 2017.

60. See KAISER FAM. FOUND., *supra* note 1, at 1.

61. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 1, at 1–2, 17; *see also* CTRS. FOR MEDICARE & MEDICAID SERVS., NO. 11-W-00296/5, HEALTHY INDIANA PLAN: SPECIAL TERMS AND CONDITIONS (2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf> [hereinafter CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY INDIANA PLAN 2018]. Pregnant women were not included in HIP 2.0 in the 2015 waiver but were added by the 2018 waiver. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 1, at 9; CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY INDIANA PLAN 2018, *supra*, at 2.

62. CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY INDIANA PLAN 2018, *supra* note 61, at 1.

63. *Id.* at 3–5. The most notable change in 2018 was the addition of a work requirement, a condition of eligibility beyond the scope of this article. Hermer & Lenihan, *supra* note 58, at 309–11. Another important change not beyond the scope of this article is a new provision dis-enrolling most adults who do not timely complete their eligibility renewal process and locking them out of coverage for three months. *Id.* at 26. For a comparison of the 2015 and 2017 waivers, *see* MaryBeth Musumeci et al., *Approved Changes in Indiana's Section 1115 Medicaid Waiver Extension*, KAISER FAM. FOUND. (Feb. 9, 2018), <https://www.kff.org/medicaid/issue-brief/approved-changes-in-indianas-section-1115-medicaid-waiver-extension/> (last visited Apr. 16, 2018).

64. CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY INDIANA PLAN 2018, *supra* note 61, at 19–20. All plans meet the minimum coverage standards under the ACA covering the ten essential health benefits. IND. FAMILY & SOC. SERVS. ADMIN., HEALTHY INDIANA PLAN 2.0 1115

premium,⁶⁵ but have no copays except for non-emergency use of the emergency room.⁶⁶ BASIC plans cover fewer benefits and have no monthly premium, but impose copays for most services.⁶⁷

All HIP 2.0 members are enrolled in one of four HMO networks managed by a private insurance company.⁶⁸ The HMO administers the POWER accounts, sends members monthly notices of their POWER Account balance and copay charges, collects monthly premiums and terminates or changes coverage for those who fail to pay their premiums.⁶⁹

The POWER Account pays for the first \$2,500 of Medicaid-covered services provided by in-network providers.⁷⁰ The POWER Account cannot be used to pay cost sharing or for services not covered by HIP 2.0.⁷¹ To incentivize

WAIVER APPLICATION, INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION 56 (July 2, 2014). About ten percent of enrollees are determined to be medically frail and thus eligible for the State Plan PLUS or State Plan Basic offerings. See LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0: INTERIM EVALUATION REPORT 1 (2016), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/in/healthy-indiana-plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf>. The State Plan options have the most generous benefit package including non-emergency medical transportation, nursing home care, and home and community-based services. *Id.* at 9 tbl. 1. People who are medically frail and eligible for State Plan coverage do not lose coverage for failure to pay their PLUS Power fee. *Id.* at 44.

65. CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY INDIANA PLAN 2018, *supra* note 61, at 5 (Indiana calls this a “POWER Account contribution” or “PAC”). However, this article refers to these as “fees” or “payments” because “contribution” is defined as a gift or donation. See *id.* These payments are required premiums that are deposited into the POWER Account. *Id.* at 2.

66. *Id.* PLUS plans include vision, dental, and chiropractic care and has higher caps on certain services like physical therapy. *Id.* HIP Plus members can get 90-day refills on prescriptions and receive medication by mail order. *Healthy Indiana Plan Member Handbook*, ANTHEM BLUECROSS BLUESHIELD 46 (2016), https://mss.anthem.com/in/inin_caid_hip_memberhandbook_eng.pdf. *Healthy Indiana Plan: Frequently Asked Questions*, IN.GOV (2018), <https://secure.in.gov/fssa/hip/2452.htm> (last visited Apr. 16, 2018). Those whom federal law exempts from cost sharing—including pregnant women and Native Americans—are also exempt from both the POWER Account contribution and copays. LEWIN GROUP, HEALTHY INDIANA PLAN 2.0: POWER ACCOUNT CONTRIBUTION ASSESSMENT 3 (2017), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf>.

67. CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY INDIANA PLAN 2018, *supra* note 61, at 2.

68. *Healthy Indiana Plan: Frequently Asked Questions*, *supra* note 66, at 8 (For 2018, the companies are Anthem, CareSource, MDWise, and MHS); In previous years, enrollees had a choice of only three plans. See CTRS. FOR MEDICARE & MEDICAID SERVS., No. 11-W-00237/5, HEALTHY INDIANA PLAN: SECTION 1115 ANNUAL REPORT 8 (2012).

69. CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY INDIANA PLAN 2018, *supra* note 61, at 7–13.

70. *Id.* at 19.

71. *Id.*

patients to get preventive care, recommended preventive services are not charged against the POWER Account.⁷²

PLUS members pay a monthly premium that is deposited into the POWER Account.⁷³ Premiums range from \$12 to \$240 annually, due in monthly installments of \$1, \$5, \$10, \$15, or \$20 depending on income and family size.⁷⁴ Smokers pay fifty percent more.⁷⁵ When the HIP 2.0 experiment started, premiums were pegged to two percent of income.⁷⁶ Now, smokers are charged closer to three percent of income.⁷⁷ Moreover, those at the very bottom of the income scale earning under twenty-two percent FPL, \$221 per month for a single person, pay more than two percent of income because the minimum premium is a \$1 per person per month.⁷⁸ Third parties, including employers, not-for-profits and health care providers may contribute all or part of a person's POWER Account premium.⁷⁹

HIP PLUS, with its premium requirement, is the only option for people earning above the FPL (\$12,060 a year for a single person) who are not medically frail.⁸⁰ Those earning above poverty who are determined eligible for HIP, but who do not pay their first month's premium within sixty days, never actually get HIP 2.0 coverage, although they can re-start the application process

72. IND. FAMILY & SOC. SERVS. ADMIN., MEMBER ELIGIBILITY AND BENEFIT COVERAGE 27 (2017).

73. *Id.* at 21.

74. Under the 2015 waiver, fees were pegged to two percent of income rather than being tiered. See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 1, at 17; *see also* Musumeci et al., *supra* note 63, at 1.

75. See IND. FAMILY & SOC. SERVS. ADMIN., HEALTHY INDIANA PLAN (HIP) 2.0 No. 11-W-00296/5, CENTERS FOR MEDICARE & MEDICAID SERVICES SPECIAL TERMS AND CONDITIONS 21 (2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf>; This is the first time CMS has allowed a state to impose a Medicaid surcharge on smokers. Musumeci, *supra* note 63, at 2.

76. Musumeci, *supra* note 63, at 2.

77. IND. FAMILY & SOC. SERVS. ADMIN., HEALTHY INDIANA PLAN (HIP) SECTION 1115 WAIVER EXTENSION APPLICATION 26 (2017). Nonsmokers earning 0–22% of federal poverty level pay one dollar per month from an income of \$0–\$221, those with incomes up to 23–50% of the federal poverty level pay five dollars per month on an income of \$222–\$50.2, those earning 51%–75% of poverty, pay \$10 per month from a monthly income of \$503–\$753 per month, those earning 101–138% of poverty pay \$20 per month from income ranging from \$1,006–\$1387, and smokers ultimately pay 50% more. CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY INDIANA PLAN 2018, *supra* note 61, at 21.

78. CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY INDIANA PLAN 2018, *supra* note 61, at 21.

79. *Id.* at 23.

80. *Id.* at 11–12.

at any time and try again.⁸¹ Those earning above poverty who make their first month's premium and then fall behind are dis-enrolled from HIP 2.0 and "locked out" of HIP 2.0 coverage for six months, at which point they can start the application process all over again.⁸²

HIP PLUS is also the preferred option for those earning below the federal poverty line and those who are medically frail. Once determined eligible for HIP, these people are automatically enrolled in HIP PLUS pending payment of their first month's premium.⁸³ People who fail to make a premium payment within sixty days continue to be eligible but are shifted to HIP BASIC with coverage beginning in month three.⁸⁴ Those who make at least one premium payment but then fall behind on their monthly premiums are switched from PLUS to BASIC with fewer services and higher copays after a sixty-day grace period.⁸⁵

HIP BASIC copays typically make it more expensive than PLUS, particularly for the medically frail and the very poor.⁸⁶ For those with the lowest incomes who are assessed a flat one-dollar monthly premium and who have multiple medical appointments or prescriptions, it is less expensive to pay the twelve-dollar annual PLUS premium than to pay the BASIC copays. Copays are four dollars for a doctor visit and most outpatient care, four dollars for generic prescriptions, eight dollars for brand name prescriptions, and seventy-five dollars for hospital care.⁸⁷ One doctor visit and a couple of maintenance prescriptions easily surpass the twelve-dollar annual premium costs for a PLUS plan.⁸⁸

81. *Id.* at 10.

82. *Id.* at 23.

83. HEALTHY IND. PLAN (HIP) 2.0 No. 11-W- 00296/5, CENTERS FOR MEDICARE & MEDICAID SERVICES WAIVER LIST 1 (2018).

84. CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY INDIANA PLAN 2018, *supra* note 61, at 11.

85. *Id.* at 2. *But see* Musumeci et al., *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana*, KAISER FAM. FOUND. 1, 13 (Jan. 31, 2017), <https://www.kff.org/report-section/an-early-look-at-medicaid-expansion-waiver-implementation-in-michigan-and-indiana-key-findings/> (explaining that about ten percent of HIP 2.0 enrollees have been determined to be medically frail); *Healthy Indiana Plan: Frequently Asked Questions*, *supra* note 66; *see also* CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY INDIANA PLAN 2018, *supra* note 61, at 14.

86. *See* LEWIN GROUP, *supra* note 64, at 37–38.

87. ANTHEM BLUECROSS BLUESHIELD, *supra* note 66, at 22.

88. Premiums and cost sharing are supposed to be capped at five percent of income on a quarterly income. Samantha Artiga et al., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings*, KAISER FAM. FOUND. 2 (June 1, 2017), <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/> (last visited Apr. 16, 2018); *see also* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 1, at 21 (“[T]he aggregate contributions paid and debt incurred during a calendar quarter cannot exceed more than 5 percent of the individual’s quarterly income per 42 CFR 447.78.”).

The state funds 100% of the \$2,500 POWER Account for BASIC members and 90–99.5% for PLUS members.⁸⁹ Patients have no claim to unspent state POWER Account funds, either at the end of the year or when they leave HIP 2.0.⁹⁰

Patients may be able to recoup unspent amounts from their \$12–\$240 a year PLUS premiums. Unspent premiums can be carried over to help pay the next year's POWER Account premium, but only for members who are enrolled for a full twelve months and who are up-to-date on the POWER Account premiums.⁹¹ When members leave HIP 2.0 PLUS, they are both entitled to a refund of their unspent POWER Account premiums and potentially liable for additional monthly premiums up to their annual premium amount if their POWER Account spending was more than their monthly contribution.⁹²

The governor of Indiana has declared, “A decade after it launched, Indiana’s HIP program has become the national model for a state-led, consumer-driven healthcare program that meets citizens’ needs, provides choices and improves lives.”⁹³ How well does HIP 2.0 fare as consumer driven health care?

IV. TEST DRIVING HIP 2.0: HOW DOES IT FARE UNDER CONSUMER DRIVEN HEALTH CARE THEORY?

Indiana describes HIP 2.0 and the POWER Accounts as “like an HSA,” but POWER Accounts are not like HSAs. HSAs are tax-free interest-bearing accounts owned by the patient. Unused balances can be carried over from year to year without limit, and the patient can use the HSA to pay for any type of medical or other expense.⁹⁴ POWER Accounts have none of these features.

POWER Accounts are more like an HRA, the employer-established accounts that attach to employer health plans.⁹⁵ The state, not the patient,

89. CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY INDIANA PLAN 2018, *supra* note 61, at 7–13.

90. See IND. FAMILY & SOC. SERVS. ADMIN., POWER ACCOUNT CONTRIBUTIONS AND COPAYMENTS INFRASTRUCTURE OPERATIONAL PROTOCOL 10 (Feb. 26, 2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-Pwr-acct-copay-prtcl-02262015.pdf>; 405 IND. ADMIN. CODE 10-10-5, 10-10-6 (2015).

91. IND. FAMILY & SOC. SERVS. ADMIN., *supra* note 90, at 1–2; 405 IND. ADMIN. CODE 10-10-5.

92. IND. FAMILY & SOC. SERVS. ADMIN., *supra* note 90, at 10–13; 405 IND. ADMIN. CODE 10-10-5, 10-10-6, 10-10-7.

93. Press Release, Gov. Holcomb, Secretary Azar Announce Federal Approval to Continue and Enhance the Healthy Indiana Plan (Feb. 2, 2018), <https://secure.in.gov/fssa/hip/files/PRESS-RELEASE-HIP-Approved-February-2-2018.pdf>; Verma & Neale, *supra* note 2. Indiana’s waiver applications and other descriptions of HIP 2.0 all describe the POWER Account as “similar to an HSA.” See IND. FAMILY & SOC. SERVS. ADMIN., *supra* note 3, at 6.

94. See *supra* notes 15–16 and accompanying text; Francis et al., *supra* note 15, at 257–58.

95. See *supra* note 20 and accompanying text.

establishes, owns and controls the POWER Account.⁹⁶ The state limits the medical expenses that can be reimbursed from the POWER Account, constrains the POWER Account funds that can be carried over from year-to-year and how they are used, and restricts what happens to enrollees' unspent premiums deposited into the POWER Account.⁹⁷

POWER Accounts do not create incentives for patients to engage in comparison shopping among providers. The POWER Account can only be used to pay for Medicaid covered services provided by in-network providers. State law requires HIP 2.0 to pay providers at Medicare rates,⁹⁸ and while some providers may get paid more by Medicare than others, this information is not made available to HIP 2.0 enrollees. Neither the state nor the HIP 2.0 HMOs provide patients with information that would allow them to comparison shop among in-network providers.⁹⁹ Furthermore, HIP 2.0 has an active case management system designed to help patients navigate the health system, matching patients with providers based on care coordination and replacing consumer cost consciousness with professional management.¹⁰⁰

POWER Accounts, like HRAs, send weak "skin in the game" signals because patients do not have much at stake with a POWER Account. The state solely funds the POWER Account for BASIC members and provides 90–99.5% of the funding for PLUS members. The patient has no claim to these state dollars. Unused state money left in the POWER Account reverts to the state when a person loses HIP coverage or at the end of the year, whichever occurs first.¹⁰¹

POWER Accounts also send weak "skin in the game" signals because it is nigh on impossible for people to understand, much less qualify for, the relatively small amounts of unspent premiums left in their POWER Account when they

96. HRAs are actually reimbursement arrangements, rather than accounts. *See* Francis et al., *supra* note 15, at 264. The employer only moves money into an account to pay claims as they come due. *Id.* No account is pre-funded, which is the case with HSAs. *Id.*

97. *See supra* Section IV for a discussion on POWER account operation.

98. IND. FAMILY & SOC. SERVS. ADMIN., *supra* note 72, at 12 (HIP 2.0 providers are to be paid Medicare rates or 130% of Medicaid rates if no comparable Medicare rates).

99. Only one of the four private HMOs that administer HIP 2.0 plans (Anthem) has information in its enrollee handbook encouraging patients to comparison shop for lower cost providers. *See* ANTHEM BLUECROSS BLUESHIELD, *supra* note 66, at 56. No HMO, however, provides information to enrollees that would allow them to compare price among network providers. *See id.*; *Member Handbook for 2018: A Reference Guide to Your Health Care Benefits*, CARESOURCE 8 (2018), <https://www.caresource.com/documents/mp-2018-in-member-handbook/>; *Healthy Indiana Member Handbook*, MDWISE 7 (2014), <https://www.mdwise.org/MediaLibraries/MDwise/Files/For%20Members/eng-mh.pdf>; *HIP Member Handbook*, MHS IND. 8 (2017), <https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/2017>.

100. LEWIN GROUP, *supra* note 64, at 97–99.

101. IND. FAMILY & SOC. SERVS. ADMIN., *supra* note 90, at 9–10 (explaining how PLUS members may have claim to a share of their premium payments but not the state's contributions and how BASIC members can earn premium reductions but do not have claim to any state money in their POWER Account at the end of the year).

leave HIP 2.0 coverage or roll-over coverage from year to year. The rules to “keep” unspent premiums are complicated.¹⁰² Premium refunds are calculated at the end of the calendar year—not when people leave HIP—making it unlikely that people will make the connection between their premium refund and their use of health care.¹⁰³ People who lose coverage because of premium non-payment are assessed a penalty that reduces any premium refund by twenty-five percent.¹⁰⁴

The rules for rolling over unspent premiums in the POWER Account to help with the next year’s premium payments are equally as byzantine and confusing. First, the only people who can roll-over premiums from one year to the next are people who remain enrolled in HIP 2.0 for a full calendar year and who are up-to-date with their premiums.¹⁰⁵ Research on Medicaid enrollment shows that generally only about sixty to seventy-five percent of Medicaid enrollees actually stay enrolled in Medicaid for a full year.¹⁰⁶ As discussed in the next section, churning in and out of HIP coverage has been an even bigger issue in Indiana: During the first year of HIP 2.0 only about twenty-five percent of enrollees kept coverage for a full year.

Second, the process for computing and rolling-over unspent POWER Account premiums at year’s end is so complicated and so slow that the reward is disconnected from the behavior it is meant to encourage.¹⁰⁷ Here is how it works: Sarah has a premium of twelve dollars a year, one dollar per month,

102. See JANE B. WISNER ET AL., MEDICAID EXPANSION, THE PRIVATE OPTION, AND PERSONAL RESPONSIBILITY REQUIREMENTS: THE USE OF SECTION 1115 WAIVERS TO IMPLEMENT MEDICAID EXPANSION UNDER THE ACA 16 (May 2015), <https://www.urban.org/sites/default/files/publication/53236/2000235-Medicaid-Expansion-The-Private-Option-and-Personal-Responsibility-Requirements.pdf>.

103. POWER Accounts are activated and funded on a yearly basis, and the patient’s POWER Account fee is also calculated as an annual contribution with payment required monthly. LEWIN GROUP, *supra* note 64, at 11. If a person loses HIP coverage for a month or more, the account is suspended and reactivated if they regain eligibility. *Id.* at 8–29. POWER Account funds and charges are calculated at year’s end to determine if there is a balance remaining. *Id.* at 84. Indiana’s HIP 2.0 enrollment suffers from a lot of “churn,” meaning people roll on and off coverage from month to month: only twenty-five percent of enrollees retain coverage for a full year. *Id.* at 106.

104. IND. FAMILY & SOC. SERVS. ADMIN., *supra* note 90, at 10.

105. Musumeci et al., *supra* note 85, at 17.

106. Benjamin D. Sommers et al., *Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower Than Expected but Still Harmful for Many*, 35 HEALTH AFF. 1816, 1818 (2016).

107. Jake Harper, *Indiana’s Model for Medicaid Could Spread—But It’s Not Working for Everyone*, WFYI.ORG (Jan. 10, 2017), <https://www.wfyi.org/news/articles/indianas-model-for-medicaid-could-spreadbut-its-not-working-for-everyone> (“According to a survey commissioned by the state, 40 percent of HIP members had never heard of a POWER account, even though they all have one. More than half of survey respondents who had been bumped to HIP Basic for missing a payment said they did not know they needed to make a contribution to their POWER account, or that they were confused about their membership and plan type.”).

meaning that her premiums contribute 0.5% of the \$2,500 in the POWER Account. Sarah stays enrolled for twelve continuous months and at the end of the year Sarah has used \$1,500 of her POWER Account, leaving a \$1,000 balance. Sarah gets credit for five dollars in unspent premiums, 0.5% of the funds remaining in the POWER Account, which the state will apply to her next year's premium. Sarah obtained her recommended preventive care, so her five dollars is doubled up to the amount of her next year's premium. Sarah's next year's premium is twelve dollars per year, one dollar per month. This means Sarah has ten dollars to roll-over to help pay for the next year's premiums, leaving her owing only two dollars for her annual premium for the next year.¹⁰⁸ However, the process for computing and reconciling unspent POWER Account funds takes three months, which means Sarah remains liable for her full monthly premium of one dollar a month for the first three months of the next year. By the time, Sarah's roll-over amount is calculated and available, she has already paid three dollars in monthly premiums and lost one dollar of her ten-dollar roll-over incentive for the year.¹⁰⁹

POWER Accounts are just plain confusing. HIP 2.0 requires that the HMOs mail all enrollees a monthly statement.¹¹⁰ The first part records the payment status and balance due for monthly premiums and copays.¹¹¹ The second part tracks the use of medical services, charges against the POWER Account, and charges covered by the "traditional" insurance portion of HIP.¹¹² The POWER Account statements are even more complicated and confusing than Estimates of Benefits (EOBs) sent by commercial insurers.¹¹³ The reader can see this for herself by reading the POWER Account statement attached as Appendix A. The costs to generate and mail these notices to nearly 400,000 people each month are substantial.¹¹⁴ The possibility of error is even more substantial.¹¹⁵ They certainly do not help educate consumers, but only serve to add to the confusion.

108. Obtaining preventive care allows enrollees to double their carry over amounts, but only up to the total amount of their annual PAC fee. ANTHEM BLUECROSS BLUESHIELD, *supra* note 66, at 33.

109. IND. FAMILY & SOC. SERVS. ADMIN., POWER ACCOUNT, *supra* note 90, at 1-3; IND. FAMILY & SOC. SERVS. ADMIN., HIP 2.0, INFORMATION ABOUT POWER ACCOUNT CREDITS AND ROLLOVERS (2017).

110. IND. FAMILY & SOC. SERVS. ADMIN., POWER ACCOUNT, *supra* note 90, at 8-9.

111. Monthly HIP POWER Account Statement, Anthem BlueCross Blue Shield (Jan. 6, 2016) (attached as Appendix A).

112. *Id.*

113. For a sample Explanation of Benefits from Blue Cross Blue Shield, see *Explanation of Benefits*, BLUECROSS BLUE SHEILD OF N. C., <https://www.bcbsnc.com/members/public/forms/eob/> (last visited May 15, 2018).

114. See Musumeci, et al, *supra* note 63, at 3 (HIP 2.0 enrolled nearly 397,000 people as of December 17, 2017).

115. IND. FAMILY & SOC. SERVS. ADMIN., *supra* note 90, at 1-3.

POWER Accounts also add administrative costs to Medicaid. HMOs must keep track of people's proper premium assessment amount as their incomes change during the year.¹¹⁶ Indiana and the HMOs have struggled to figure out how to collect small monthly payments of one to twelve dollars from people who typically do not have bank accounts or access to automatic debit systems.¹¹⁷ HMOs must also track POWER Account payments, send notices to those who fall behind, and terminate or change coverage for those who miss two months payment. The possibility for error in such a complicated system is large.

Finally, the POWER Account premium obligation imposes a confusing and misleading requirement that has no corollary in the world of consumer driven health plans, HSAs and HRAs. Indiana calls these payments "POWER Account contributions" or "PACs," and claims they are *not* premiums because they are deposited in the POWER Account, and, under the state's stringent and complex rules, may be available for rollover or return.¹¹⁸ However, "POWER Account contributions," by whatever name, should appropriately be classified as premiums because they are a condition of eligibility and failure to pay results in loss of coverage or movement to the less generous and more costly BASIC coverage.¹¹⁹

Indiana claims that POWER Account premiums help educate HIP enrollees about how private insurance works, but POWER Account premiums are unlike anything in the employer or individual market. In the commercial market people pay premiums but they are not deposited into their HSAs or HRAs. In fact, employees are prohibited from contributing to their HRAs. While people may deposit money into their HSAs, they are not at risk of losing private insurance coverage if they are unable to fund their HSA. Indiana's POWER Account premium is more likely to confuse people about how private insurance, HSAs and HRAs work than it is to educate them.

While Indiana may claim that paying a monthly POWER Account premium is good practice for learning to pay a health insurance premium, most working age Americans are covered by employer sponsored insurance.¹²⁰ Employee premiums are deducted automatically from their pay checks on a pre-tax

116. *Id.* at 17–18, 20.

117. *See Harper, supra* note 107.

118. *See* IND. FAMILY & SOC. SERVS. ADMIN., POWER ACCOUNT, *supra* note 90, at 10–11.

119. 2018 HIP Waiver Renewal, IND. FAMILY & SOC. SERVS. ADMIN. 39, 60 (Feb. 20, 2018), <http://www.in.gov/fssa/hip/files/HIP%20Navigator%20and%20Stakeholder%20Presentation%202.16.18.pdf>. (Those earning over 100% FPL are terminated from HIP and locked out of coverage and may not re-enroll for six months. Those earning under 100% or are medically frail are moved to BASIC coverage with fewer benefits and copayments that must be paid out of pocket and cannot come from the POWER Account).

120. *See Health Insurance Coverage of Adults 19-64*, KAISER FAM. FOUND. (2016) <https://www.kff.org/other/state-indicator/adults-19-64/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited May 15, 2018) (fifty-nine percent covered by employer sponsored insurance).

basis.¹²¹ Most working age Americans really do not have to worry about paying their monthly health insurance premium. It is done for them by their employer.

POWER Accounts are nothing like HSAs. POWER Account premiums are nothing like HSA contributions. HIP 2.0 is really nothing like HSA plans in the commercial market. Consumer driven health care theory predicts that HIP 2.0 and POWER Accounts will not be effective at empowering consumers or reducing unnecessary costs. However, one has to be concerned that PLUS premiums will create barriers to enrollment and BASIC copays will create barriers to care.

V. ROAD TESTING HIP 2.0 AND POWER ACCOUNTS: HOW DOES CONSUMER DRIVEN MEDICAID PERFORM IN THE REAL WORLD?

How is consumer driven Medicaid working in Indiana? Certainly, HIP 2.0's Medicaid expansion has brought needed health insurance and health care to poor and sick Hoosiers.¹²² As of December 2017, HIP 2.0 covered nearly 397,000 people.¹²³ HIP, like every other Medicaid expansion, has reduced the number of uninsured people in Indiana, providing coverage to many who were uninsured or had only sporadic coverage.¹²⁴ It has increased access to medical care including primary, preventive and specialty care, and mental health services.¹²⁵

HIP 2.0 covers a group of extremely poor and very sick people: A whopping forty-four percent of HIP 2.0 enrollees have incomes below five percent of poverty, \$603 a year for a single person.¹²⁶ Eighty-three percent live below the

121. See *Key Elements of the U.S. Tax System: How Does the Tax Exclusion for Employer-Sponsored Health Insurance Work?*, TAX POLICY CRTR., URBAN INST. & BROOKINGS INST., <http://www.taxpolicycenter.org/briefing-book/how-does-tax-exclusion-employer-sponsored-health-insurance-work> (last visited May 15, 2018) (explaining a portion of premiums paid by employees is typically excluded from taxable income).

122. IND. FAMILY & SOC. SERVS. ADMIN., HIP CMS METRICS 1 (Dec. 19, 2017), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-2017-dec-metrics-rpt-12192017.pdf>; LEWIN GROUP, *supra* note 64, at 18–20; Musumeci et al., *supra* note 85, at 10.

123. Musumeci et al., *supra* note 63, at 3.

124. See Robin Rudowitz et al., *Digging Into the Data: What Can We Learn From the State Evaluation of Healthy Indiana (HIP 2.0) Premiums*, KAISER FAM. FOUND. 2 (Mar. 2018), <http://files.kff.org/attachment/Issue-Brief-Digging-Into-the-Data-What-Can-We-Learn-from-the-State-Evaluation-of-Healthy-Indiana-HIP-20-Premiums> (“Between 2013-2016, the nonelderly uninsured rate dropped by 7.0 percentage points in Indiana, larger than both the national average decrease of 5.2 % and the 5.5 % decrease in all Medicaid expansion states.”); Musumeci et al., *supra* note 85, at 10. Most people who lose or never got HIP 2.0 coverage became uninsured. Rudowitz et al. *supra* note 124, at 4. (In a survey of those who never enrolled or left coverage, fifty-nine percent of those who were unable to enroll and fifty-three percent of those who lost coverage reported being uninsured).

125. LEWIN GROUP, *supra* note 64, at 17; Musumeci et al., *supra* note 85, at 10.

126. IND. FAMILY & SOC. SERVS. ADMIN., *supra* note 122; *Federal Poverty Guidelines*, FAMILIES USA (Feb. 2017), <http://familiesusa.org/product/federal-poverty-guidelines> (last visited

poverty line, \$12,060 for a single person.¹²⁷ The remaining seventeen percent earn between 100–138% of poverty, \$12,061 to \$16,040 for a single person.¹²⁸ Almost sixty percent suffer from one or more chronic behavioral or physical health condition.¹²⁹ Twenty-two percent have chronic psychiatric problems, twenty-one percent have chronic cardiovascular problems, fourteen percent have chronic skeletal conditions, and thirteen percent have chronic gastrointestinal illness.¹³⁰

Most HIP 2.0 members are enrolled in PLUS plans with a premium requirement. As of December 2017, about two-thirds of HIP enrollees were in PLUS plans and one-third were in BASIC plans.¹³¹ HIP enrollees say they prefer the predictability of PLUS plan premiums over HIP BASIC's often more expensive copayments.¹³² Advocates and enrollment assisters report that people are more motivated to pay monthly POWER Account premiums to avoid copays than to access HIP PLUS's more generous benefit package.¹³³

PLUS members are older and sicker than BASIC members.¹³⁴ Not surprisingly, PLUS enrollees also use more health care services than do BASIC members for most types of services: primary, specialty, preventive and urgent care.¹³⁵ While PLUS members' greater use of medical care correlates with their poorer health status and greater health care needs,¹³⁶ copays in the BASIC plan may also be reducing usage among BASIC members.

How well do HIP 2.0, POWER Accounts and consumer driven health care perform when covering such poor and sick people? Do people understand how the POWER Accounts work? Do POWER Accounts encourage cost conscious use of medical services for people who have such serious and ongoing health care needs while encouraging the use of high quality care? Do the copays in the

Apr. 18, 2018) (100% of FPL for a single person is \$12,060). The state has consistently reported that about half of enrollees are extremely low income. *See* Musumeci et al., *supra* note 85, at 12 (opining that these high numbers could be the result of administrative challenges of tracking income for a population that has frequent income changes). *See* LEWIN GROUP, *supra* note 64, at 20–21 (Explaining the high poverty level numbers may be the result of point in time information rather than average income for the year, which is used by national surveys).

127. IND. FAMILY & SOC. SERVS. ADMIN., *supra* note 122, at 1.

128. *Id.* Lewin GROUP, *supra* note 64, at 102 (reporting thirty-seven percent have one to two chronic conditions and another twenty-four percent have more than two chronic conditions).

129. LEWIN GROUP, *supra* note 64, at 102 (reporting thirty-seven percent have one to two chronic conditions and another twenty-four percent have more than two chronic conditions).

130. *Id.* at 19–20, 101.

131. IND. FAMILY & SOC. SERVS., *supra* note 122.

132. Musumeci et al., *supra* note 85, at 14 (based on focus group research).

133. *Id.* at 14–15.

134. LEWIN GROUP, *supra* note 64, at 71.

135. *Id.* at 96. The only exception is emergency room use, which tends to correlate to income more than plan enrollment or health status. *Id.* at 57, 89.

136. *Id.* at 4.

BASIC plans create barriers to care? How do HIP enrollees' use of medical care compare to that of Medicaid enrollees without a consumer driven health plan? Do premiums create barriers to enrollment?

HIP 2.0 is being implemented pursuant to a Section 1115 demonstration waiver. The ACA created new requirements intended to ensure that such experiments are rigorously evaluated and that the evaluations are publicly available.¹³⁷ Pursuant to these new provisions, Indiana is obliged to conduct interim and final evaluations of HIP 2.0. The state has contracted with The Lewin Group for those evaluations and The Lewin Group has produced two interim evaluations, a first-year evaluation of HIP 2.0 generally and a second evaluation after twenty-two months that looks specifically at POWER Account premiums.¹³⁸ The final evaluation is due in April 2018.¹³⁹

So far, Indiana's state-level evaluations have disappointed. The Government Accountability Office (GAO) has criticized Indiana's interim reports for their failure to use comparison groups and for relying on surveys with insufficient sample sizes and response rates.¹⁴⁰ Much of the data is presented in ways that tend to obfuscate and hide the ball, making it hard for the public and other researchers to evaluate the underlying data.¹⁴¹ The state evaluations do not address many of the key questions one would like answered to be able to compare consumer driven Medicaid with traditional Medicaid coverage, including how enrollment and spending in HIP 2.0 compares with traditional Medicaid.¹⁴² For example, Indiana's evaluation will not look at the effect of the six-month coverage lockout for those who fail to pay their POWER Account premiums.¹⁴³

137. See Sidney D. Watson, *Out of the Black Box and Into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion*, 15 YALE J.L. POL'Y & ETHICS 213, 215 (2015).

138. Both of these evaluations are required under the Special Terms and Conditions for the waiver. For a discussion of federal requirements for state evaluations of Section 1115 waivers, see GOV'T ACCOUNTABILITY OFF., GAO-18-220, MEDICAID DEMONSTRATIONS: EVALUATIONS YIELDED LIMITED RESULTS, UNDERSCORING NEED FOR CHANGES TO FEDERAL POLICIES AND PROCEDURES 8-9 (2018).

139. *Id.* at 9 ("CMS requires states to submit a final evaluation report for review and approval generally after the end of the demonstration, at which time the agency can work with the state to, for example, add clarity and disclose the limitations of the evaluation before the final evaluation report is made public.").

140. *Id.* at 13 ("For example, CMS's contractor [Mathematica Policy Research] raised concerns about the comparison groups, or lack thereof, used to isolate and measure the effects of the demonstrations in the Arkansas, California, Indiana, and Maryland evaluations.").

141. For example, The Lewin Group reports the percentage of total HIP 2.0 enrollees who lost coverage because of failure to pay premiums. Really, the relevant data point is what percentage of those with incomes over 100% of poverty who could lose coverage because of failure to pay premiums did, in fact, lose coverage. See LEWIN GROUP, *supra* note 64, at 44.

142. See GOV'T ACCOUNTABILITY OFF., *supra* note 138, at 26.

143. *Id.* at 29.

CMS planned to produce two federal multi-state evaluations that would have addressed some of these key questions using cross-state data. However, CMS's efforts have been stymied by Indiana's refusal to share data with CMS's evaluation contractors—allegedly because of privacy concerns.¹⁴⁴ One federal evaluation was intended to compare outcomes from Indiana's demonstration to those for states that expanded Medicaid without a demonstration and to some states that did not expand Medicaid. It was expected to provide information on whether monthly POWER Account premiums affect enrollment.¹⁴⁵ The federal evaluation was also designed to test the impact of POWER Account premiums on those below and above poverty, and the impact of the lock out period.¹⁴⁶

Despite the lack of vital data about HIP, one thing is clear: HIP PLUS premiums have created serious barriers to enrollment and coverage in Indiana. During the first two years of HIP 2.0, more than half (fifty-five percent) of those required to pay premiums failed to do so and suffered for it.¹⁴⁷ Those with incomes above poverty either never got covered or got covered and lost their coverage. Those below poverty were moved to less generous BASIC plans with copays.

Over half (fifty-one percent) of those with incomes above poverty who were determined eligible for HIP 2.0 either never enrolled or lost coverage for failure to pay premiums.¹⁴⁸ In people terms, almost 60,000 people were either dis-enrolled or not enrolled in HIP 2.0 because of missed POWER Account premiums: 46,000 never got coverage because they did not make their first POWER Account premium; 13,550 people enrolled but later lost coverage because of missed premiums; 9,600 people were dis-enrolled and locked out of coverage for six months; and 4,000 people were dis-enrolled without a lock out.¹⁴⁹

Almost sixty percent of people with incomes below poverty who enrolled in HIP 2.0 were moved from HIP PLUS to HIP BASIC because of premium non-

144. *Id.* at 11–12, 24, 26, 29.

145. *Id.* at 27 (“The multi-state evaluation, for example, is expected to provide information on whether living in a state that collects monthly contributions from beneficiaries affects the likelihood of beneficiaries enrolling in Medicaid and how per-beneficiary spending differs between premium assistance demonstration states and states that have implemented more traditional Medicaid expansions.”).

146. *Id.* at 12, 27.

147. LEWIN GROUP, *supra* note 64, at 8 (The study was commissioned by the State of Indiana as part of the required evaluation of HIP 2.0's Section 1115 Waiver. It is based upon data from the first 20 months of the HIP 2.0 program).

148. Rudowitz et al., *supra* note 124, at 3; LEWIN GROUP, *supra* note 66, at 6–8 (During the first twenty months 57,189 members were dis-enrolled or not enrolled due to non-payment, which represents fifty-one percent of individuals with income over 100% of poverty determined eligible).

149. Rudowitz et al., *supra* note 124, at 3 (Figure 2 illustrates “[a]ffordability and confusion were the top 2 reasons for premium non-payment reported in Indiana.”); LEWIN GROUP, *supra* note 66, at 8–10.

payment.¹⁵⁰ In a two-year period, 287,000 people were moved from PLUS to BASIC coverage because of missed premiums.¹⁵¹

Even though HIP enrollees prefer the predictability of POWER Account premiums over HIP BASIC's often more expensive copayments,¹⁵² the premium requirement thwarts and confounds them. People report the chief reasons they missed paying POWER Account premiums were they "could not afford to pay" or "confusion about payment policies."¹⁵³ Unaffordability tops the list: Forty-four percent of those who lost coverage, twenty-two percent of those who never made a premium payment, and thirty-four percent of those moved to BASIC plans because of a missed premium say they missed payments because they could not afford it.¹⁵⁴ Confusion over the premium policies came in second: twenty-seven percent of those who never enrolled, seventeen percent of those who lost coverage, and seventeen percent of those who were moved to BASIC failed to pay their premiums because they were confused about the payment rules.¹⁵⁵ Another twenty-five percent of those moved to BASIC did not realize that a premium was even required.¹⁵⁶

People need help to meet their premium payments. One in four HIP 2.0 PLUS enrollees report getting help to pay their premiums.¹⁵⁷ Most people got help from a family member, eighty-seven percent. Twenty-four percent got help from a friend.¹⁵⁸ Very few people reported receiving help from an employer, charity, or religious organization, even though Indiana has encouraged employers, not-for-profits and providers to provide help.¹⁵⁹

150. Rudowitz et al., *supra* note 124, at 3; LEWIN GROUP, *supra* note 66, at 8–10 (finding fifty-seven percent were moved from HIP Basic to Plus).

151. LEWIN GROUP, *supra* note 66, at 8 (finding an exact total of 286,914 people).

152. Musumeci et al., *supra* note 85, at 14 (Based on focus group research of different HIP stakeholders. "Advocates and enrollment assisters reported that beneficiaries appeared to be more motivated to pay monthly premiums based on the opportunity to avoid point-of-service copayments than by the ability to obtain additional benefits like vision and dental available in HIP Plus, although those services were cited as valued by beneficiaries as well.").

153. LEWIN GROUP, *supra* note 66, at 19–20. (Respondents reported confusion as to the amount due, the date due, and to whom the payment was due); Rudowitz et al., *supra* note 124, at 4. ("The top two reasons cited by people who never enrolled in or lost HIP 2.0 coverage were affordability and confusion about the payment process.").

154. LEWIN GROUP, *supra* note 66, at 19–20; Rudowitz et al., *supra* note 124, at 4.

155. LEWIN GROUP, *supra* note 66, at 19–20; Rudowitz et al., *supra* note 124, at 4 ("Another 22 percent of those who never made an initial payment and 17 percent of those who were disenrolled for missing a payment said that they were confused about how much, when or where to pay.").

156. LEWIN GROUP, *supra* note 66, at 19–20; Rudowitz et al., *supra* note 124, at 4.

157. LEWIN GROUP, *supra* note 66, at 15 ("About 24 percent of HIP Plus Member respondents [] indicated that they received help from a third party."); Rudowitz et al., *supra* note 124, at 4.

158. LEWIN GROUP, *supra* note 66, at 15; Rudowitz et al., *supra* note 124, at 4.

159. LEWIN GROUP, *supra* note 66, at 15 ("Very few members reported receiving help from an employer ... or a charity or religious organization.").

The POWER Accounts also confuse people. In focus groups organized by Kaiser Family Foundation, HIP enrollees, advocates and providers all said they were confused about how POWER Accounts work, their purpose and the monthly statements.¹⁶⁰ Some enrollees thought the \$2,500 starting balance on the POWER Account card was a cap on services.¹⁶¹ The POWER Account card is a debit card that is supposed to be presented to the provider at the time of service for payment, but many enrollees do not understand this and some providers refuse to accept the POWER Account debit card, preferring to use the traditional billing and reimbursement process.¹⁶² Indiana starting using POWER Accounts with HIP 1.0 in 2007.¹⁶³ Almost ten years later people still did not understand how they work.

Focus group participants also reported being confused by the monthly POWER Account statements.¹⁶⁴ As one participant said, “When I get those statements...I’m not really understanding what it’s all about...I mean you’re seeing all your services, but I really don’t understand the POWER Account, what it’s all about and so on. It’s hard to understand.”¹⁶⁵

It seems unlikely that POWER Accounts have made enrollees more cost-conscious consumers of medical care since most HIP 2.0 enrollees do not even realize they have a POWER Account. In a survey conducted as part of Indiana’s one-year evaluation, only about one-third of BASIC members and less than one-half of PLUS members surveyed reported knowing they had a POWER Account.¹⁶⁶ Only ten percent of BASIC members and nineteen percent of PLUS members reporting reading their monthly POWER Account statement.¹⁶⁷

160. Musumeci et al., *supra* note 85, at 15.

161. *Id.* (The authors posit this “could inhibit, rather than encourage the receipt of necessary preventive services.”).

162. *Id.* at 15–16.

163. Hermer & Lenihan, *supra* note 58, at 308.

164. Musumeci et al., *supra* note 85, at 15.

165. *Id.* at 16 (quoting an Indiana Medicaid enrollee). The reader can see a POWER Account statement and decide for herself if it is confusing. A monthly POWER Account statement is reproduced in Appendix A, with personal information deleted.

166. *See* LEWIN GROUP, *supra* note 64, at 65, 66 tbl. 2.1.2. Among Basic members surveyed, forty-six percent had heard of a POWER Account and, of those, seventy-six percent said they had a POWER Account, meaning that thirty-five percent of all enrollees responded that they had a POWER Account. *See id.* Among PLUS enrollees sixty-six percent had heard of POWER Accounts and, of those, seventy-two percent said they had a POWER Account, meaning that only forty-eight percent of PLUS enrollees were aware they had a POWER Account. *See id.*

167. *See id.* at 65–66. Indiana’s HIP 2.0 Waiver Extension Application claimed the POWER Accounts were producing more cost-conscious consumers because “40% of HIP Plus and 30% of HIP Basic members reported checking their POWER Account balance monthly.” IND. FAMILY & SOC. SERVS. ADMIN., *supra* note 90, at 5 (“[T]he POWER account has helped engage members and educate them about the cost of healthcare in a way that traditional Medicaid is unable to do.”). However, this misstates the survey data which reports “[a]mong members *who reported having a*

No data is yet available to evaluate how well the POWER Account roll-over incentive is working, but as of 2016 only twenty-five percent of HIP 2.0 participants had been enrolled for a full twelve months and qualified to take advantage of the roll-over incentives.¹⁶⁸ As of August 2016, few enrollees, advocates or providers understood the roll-over incentives structure.¹⁶⁹ Focus groups members opined that gift cards would be a better incentive to reward healthy behavior (like getting primary care) than the roll-over of POWER Account funds to reduce future premiums.¹⁷⁰

How is consumer driven Medicaid working in Indiana? Indiana has failed to produce evidence to support its claims that HIP 2.0 encourages Medicaid enrollees to become better consumers of health care, helps familiarize members with how commercial health insurance works, or encourages continuous Medicaid enrollment. Instead, the available data paints a picture of HIP 2.0 as a program rife with confusion and administrative complexity.

Indiana's own data confirms that PLUS premiums have created substantial barriers to enrollment and coverage. More than half of those eligible for HIP coverage either lost coverage or were moved to more costly, less comprehensive BASIC plans because of their failure to comply with the premium requirement. Nearly 60,000 people lost coverage and another 300,000 were moved to BASIC plans.

VI. CONCLUSION

HIP 2.0 and POWER Accounts are a pale imitation of HSAs and consumer driven health care. While good evaluative data is limited, the POWER Accounts seem to be creating more confusion than consumer empowerment. What is clear is that POWER Account premiums have created barriers to coverage and disruptions in coverage unheard of in traditional Medicaid.

HHS was wrong when it used its Section 1115 authority to grant Indiana a waiver to operate HIP 2.0 as an experimental project that furthers the objectives of the Medicaid Act. Indiana's experiment has proved that consumer driven Medicaid—that relies on premiums—suppresses enrollment, creating barriers to coverage and care.

POWER Account, 40 percent of HIP Plus and 30 percent of HIP Basic members reported checking their POWER Account balance monthly." LEWIN GROUP, *supra* note 64, at 3 (emphasis added).

168. LEWIN GROUP, *supra* note 64, at 1.

169. Musumeci et al., *supra* note 85, at 1 ("Beneficiaries in our focus groups as well as advocates and providers in both states did not demonstrate a clear understanding of the policies associated with these models. This feedback shows that these models are hard to understand even in Indiana, a state with the long-standing experience in health accounts.").

170. *Id.* at 3 (explaining gift cards were more appealing because they could be used to meet more immediate needs).