



# Incentives to Change Health Behaviors: Beneficiary Engagement Strategies in Indiana, Iowa, and Michigan

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## Executive summary

As part of their Medicaid expansions to adults with incomes up to 133 percent of the federal poverty level (FPL),<sup>1</sup> Indiana, Iowa, and Michigan used section 1115 authority to implement incentives for beneficiaries to use regular preventive care, change certain health behaviors, achieve personal health goals, and, in some cases, build awareness of health care costs. Each demonstration has a distinct set of encouraged behaviors and corresponding rewards, which are collectively termed “beneficiary engagement” strategies.

Managed care organizations (MCOs), which provide care for at least part of each state’s expansion population, support the beneficiary engagement activities specified in the states’ demonstration designs and often conduct other plan-specific beneficiary engagement activities.<sup>2</sup> In addition, the states and health plans use various approaches to involve primary care providers in beneficiary engagement programs, adding a layer of complexity to program implementation. Understanding how the implementation of beneficiary engagement strategies varies by plan provides important context for assessments of the outcomes and effectiveness of these programs. For example, if outcomes vary across plans within each state, it will be useful to analyze whether the sources of implementation variation seem to distinguish plans with strong outcomes from those with weaker ones.

Early findings on beneficiary engagement strategies suggest that beneficiaries’ understanding of healthy behavior incentives and behavior completion rates are mixed (Miller, Maurer and Bradley 2017). Implementation experiences suggest the importance of streamlining processes for obtaining rewards and ensuring that beneficiaries receive a summary of the information about their health status and care needs that is collected through health risk assessments (HRAs) or other tools. In addition, the demonstrations highlight the potential to draw on lessons from behavioral economics in designing beneficiary communications and incentive strategies as low-cost ways to increase engagement. Officials from the three states and participating MCOs are generally enthusiastic about the possibility of using incentives to alter health behaviors.

## Introduction

Beneficiary engagement has become an important priority for health care payers. The growing prevalence of preventable chronic diseases and suboptimal use of health care services (such as nonemergent use of the emergency department [ED]) can strain resources. Mounting evidence suggests that patients who take an active role in their health care can achieve improved health outcomes (see Hibbard and Greene 2013 for a review) and that patient engagement can also lower costs (Hibbard and Greene 2013; Hibbard et al. 2013). Payers

## THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves low-income children, adults, individuals with disabilities, and seniors. Medicaid is administered by states and is jointly funded by states and the federal government. Within a framework established by federal statutes, regulations and guidance, states can choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Although federal guidelines may impose some uniformity across states, federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches to administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and are budget neutral to the federal government.

Some of these new approaches being tested under 1115 authority draw on established practices in commercial health insurance, such as cost-sharing at levels that exceed Medicaid limits and financial incentives for pursuing healthy behaviors. Other new approaches involve partnerships with private-sector entities, such as issuers that offer qualified health plans. However, Medicaid beneficiaries have lower incomes and poorer health status than most privately insured individuals and Medicaid expansion demonstrations have required multiple beneficiary protections, such as limits on total cost-sharing, access to certain mandatory benefits, and rights to fair hearings.

therefore have an interest in encouraging beneficiaries to make better health care choices, including obtaining timely preventive care and avoiding unnecessary service use.

Indiana, Iowa, and Michigan have introduced beneficiary engagement policies that incentivize beneficiaries to use regular preventive care and change certain health behaviors. These states used section 1115 authority to implement beneficiary engagement policies as part of their expanded Medicaid programs, which cover adults with incomes up to 133 percent of the FPL.

This brief describes the three states' beneficiary engagement strategies, emphasizing between- and within-state variation in implementation. We highlight the degree to which the demonstration designs incorporate individually targeted strategies (such as setting a personal health goal) versus more general ones (such as encouraging a wellness visit) to help change health behaviors. Evidence from psychology and behavioral economics suggests that individuals are more likely to respond to personalized messages (Service et al. 2015), which suggests that individually targeted incentives may be more effective. However, the evidence for using individually targeted strategies to change health behavior is mixed (for example, see Latimer et al. 2010).

We also discuss the extent to which incentives are designed to keep beneficiaries engaged in their health care throughout the year versus those that encourage a single action (or behavior) per year, such as an annual wellness visit. Insights from behavioral economics suggest that small, frequent rewards for encouraged behavior are more effective in keeping beneficiaries engaged than one-time payoffs (Kahneman and Tversky 1979). However, our review of previous beneficiary engagement-style programs in Medicaid suggests that it may be hard to sustain beneficiary engagement over time (see, for example, Blumenthal et al. 2013).

All three states contract with health plans under a capitation system to provide care for at least part of their expansion populations and to implement the beneficiary engagement strategies outlined in the demonstration design. In Indiana and Michigan, MCOs have provided care for all newly enrolled beneficiaries for several years.<sup>3</sup> In Iowa, MCOs covered some beneficiaries with incomes between 50 and 100 percent of the FPL from 2014 to 2016. Beneficiaries with incomes between 100 and 133 percent of the FPL were covered by qualified health plans (QHPs) in the Marketplace in 2014 and 2015, then covered directly by the state in early 2016. Beginning April 1, 2016, all Iowa demonstration beneficiaries began enrolling with new MCOs, and the transition to MCO coverage was completed by the end of 2016.

Both state Medicaid agencies and contracted health plans are motivated to engage beneficiaries in their own health care—

Medicaid agencies as the purchasers of health care coverage and the contracted plans as the ultimate bearers of health risks and costs for their covered populations. Collaboration between state Medicaid programs and contracted plans is therefore an important component of successful beneficiary engagement. Medicaid agencies often rely on the plans to encourage beneficiaries to complete engagement activities included in the demonstration. Most plans also conduct plan-specific engagement activities in addition to encouraging demonstration-level activities. This brief focuses on the states' demonstration-level designs and on the plan-level implementation and enhancement of those designs, recognizing that both strongly influence beneficiaries' experiences with incentives in the demonstration.

## State demonstration designs for beneficiary engagement

In all three states, incentives for beneficiary engagement involve a set of financial or other rewards for completing encouraged health behaviors. The specific behaviors that states encourage and the rewards they offer vary. Generally, the incentivized behaviors include one or more of the following: completing a health risk assessment (HRA), establishing a primary care relationship, completing preventive services, setting a personal health goal, or managing health care costs. By engaging in these behaviors, beneficiaries can earn reductions in the monthly payments and/or service copayments that they otherwise must pay in the demonstrations, and in some cases they can earn additional rewards. Table 1 summarizes the financial contributions that demonstration beneficiaries must make in each state and the rewards they can earn for completing encouraged behaviors.

Beneficiary engagement strategies can be categorized along three dimensions reflecting the degree to which (1) the incentivized behaviors are general versus personalized, (2) the design has potential to keep beneficiaries engaged in their health care throughout the year, and (3) beneficiaries can quantify rewards with certainty. In the remainder of this section, we describe the engagement strategies in Indiana, Iowa, and Michigan and characterize their demonstration designs along these three dimensions.

**Indiana.** The Healthy Indiana Plan (HIP) 2.0 involves general incentives for beneficiaries to engage in two types of behavior: (1) receiving a preventive service recommended for their age and sex and (2) managing health costs. Although beneficiaries can fulfill the preventive service requirement by a one-time action, the design engages them in managing health costs throughout the year by giving them a Personal Wellness and Responsibility (POWER) account that serves as a deductible jointly financed by the state and the individual. Beneficiaries who complete these activities may be able to earn reductions

in the monthly payments that they would otherwise pay during their next enrollment year. However, calculating the value of the reward is complex and depends on the amount remaining in the account at the end of the enrollment year, so beneficiaries learn about their ultimate rewards in the next enrollment year.

The first \$2,500 of covered services are paid out of beneficiaries' POWER Accounts. Beneficiaries who make contributions to their POWER Accounts are enrolled in HIP Plus, which includes vision and dental benefits and does not require copayments at the point of care. HIP Plus is the only option for beneficiaries with incomes above 100 percent of the FPL (\$12,060 for an individual in 2017); beneficiaries below 100 percent of the FPL who do not make contributions are instead enrolled in HIP Basic, which does not include the vision and dental benefits and requires copayments. To be enrolled in HIP Plus, beneficiaries with incomes above 5 percent of the FPL contribute 2 percent of income and the state contributes the remainder of the \$2,500 to the POWER Account; beneficiaries below 5 percent of the FPL contribute \$1 per month. Indiana designed the POWER Account with the aim of incentivizing beneficiaries to use health services as prudently as possible by allowing a portion of unspent POWER Account funds from one enrollment year to roll over to the next, potentially lessening the beneficiary's future monthly payments. Beneficiaries with funds remaining in the POWER Account are rewarded with reduced payments. Monthly statements help beneficiaries keep track of their expenditures and account balance.

Preventive services are funded outside of the POWER Account and are exempt from copayments, and therefore do not result in deductions from the POWER Account. The state also actively incentivizes beneficiaries in HIP Plus to receive preventive care by doubling the amount from the POWER Account they can roll over when they receive at least one of the preventive services recommended for their age and sex. Beneficiaries below 100 percent of the FPL who are enrolled in HIP Basic must receive a recommended preventive service to qualify for any rollover amount, which could reduce their future contributions by up to 50 percent if they opt into HIP Plus at renewal.

**Iowa.** In 2014 and 2015, the Iowa Health and Wellness Plan (IHAWP) consisted of two programs. Beneficiaries with incomes up to 100 percent of the FPL were enrolled in the Iowa Wellness Plan and received services from an MCO. Beneficiaries above 100 percent of the FPL were enrolled in Iowa Marketplace Choice and received services through a QHP. Beginning in 2016, the state discontinued the distinction between the Wellness Plan and Marketplace Choice, and all beneficiaries transitioned to receiving care through new MCOs. Throughout these transitions, monthly payment requirements have remained the same: those with incomes between 50 and 100 percent of the FPL are required to make monthly payments of \$5 per month and those with incomes above 100 percent of the FPL are required to pay \$10 per month.

No payments are required of those with incomes below 50 percent of the FPL. In all cases, beneficiaries are exempt from monthly payments in their first enrollment year.

Iowa's beneficiary engagement strategy involves general incentives for beneficiaries to (1) complete an annual HRA and (2) complete an annual wellness visit; for these incentives, they are exempted from monthly payments in their second and subsequent enrollment years. Because monthly payments are either \$5 or \$10 per month, beneficiaries can easily calculate the total value of rewards available to them for completing the incentivized behaviors. Initially, only a comprehensive annual physical would satisfy the annual wellness exam requirement. Over time, Iowa has accepted routine medical exams, physician office visits for acute care, and dental wellness visits as fulfilling the annual wellness exam requirement.

In addition to the rewards that can be earned through the annual actions of receiving a wellness exam and completing an HRA, Iowa's plan includes progressively escalating dental benefits, which provide rewards for consistent engagement in oral health care throughout the year. All beneficiaries receive coverage for core dental services as part of the demonstration. Core services include diagnostic and preventive services, emergency services, and stabilization services. Beneficiaries who return for a periodic exam 6 to 12 months after their first visit qualify for enhanced benefits, including some restorative services, endodontic care, and certain oral surgery services, among others. Those who return for a second periodic exam 6 to 12 months after the first follow-up visit qualify for additional enhanced benefits, including crowns, tooth replacements, and gum surgery. Earned benefits are maintained by adhering to a schedule of receiving an exam every 6 to 12 months, rewarding continuous engagement.

**Michigan.** As part of the Healthy Michigan Plan, Michigan designed an individually targeted beneficiary engagement strategy that incentivizes beneficiaries to (1) complete an HRA with the assistance of a primary care provider and (2) agree to address or maintain a healthy behavior of their choosing. The requirement to complete the HRA with a physician amounts to an implicit incentive to establish a primary care relationship.

By completing the two incentivized behaviors, beneficiaries can earn a \$50 gift card (for beneficiaries with income at or below 100 percent of the FPL) or a 50 percent reduction in required contributions to MI Health Accounts (set at 2 percent of income for beneficiaries with incomes above 100 percent of the FPL). The MI Health Accounts are intended to teach beneficiaries about the costs of care and prepare them for paying regular premiums for commercial coverage in the future. Beneficiaries at all income levels who complete the two incentivized behaviors also earn a 50 percent reduction in point-of-service copayments, once they spend 2 percent of their annual income on cost sharing. (Copayments stop entirely when they reach the 5 percent out-of-pocket maximum.)

Preventive services and services for the management of chronic conditions (such as diabetes) are fully exempt from copayments.

For beneficiaries who must make MI Health Account contributions, calculating the magnitude and timing of the reward that reduces monthly payments by 50 percent is complex. Monthly payments do not start until six months after the beneficiary is enrolled and are billed quarterly thereafter through the MI Health Account statements. Therefore, if beneficiaries complete the incentivized activities in the month they enroll, they may be unaware of their monthly payment amount and the amount of the earned reduction until they receive their first statement six months later.

Of the three states, Michigan's design involves the highest degree of personalization, with the selection of an individual health goal. To earn a reward, Michigan's demonstration requires beneficiaries to perform the annual activities of completing an HRA and pledging to engage in a healthy behavior; however, the state reports that it expects MCOs to act on beneficiaries' attestations by engaging them in working toward their individual health goals throughout the year. Thus, the degree to which the design results in beneficiary engagement throughout the enrollment year will depend on implementation efforts by the MCOs.

**Table 1. Beneficiary cost of care and beneficiary engagement strategies in Indiana, Iowa, and Michigan**

	Indiana: Healthy Indiana Plan (HIP)	Iowa: Iowa Health and Wellness Plan (IHAWP)	Michigan: Healthy Michigan Plan
<b>Beneficiary costs of care that can be reduced through participation in beneficiary engagement programs</b>			
<b>Monthly contributions: 0–100% FPL</b>	0–5% FPL: \$1 6–100% FPL: 2% of income, equivalent to \$1–\$20 <sup>a</sup>	0–49% FPL: \$0 50–100% FPL: \$5	\$0
<b>Monthly contributions: &gt;100–133% FPL</b>	2% of income, equivalent to \$20–\$27 <sup>a</sup>	\$10	2% of income, equivalent to \$20–\$27 <sup>a</sup>
<b>Copayments</b>	For beneficiaries 0–100% FPL: Failure to pay contributions results in enrollment in HIP Basic, requiring point-of-service cost sharing for all services except preventive care  For all beneficiaries: \$8 for the first nonemergent ED visit, \$25 for additional nonemergent ED visits	For all beneficiaries: \$8 for nonemergent ED visits <sup>b</sup>	For all beneficiaries: Cost sharing for all services except preventive care and chronic care management
<b>Beneficiary engagement strategies that reward beneficiaries by offsetting costs of care or enhancing benefits</b>			
<b>Health Risk Assessment (HRA)</b>	The state requires plans to use an HRA; plans provide beneficiary rewards for completion (for example, \$10–\$30 gift cards)	HRA completion is one of two behaviors required to earn monthly payment exemptions in the second enrollment year	HRA completion is one of two behaviors required to earn either monthly payment reductions in the current enrollment year or a \$50 gift card. Beneficiaries must complete the questionnaire with a primary care provider during an office visit.
<b>Complete basic wellness visit or establish primary care relationship</b>	None	A medical exam or dental exam is one of two healthy behaviors required to earn monthly payment exemptions in the second enrollment year	To earn either monthly payment reductions in the current enrollment year or a \$50 gift card, beneficiaries must complete the HRA with a primary care provider during an office visit (see cell above)
<b>Complete preventive services (for example, screenings, immunizations)</b>	HIP Plus beneficiaries who receive a preventive care service recommended for their age and sex are eligible for a doubling of their POWER Account rollover  HIP Basic beneficiaries become eligible for rollover if they complete a preventive service and switch to HIP Plus at renewal	Receipt of regular dental care earns beneficiaries enhanced dental coverage	None
<b>Set a personal health goal</b>	None	None	When completing an HRA, beneficiaries agree to address or maintain one healthy behavior. This is one of two actions required to earn either monthly payment reductions in the current enrollment year or a \$50 gift card.

(continued)



	Indiana: Healthy Indiana Plan (HIP)	Iowa: Iowa Health and Wellness Plan (IHAWP)	Michigan: Healthy Michigan Plan
<b>Consider the cost of health care received</b>	HIP Plus beneficiaries who have a positive POWER Account balance at the end of the enrollment year can roll over funds to the next year, potentially reducing future contributions  Beneficiaries in HIP Basic are subject to copayments for services (except preventive services)	None	None

<sup>a</sup> Monthly contribution amounts are 2 percent of income. This dollar estimate is calculated for a family of one using the 2017 FPL threshold (\$12,060/year).

<sup>b</sup> As of 2016, the \$8 copayment policy for nonemergent ED visits had not been enforced in Iowa.

ED = emergency department; FPL = federal poverty level.

## Health plan implementation of beneficiary engagement

As noted above, Medicaid agencies and health plans play a shared role in implementing beneficiary engagement strategies. MCOs' involvement in these demonstrations has the potential to introduce variation within as well as between states in how individual beneficiaries experience the incentives and the ultimate effects of these policies on health outcomes. In Indiana and Iowa we spoke with all three MCOs currently providing care for the demonstration population in each state.<sup>4</sup> In Michigan we spoke with only a subset of participating plans, and therefore we can describe some but not all of the different approaches MCOs took in that state.

Contracts between the states and their participating health plans spell out their respective responsibilities regarding beneficiary engagement strategies featured in each demonstration. All MCOs we interviewed also reported conducting additional beneficiary engagement activities in the form of plan-specific incentives that go beyond those in the demonstration design. In contrast, a QHP in Iowa that operated before the managed care transition reported that the state was responsible for all beneficiary engagement activities, including encouraging HRA completion and communication about incentivized healthy behaviors, and the QHP served simply as a payer.

This section presents findings from our key informant interviews with health plans on four aspects of implementation: (1) communication with beneficiaries about each demonstration's requirements and rewards, (2) administration of HRAs, (3) encouragement and monitoring of behavior changes that earn rewards, and (4) provider involvement. Each subsection begins with a cross-state comparison, then describes state-specific implementation factors that are likely to influence observed health outcomes.

### A. Communicating desired behaviors and rewards to beneficiaries

In all three states, Medicaid agencies rarely contact beneficiaries directly, except regarding enrollment and eligibility.

Most of the communication beneficiaries receive about their state's demonstration comes from MCOs. MCOs report that they contact beneficiaries regularly and frequently, using many modes of communication (see Exhibit 1). Some types of communication, such as welcome packets, member handbooks, and call centers, are contractually required by the states, but many others are the result of individual plan initiatives. MCOs in all three states report that they devote significant resources to engaging demonstration beneficiaries, including educating them about demonstration incentives.

#### Design of beneficiary communication materials.

States retain final approval of materials that are distributed to beneficiaries, although the degree of regulation varies by state. In Indiana, MCOs must use state-provided text in their beneficiary communications about the program, although both Indiana Medicaid and the MCOs report that plans can make small changes, subject to state approval. Under the new managed care system in Iowa, the state provides initial information to beneficiaries about the healthy behaviors program at enrollment, then the plans include additional information in their member handbooks and send healthy behaviors reminder letters using content generated by the state. Michigan allows more leeway in communication materials; the state has basic requirements about the materials that must be provided, but MCOs develop the content themselves, so the information beneficiaries receive can vary.

MCO respondents reported that the plans design most communication materials in-house, although they often use focus groups or other consumer testing to refine the form and content. In some cases they incorporate feedback from call centers, provider relations teams, and community partners into the design.

#### Communication about incentivized healthy behaviors.

All states provide initial information about incentivized healthy behaviors when beneficiaries enroll. From that point, beneficiaries enrolled in MCOs receive further information, and possibly reminders, from their health plans.

In Indiana, all three MCOs report that they proactively reach out by phone or mail to beneficiaries who have not yet received a

## EXHIBIT 1. REPORTED PLAN POINTS OF CONTACT WITH BENEFICIARIES

- Welcome packet
- Member handbook
- Plan website
- Welcome calls
- Monthly or quarterly general and program-specific newsletters
- Reminder calls or mailings to access state-encouraged services
- Reminder calls or mailings to access plan-specific services
- Topic-specific awareness or reminder calls or mailings (e.g., for “heart health month”)
- Calls triggered by HRA responses
- Targeted calls or mailings from care/disease management programs to which beneficiaries are assigned
- Calls triggered by a lapse in care as identified via claims data
- Calls triggered by an ED visit as identified via claims data
- Reminders about services when beneficiaries call the plan call center with a question
- Monthly, weekly, or daily contacts for beneficiaries with severe or chronic conditions
- Emails or texts instead of phone calls (some plans are exploring these methods)

In both Indiana and Michigan, member handbooks and state and MCO websites provide information on copayments, and beneficiaries can speak to call center representatives to inquire about specific services. In Indiana, plan websites must post the total POWER Account deduction for common services, although the set of services posted varies by MCO. One MCO in Indiana reported that the second most frequent type of call center inquiry is whether a particular service counts as preventive and is thus exempt from copayment. The frequency of that question highlights that call center interactions are an important complement to other cost documentation that beneficiaries can access. Doctors are another potential source of cost information. State surveys found that some beneficiaries ask their doctors about the cost of their care: about one-fourth of surveyed Indiana HIP Plus beneficiaries reported doing so (Lewin Group 2016), and about two-thirds of Michigan survey respondents reported being somewhat or very likely to talk with their doctor about the cost of their care (Dorr Gould et al. 2016).

MCOs also inform beneficiaries of the costs of services after they receive them, to enable beneficiaries to track and manage their health care costs. In Indiana, MCOs send beneficiaries monthly POWER Account statements that show their health care use and the recommended preventive services for their age and sex. Michigan beneficiaries receive quarterly statements about their utilization, but these come from the third-party administrator of the MI Health Accounts. We cover the POWER and MI Health

recommended preventive service that earns the state’s POWER Account rollover incentive. One MCO sends an annual preventive care statement 90 days before the end of a beneficiary’s enrollment year showing what is still needed to earn the rollover incentive. The other two MCOs reach out by phone or mail throughout the year. One potential point of variation is that key informants from one MCO reported that beneficiaries must receive all recommended preventive services for their age and sex; the state and the other MCOs described the requirement as receipt of only one of the recommended services. The state reported that they planned to clarify this misunderstanding. Because the state will closely oversee POWER Account reconciliation, we do not expect this discrepancy to affect the actual rewards beneficiaries receive at rollover time. However, if beneficiaries in different MCOs receive different communications about preventive service use during the enrollment year, use patterns may differ by MCO.

During 2014–2016 in Iowa, there was some variation in beneficiary communications about the incentivized healthy behaviors. All beneficiaries received information about the behaviors from the state upon enrollment, and reminder postcards from the state in 2014. Also, beneficiaries covered by an MCO received reminders directly from their plan. But beneficiaries enrolled in a QHP received no further reminders until they enrolled with MCOs in 2016. As of 2016, all MCOs now provide some information about the healthy behavior incentives in their member handbooks and send state-mandated reminder letters a few months before the end of the enrollment year notifying beneficiaries that if they do not complete their remaining behavior(s) they will have to start making monthly payments in the next enrollment year. Other than the information in the handbook and the reminder letters, the MCOs did not report providing any further communications tailored specifically for their IHAWP enrollees. Instead, all Medicaid-covered populations receive the same regular communication from their plans.

In Michigan, all of the MCOs we spoke with reported that they conduct outreach to beneficiaries encouraging them to complete the HRA with their primary care provider. One MCO described a unique strategy of individualized communication in which service reminders were customized to appear to come from the beneficiary’s primary care provider rather than from the plan. The MCOs have found that communications from providers elicit a better response rate than communications directly from the plan. This strategy mobilizes beneficiaries to respond while not overburdening providers with communication requirements.

### **Communication about the cost of health services.**

Communication about the cost of health services is particularly important if—as in Indiana and Michigan—the demonstration design aims to (1) engage beneficiaries in understanding health care costs or (2) ensure that financial barriers to receiving preventive care are removed. For both purposes, beneficiaries must be aware of the costs they face before receiving services.

Accounts in a separate issue brief (Miller and Contreary 2017), so we do not discuss them in detail here.

## B. Conducting and using HRAs

In all three states, beneficiaries can earn rewards by completing an HRA, although the source of financial incentives varies. We noted significant variation in administration of HRAs, but fairly consistent use of the resulting assessment information by plans (see Table 2).

**Conducting health risk assessments.** In Iowa and Michigan, the demonstration design includes explicit incentives for completing an HRA. In Indiana, MCOs are required by contract to use HRAs, but the demonstration design does not otherwise connect HRAs to any explicit incentive. In Iowa, HRA completion is one of two behaviors that, together, can exempt beneficiaries from owing monthly payments in the following enrollment year. Before the managed care transition in 2016, Iowa's HRA administration process was the least standardized of the three states: plans could select their own questionnaires to use instead of the state HRA, and beneficiaries could get credit for completion in a number of ways. For QHP beneficiaries, Iowa Medicaid was responsible for communication about the HRA reward, and either the state or 3M/TREO Solutions, a state-contracted organization, was responsible for collecting HRA data. Regardless of the health plan in which they were enrolled, beneficiaries could satisfy the requirement by completing the HRA in several ways: online; by phone with the Iowa Medicaid call center, the third-party administrator, or their health plan (if they were enrolled in an MCO); or in the doctor's office with their provider. Beneficiaries could also verbally attest to the state that they had completed an HRA and get credit for meeting the requirement.<sup>5</sup> This multiplicity of HRA alternatives, particularly the option to verbally attest to completion, reduces the likelihood that the HRA requirement was a significant driver of beneficiary behavior.

Since the 2016 managed care transition, all beneficiaries now complete the HRAs with their plans, either online, over the phone with the plan's call center, or in person at health fairs and other events. Plans still have the option of using the state HRA or their own, but all three current MCOs reported using their own HRAs, which they described as providing tailored information that better enables them to appropriately manage their beneficiaries. Varied implementation across plans presents a challenge for evaluating this component of the Iowa demonstration. With a number of different types of HRA available (and many beneficiaries having been exposed previously to multiple HRAs, such as the online state HRA and their plan's specific HRA), it is hard to attribute any change in health care outcomes to the HRA requirement or to know which version and strategy are most effective.

In contrast to Iowa, all beneficiaries in Indiana and Michigan respond to the same state-selected HRA form, and the process for completing it is standardized. Indiana MCOs are solely responsible for administering the HRA to new beneficiaries. All of the MCOs in Indiana use the HRA that the state requires, but the state does not provide rewards to beneficiaries for completing it.

Similar to Iowa, Michigan also financially incentivizes HRA completion as part of its demonstration design. The state has a multistep process for completing the HRA: (1) the beneficiary completes part of the HRA with an enrollment representative, (2) the beneficiary finishes the HRA with his or her provider at a wellness visit, and (3) the provider submits the completed HRA to the beneficiary's MCO. Respondents reported that this process has been difficult to implement, resulting in completion rates of 18 percent as of March 2017 (Michigan Department of Health and Human Services [MDHHS] 2017). Michigan Medicaid explained that there are two main purposes for requiring beneficiaries to complete the HRA with their primary care provider: (1) to encourage the formation of a primary care relationship and facilitate discussion about healthy life choices, including selecting a healthy behavior for the beneficiary to work on, and (2) to assist the provider in collecting information needed to assess the beneficiary's health. However, the respondents acknowledged that the administrative burden on providers was greater than anticipated. In addition, one Michigan plan related that providers have not embraced the HRA because they feel it does not provide them with relevant information about their patients' health.

**Using health risk assessments.** In Michigan, the HRA is meant to inform a conversation between beneficiary and provider about health care goals that culminates in the selection of a healthy behavior that the beneficiary pledges to address. In Indiana and Iowa, demonstration designs do not specify a particular role for providers in using HRA data; instead, health plans make use of the HRA data as they choose.

In all three states, regardless of whether the demonstration includes specific requirements for using HRAs, MCOs report that once they complete the HRA or obtain the completed HRA data, they use the data to address beneficiaries' care needs and enroll them into disease management or extra care programs. In addition, they often pair HRA results with other available data sources, such as claims and pharmacy data, to determine the best care approach. A few plans said that they use the HRA data at the population level to do cross-population comparisons, analyze disease prevalence, and in some cases improve provider networks. However, plans more commonly use claims and other data sources to conduct population-level analyses. In most cases beneficiaries do not see the results of the completed HRA, in which case they cannot use it as a potential tool to inform their own health care planning.

All three Michigan MCOs we spoke with reported that they follow up on the HRA healthy behavior attestation with outreach to the beneficiary and, if applicable, enrollment in a specific program to encourage the healthy behavior. The state has done some initial analysis to find out whether beneficiaries who attest that they wish to quit smoking are indeed accessing tobacco cessation therapies; the finding was that close to two-thirds have claims for pharmaceuticals or counseling related to cessation. One Michigan MCO also described using HRA data to refine its communications and benefits in areas of particular beneficiary interest, such as dental benefits and smoking cessation services.

Notably, one current MCO in Iowa offers two different HRA options: a briefer HRA completed on the phone with a plan representative

and a more detailed HRA that the beneficiary completes online. Beneficiaries who choose the online option receive immediate feedback about health issues identified from their HRA responses. No other MCO in any of the three states reported providing such direct feedback to beneficiaries on their HRA data.

Also unique among the three states, the current Iowa MCOs described designing their HRAs to capture information about social determinants of health, to help the plans target and remove barriers that may prevent their beneficiaries from accessing needed care. However, it is important to note that we interviewed the current Iowa MCOs over a year after we interviewed plans in the other states, so it is possible that plans in Indiana and Michigan have begun collecting similar data through HRAs.

**Table 2. HRA procedures and use in Indiana, Iowa, and Michigan**

HRA procedures	Indiana: Healthy Indiana Plan (HIP)	Iowa: Iowa Health and Wellness Plan (IHAWP)	Michigan: Healthy Michigan Plan
<b>Responsibility for conducting HRA</b>	MCOs	MCOs	First section completed with enrollment broker  Second section completed with provider  Provider sends completed HRA to MCO
<b>State rewards for completion</b>	None	Waiver of monthly payments in second and subsequent years (if beneficiary also gets an annual medical or dental exam)	Monthly payment reduction in current year or \$50 gift card  Copayment reduction if spend 2% of income in copayments
<b>Plan rewards for completion</b>	Gift cards or store credits; varies by plan	Rewards credits or coupons; varies by plan	None
<b>Use of HRA data</b>	MCOs use data to enroll beneficiaries in coordinated care programs	MCOs use data to enroll beneficiaries in coordinated care programs, conduct population-level analysis, and address social determinants of health	Providers use data to assist beneficiaries in selecting personalized health goal  MCOs use data to enroll beneficiaries in coordinated care programs

HRA = health risk assessment; MCO = managed care organization.

### C. Encouraging healthy behaviors

MCOs in all three states report that they layer additional incentives on top of the incentives built into the states' demonstrations. The rewards are usually financial or material, often involving gift cards or rewards cards that can be credited with amounts ranging from \$5 to \$25 when beneficiaries receive a recommended preventive service or engage with their care management program. In some cases, the rewards are restricted to purchases of health-related items; in other cases, beneficiaries can use them for any purchase in participating stores. The attractiveness of the rewards (and hence their effectiveness as incentives) may depend on both the amount and the flexibility of use, which varies by MCO. In most cases, these incentives are not unique to the demonstration population but apply to the plans' other covered populations as

well. Some Michigan MCOs reportedly use raffles for goods, such as iPads, for targeted campaigns (such as to boost mammogram rates). One Michigan MCO also reported that it distributed canned goods to beneficiaries who received a mammogram.

Notably, the current Iowa MCOs described less focus on encouraging receipt of preventive care and more focus on encouraging lifestyle changes such as weight loss, exercise, and smoking cessation. The MCOs also emphasized that they focus on addressing social determinants of health for their beneficiaries, including coordinating transportation assistance, housing support, childcare, and other social services. In most cases, plans did not cover or incentivize these services directly, but they described taking their role as service coordinator for their beneficiaries very seriously. In our previous round of interviews, one Michigan MCO



reported piloting a similar program, but we do not have current information on the status of that program.

**Early evidence on beneficiary engagement.** Key informants consistently observed that members of the Medicaid demonstration population seem more engaged with their health care than the traditional Medicaid population, and they are willing to engage with plans and providers to receive care they need or want. Respondents also noted that demonstration beneficiaries are easier to contact and less transitory, hence MCO outreach efforts are more likely to reach their intended audience.

Some states have reported early findings on beneficiary completion of incentivized behaviors. These findings represent experience in the first one to three years of these demonstrations. They are early findings, and over time reported rates may change due to demonstration maturation and increased beneficiary experience.

Before the 2016 managed care transition, HRA completion rates in Iowa varied depending on the data source, but in all cases were 25 percent or lower. According to Iowa Department of Human Services data, 8 percent of demonstration beneficiaries with incomes over 100 percent of the FPL and 17 percent of beneficiaries under 100 percent of the FPL completed both an HRA and a wellness exam in 2014 (Askelson et al. 2016). Completion rates from calendar year 2015 appear comparable.<sup>6</sup> These completion rates may reflect the irregular reminders beneficiaries received about the financial rewards associated with the healthy behaviors. These completion rates may also reflect the instability of early implementation in Iowa, because some beneficiaries may have experienced up to three coverage transitions between 2014 and 2016. We have limited data on completion rates for healthy behaviors after the managed care transition, but with plans now taking responsibility for reminding beneficiaries about the healthy behaviors, it is possible completion rates may rise.

In Michigan, the complexity of the HRA process has resulted in lower-than-expected completion rates. According to state officials in 2016, 60 percent of beneficiaries completed a primary care visit within 150 days of enrollment; however, less than 15 percent of those beneficiaries had received credit for completing the HRA requirement by their provider submitting the completed HRA to their MCO. More recent data are similar: As of March 2017, 18 percent of beneficiaries who had been enrolled in a health plan for at least 6 months had received credit for completing the HRA with their primary care provider (MDHHS 2017). Michigan beneficiaries who complete the HRA with their provider have had consistently high rates of health goal attestations—about 99 percent (MDHHS 2017). Several informants remarked that they were impressed that beneficiaries were not simply choosing easy health behaviors (such as

getting an immunization) to “tick the box.” Rather, beneficiaries commonly select multiple healthy behaviors, and many have chosen to address substance abuse.

In Indiana, where receipt of preventive services is incentivized, survey data suggest that beneficiaries have a higher understanding of the preventive service incentive than of the preventive service copayment policy. An initial evaluation report indicated that 52 percent of HIP Plus beneficiaries understood that if they did not receive a recommended preventive service in the past year their rollover amount would not be doubled, and 35 percent of HIP Basic beneficiaries understood that if they agreed to move up to HIP Plus but had not received a preventive service in the past year then their remaining account balance would not be rolled over. In contrast, 9 percent of surveyed HIP Plus beneficiaries and 7 percent of surveyed HIP Basic beneficiaries reported knowing that the costs of preventive services are not deducted from their POWER Accounts.

Although HIP 2.0 beneficiaries’ understanding of copayments and incentives was mixed, the proportion of beneficiaries who actually received preventive care was higher than the proportion who indicated that they understood either of the financial incentives; analysis of claims data in the state’s interim evaluation report shows that 74 percent of beneficiaries enrolled for at least 10 months received a qualifying preventive service (Lewin Group 2016). Thus, the majority of beneficiaries obtained preventive services even though fewer reported understanding the rewards associated with this behavior. These findings suggest that, for some beneficiaries, the POWER Accounts and related communications might have been less important as an inducement for seeking preventive care during the first enrollment year than intrinsic motivation, prompts from care providers, or financial rewards provided by health plans.

#### **D. Role of providers**

Health care providers are an important partner in beneficiary engagement because they are a trusted source of health information and advice. States and MCOs rely on providers to varying degrees to help beneficiaries obtain preventive care services or complete program requirements. Michigan’s demonstration most actively incorporates providers in beneficiary engagement strategies by requiring beneficiaries to complete the HRA with their primary care provider. In Iowa and Indiana, providers are less integral to completing program incentives, but beneficiaries still must establish relationships with providers to complete the incentivized healthy behaviors. In this section, we discuss provider incentives and communication; however, several MCOs argued that incentives and communication can go only so far in motivating providers to spend time on a requirement that they do not perceive as improving their ability to provide care.

**Provider financial rewards.** States and MCOs promote provider participation in beneficiary engagement strategies through direct financial rewards. All of the Michigan MCOs we spoke with offer monetary rewards to providers for completing beneficiary HRAs, but the current financial incentives have thus far been insufficient to reach target completion rates, possibly because physicians do not perceive that the HRA is clinically useful. In Iowa, before 2016, providers received incentive payments from both the state and the MCO (for Wellness Plan beneficiaries) when a member completed the HRA. The state provided a \$25 incentive payment for each beneficiary attributed to a provider who completed the HRA requirement, in addition to the monetary reward the MCO paid to the provider—even if the HRA was not completed in the provider’s office. Since the transition to managed care in 2016, the state still allows health plans to pay providers direct financial incentives for completing the state HRA with a patient. However, the MCOs reported that they prefer that beneficiaries complete their plan-specific HRAs, and so do not actively encourage physicians to complete the state HRA. MCOs also reported that few providers want to spend time during the office visit working through the HRA and would prefer that the MCOs take primary responsibility. MCOs in Indiana and Michigan also offer financial rewards to providers when beneficiaries for whom they are the designated provider complete recommended preventive health care screenings or services. The size of the reward varies significantly, from \$5 to \$200 per service or screening. One MCO in Michigan paid out over \$8 million in reward payments in a single year. Current Iowa MCOs do not offer provider incentives of this kind.

**Provider communication.** States and MCOs also need to communicate with providers to ensure that providers are familiar with the administrative requirements of the demonstration and the specific incentivized services beneficiaries should receive. Most plans offer incentives to providers to provide certain services, but, as with beneficiaries, providers are unlikely to take advantage of financial incentives if they are unaware of them. Communication with providers occurs mainly at the MCO level, although some states also created provider toolkits to educate providers about the demonstration incentives.

Michigan MCOs and the state Medicaid agency described diverse methods for communicating with and educating providers. Two large Michigan MCOs have representatives who visit providers on a monthly or quarterly basis. MCOs use these “rounding” visits to share information with providers about their HRA completion rates, the number of beneficiaries assigned to them who are due for services, and the financial rewards available for providing the recommended services. Several Michigan MCOs also described using regular fax updates to share new or important information with providers, who rely on fax as a common method of communication. One MCO also

hosts an online provider portal where providers can easily obtain information about their demonstration patients.

Although providers play a less explicit role in beneficiary engagement strategies in Iowa and Indiana, MCO respondents in both states described (1) using mailings and newsletters to keep their providers informed about new requirements or developments to the program design; (2) conducting regular provider meetings (often together with the state Medicaid office or other agencies); and (3) attending professional association meetings, webinars, and seminars. Before 2016, one MCO respondent in Iowa described encouraging providers to increase their HRA completion rates by providing information comparing their completion rate to those of other providers. Some current Iowa MCOs also report maintaining regular communication with providers specifically to help the plans stay in contact with hard-to-reach beneficiaries. This helps to remove potential barriers to beneficiaries’ receiving care as well as to encourage providers to support beneficiaries in completing incentivized or recommended behaviors.

## Implications for demonstration design

Early implementation of incentives for healthy behaviors in Indiana, Iowa, and Michigan provide a number of lessons: (1) involving providers in the completion of incentivized healthy behaviors can be challenging, (2) beneficiaries should have access to summary information on their health status and needs, and (3) low-cost strategies inspired by social sciences hold potential for states interested in supplementing financial incentives as tools to engage beneficiaries.

### A. Involving providers in beneficiary engagement strategies

Michigan’s experience suggests that it is important for beneficiaries to have control over whether they complete incentivized healthy behaviors. Informants in Michigan noted that the process of receiving a reward for HRA completion requires numerous steps that involve the state, the plan, the provider, and the beneficiary, thus creating multiple points of possible breakdown. Under this design, beneficiaries’ rewards depend on their primary care provider taking action. Beneficiaries can make a primary care appointment and bring the HRA to their doctor, but if the physician does not complete the questionnaire or if the physician’s office does not return the completed HRA to the MCO, the beneficiaries do not receive the reward. Indeed, informants reported that, although the vast majority of new beneficiaries complete a primary care visit, HRA completion rates are quite low.

Financial incentives for providers to complete their obligations as part of beneficiary incentive programs are of limited use if they are too small to overcome resistance to completing the

activity. Plans in all three states have used incentive programs for providers, but their success seemed to depend on whether providers assessed requested actions as clinically relevant. Informants reported that rewards for providers for encouraging beneficiaries to complete recommended screenings were more effective than rewards for completing an HRA. In Iowa and Michigan, informants reported that providers are often unwilling to use visit time to complete HRAs, even for financial rewards, because they do not consider the assessments clinically relevant.

The incentive gap could be closed in a number of ways. First, the state could select an HRA that providers feel is clinically relevant and are therefore willing to use. Second, the state could provide strong enough financial rewards so that providers would be willing to complete HRAs even if they do not find them useful in their practice (this option is likely quite costly). Finally, the state could reassess the importance of involving providers in this aspect of the beneficiary engagement program.

### **B. Using HRA findings as an opportunity to educate beneficiaries**

All three states emphasize HRA completion as an important strategy for beneficiary engagement, but beneficiaries rarely receive any information as a result of their HRA. One exception is an MCO in Iowa that gives beneficiaries the option to receive immediate feedback on their online HRA responses. In general, beneficiaries might value receiving a report about their health, and they might become more engaged on certain health topics if they had easily accessible information about their individual needs, as identified through the HRA.

### **C. Using behavioral insights to design and implement engagement strategies**

Individual decision making, including health decision making, is subject to a number of cognitive biases and limitations. Behavioral economics and related disciplines have uncovered a number of low-cost strategies for influencing human behavior (Service et al. 2015). These include altering the form or content of existing communications, providing social feedback, and eliminating hassles, for example, by making some processes automatic. Although these approaches have been successful in many environments, relatively few informants reported using these insights to improve beneficiary engagement. States might consider adding behaviorally inspired features to complement their financial incentives, particularly for incentivizing behaviors that beneficiaries themselves perceive as intrinsically worthwhile. Some possibilities follow:

- Before 2016, one MCO in Iowa shared information with providers on their HRA completion performance relative to that of competitors; such sharing is a form of social feedback intended to increase completion rates.

## **ABOUT THE MEDICAID SECTION 1115 EVALUATION**

In 2014, the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica Policy Research, Truven Health Analytics, and the Center for Health Care Strategies to conduct an independent national evaluation of the implementation and outcomes of Medicaid section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program, as well as to inform CMS decisions regarding future section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four categories of demonstrations: (1) delivery system reform incentive payment (DSRIP) programs, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports (MLTSS). This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. The reports will inform an interim outcomes evaluation in 2017 and a final evaluation report in 2019.

Similarly, beneficiary communication materials could include information on how many other beneficiaries have completed encouraged behaviors and received a reward.

- Some MCOs in Iowa and Michigan described using three-way calling between the plan, provider, and beneficiary to help beneficiaries schedule appointments. For example, one MCO explained that, when a beneficiary calls to ask about the wellness visit requirement, the call center representative calls the beneficiary's provider with the beneficiary still on the line to make the appointment. This removes from the beneficiary the burden of making the appointment. Eliminating hassle factors and reducing the scope for procrastination can be effective in ensuring timely completion of behaviors.
- Although financial rewards for specific behaviors can be effective, alternative designs such as raffles can produce the desired impact at a lower cost. Some MCOs in Michigan described using raffles occasionally, but the practice is not widespread. Timing is important—immediate rewards are more enticing than distant ones. For example, one Michigan MCO reported that the \$50 gift card was more attractive to beneficiaries than the monthly payment reduction, which is more complicated to understand and is received only after a delay.

## Implications for evaluating demonstration outcomes

Identifying the effects of these beneficiary engagement programs requires consideration of the many sources of variation in implementation. Exploring the consistency of results across health plans will be especially important, as plans strongly influence how demonstration policies for beneficiary engagement are implemented. In all three states, plans bear much of the responsibility for communicating with beneficiaries and encouraging beneficiaries to complete the state's incentivized behaviors, and they also layer on incentives for other behaviors. In Indiana, they are also involved in administrative processes such as calculating the POWER Account rollover. Therefore, evaluations should aim to examine demonstration outcomes by plan to understand whether state-wide effects are masking plan-by-plan variation.

Evaluations should also consider changes to policies that occurred during the demonstration, such as the alteration of beneficiary incentives. For example, in Iowa, in addition to allowing a variety of HRA completion mechanisms in the initial years of the demonstration, the state made multiple changes to the set of services that satisfy the wellness visit component of the demonstration. It may be necessary to define separate implementation phases and consider outcomes in each of those phases. Likewise, early findings indicate that issues arising during implementation may dampen the effects of certain aspects of states' demonstration designs. For example, we anticipate that the effect of Michigan's HRA requirement will be reduced because of the low HRA completion rates to date. Iowa also voluntarily modified its HRA incentive by allowing beneficiaries a one-month grace period to complete the HRA following their first full year of enrollment and by allowing self-attestation to meet the requirement. HRA completion options in Iowa changed further after the managed care transition in 2016, adding additional variation to an already complex policy environment.

## METHODS AND DATA SOURCES

Descriptive information about section 1115 demonstrations is based on Mathematica's analysis of demonstration documents for Indiana, Iowa, and Michigan, as listed below.

- Indiana Special Terms and Conditions, Approval Period: February 1, 2015 – December 31, 2018.
- Iowa Wellness Plan Special Terms and Conditions, Approval Period: January 1, 2014 – December 31, 2016; as amended December 31, 2014. Section 1115 demonstration monitoring reports: 2014 Q1 – Q4; 2015 Q1; 2014 annual report.
- Michigan Special Terms and Conditions, Approval Period: December 30, 2013 – December 31, 2018. Section 1115 demonstration monitoring reports: 2014 Q1 – Q4; 2015 Q1; 2014 annual report.
- Michigan Adult Coverage Demonstration Section 1115 Quarterly Report. Demonstration Year 6 (January 1, 2015 – December 31, 2015), Federal Fiscal Quarter 1 (October 1, 2015 – December 31, 2015).

We also conducted key informant interviews with Medicaid officials and plan representatives in Indiana, Iowa, and Michigan from January through May 2016, and in June 2017 we conducted a second round of interviews with representatives from the new MCOs in Iowa that began serving beneficiaries in 2016. We designed interview protocols to clarify information in the Special Terms and Conditions and in state monitoring reports for each demonstration, and to assess the implementation of demonstration policies. Each interview included a lead interviewer and a note taker.



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## Endnotes

- <sup>1</sup> The Affordable Care Act established a 5 percent income disregard that increases the effective income limit from 133 to 138 percent of the federal poverty level.
- <sup>2</sup> In Iowa, Qualified Health Plans also provided care for beneficiaries in the early years of the demonstration.
- <sup>3</sup> In Indiana, "managed care entity" (MCE) is the preferred term for what is called an MCO in other states. We use MCO to describe such plans in all three states.
- <sup>4</sup> In a previous round of interviews we also spoke with an MCO and a QHP that covered the Iowa demonstration population before the managed care transition in 2016.
- <sup>5</sup> Medicaid claims, 3M/TREO Solutions (a state-contracted organization charged with collecting HRA data), and Iowa Department of Human Services records have documented different HRA completion rates, according to the March 1, 2016, Healthy Behaviors Incentive Program Evaluation Interim Report (Askelson et al. 2016).
- <sup>6</sup> We do not have access to the full data used in the state's interim report, but we constructed rough completion rates using completion counts for healthy behavior in 2014 and 2015 from the IHAWP February 2016 monthly report ([https://dhs.iowa.gov/sites/default/files/IHAWP\\_Monthly\\_Report\\_February2016.pdf](https://dhs.iowa.gov/sites/default/files/IHAWP_Monthly_Report_February2016.pdf)) and total enrollment counts from the 2014 annual report and the 2015 Q4 report. Using these numbers, we estimate that 15 percent of beneficiaries completed both incentivized behaviors in 2014 and 11 percent did so in 2015.