

Healthy Behavior Incentives: Opportunities for Medicaid

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IN BRIEF

Financial incentives offer a new tool for Medicaid programs to encourage beneficiaries to choose healthy behaviors, such as exercise, smoking cessation, disease prevention, and health screenings. Programs serving non-Medicaid populations have demonstrated that financial incentives can help influence healthy behaviors, enhance long-term health outcomes, and reduce health care costs. Several states are considering incentive strategies within new Medicaid expansion programs.

This brief explores how financial incentives can be used to influence healthy behaviors. It reports on findings from past Medicaid healthy behavior incentive programs; highlights current Medicaid incentive approaches, including New Mexico's model; and offers recommendations for states that are establishing or modifying programs to encourage healthy behaviors in Medicaid.

Medicaid programs are increasingly using financial incentives to encourage beneficiaries to engage in healthy behaviors, such as exercise, smoking cessation, disease prevention, and health screenings and assessments. This interest in incentive programs stems from growing evidence from non-Medicaid populations that: (1) financial incentives can successfully influence healthy behaviors;¹ and (2) individual choices and behaviors—like diet, activity level, and smoking status—impact long-term health outcomes, mortality rates, and health care costs.² There is also substantial discussion in some states regarding incorporating incentives into Medicaid expansion proposals under the Affordable Care Act (ACA). States interested in requiring traditional or expansion Medicaid populations to participate in a healthy behavior incentive program must submit a State Plan Amendment or Section 1115 Waiver to the Centers for Medicare & Medicaid Services (CMS) for approval.

This brief explores the link between behavioral economics and financial incentives. It reports on findings from past Medicaid healthy behavior incentive programs; highlights current Medicaid incentive programs (with a spotlight on New Mexico's innovative Centennial Rewards program); and offers recommendations for states that are establishing or modifying initiatives to encourage healthy behaviors in Medicaid.

Behavioral Economics and Healthy Incentive Programs

Behavioral economics is a method of analysis that explores the psychology behind the economic decisions that people make. The field has demonstrated that the “rational choice model,” which assumes that individuals always know and adhere to their preferences, does not describe true human behavior. Instead, people often behave irrationally: contradicting previously stated preferences, going against their best interest, and choosing not to maximize outcomes or efficiency.

Increasingly, health care policymakers are using behavioral economics concepts to design healthy behavior incentive programs that account for—or perhaps even capitalize on—individuals’ biases (see box to the right for a list of common behavioral biases), as a means to increase the likelihood for achieving a desired health behavior or outcome. For example, behavioral economic research suggests that individuals are more sensitive to immediate gratification than to delayed feedback (they are “present biased”), so successful incentive programs may seek to target current (not future) behavior and offer rewards quickly after an individual completes a desired task.³

Research has demonstrated that financial incentives are effective at improving healthy behaviors, though the effect of incentives may decrease over time.⁴ Financial incentives have shown positive results in: (1) improving vaccination rates in vulnerable communities; (2) improving the uptake of cancer screenings; (3) promoting low-income patients’ adherence to tuberculosis testing and treatment; (4) increasing attendance at prenatal and postnatal appointments; (5) encouraging sexual health risk reduction education and counseling; and (6) quitting smoking.^{5,6} The least promising results for financial incentives are related to weight loss: while incentives can help motivate lifestyle alterations to lower cholesterol and adopt healthy behaviors, the positive effects tend to diminish over time. All told, financial incentives’ impact on weight loss is inconclusive.⁷

Medicaid Incentive Programs’ Impact on Healthy Behaviors

Few academic studies, if any, have examined the impact of financial incentives within the Medicaid population – particularly regarding whether incentive programs influence short- or long-term health outcomes or behaviors. Outcomes do exist, however, for some state-specific

Behavioral Biases

- **Irrational valuation:** The value an individual experiences from a product depends on its price: the higher the price, the higher its perceived value.
- **Endowment effect:** People tend to demand a considerably higher price for a product that they own than they would be prepared to pay for it.
- **Framing effect:** The way in which a choice is framed or presented can strongly affect the decision that results.
- **Loss aversion:** Changes that are framed as losses are weighed more heavily than changes framed as gains.
- **Diminishing sensitivity:** Changes in a variable have less impact the farther the variable is from a reference point.
- **Status quo bias:** A preference for the current situation, as the unfamiliar territory of leaving the status quo is perceived negatively.
- **Priming/Anchoring:** Seemingly trivial alterations or influences can produce major changes in how people act.
- **Sunk cost fallacy:** The belief that further investment is warranted because resources already invested will otherwise be lost.

Medicaid incentive programs. In some cases, these results only address program participation, yet these early state findings can help inform the design of future Medicaid incentive programs. (See [Examples of Consumer Incentives and Personal Responsibility Requirements in Medicaid](#) for a more detailed look at past and current Medicaid incentive programs.⁸) Results to date include:

- **Florida’s Enhanced Benefits Reward\$ Program (2006 – 2014):** Medicaid beneficiaries earned \$15 to \$25 credits for compliance with 19 healthy behaviors. About half of available credits were redeemed, with the majority of credits earned for childhood preventive care (45 percent) or adult/child primary care office visits (25 percent).⁹
- **Idaho’s Behavioral Preventive Health Assistance Program (2007 – 2014):** Medicaid beneficiaries who consulted with a doctor about losing weight or quitting smoking could earn a \$100 voucher, to be used for gym memberships, weight management programs, nutrition counseling, and tobacco cessation products. Of the approximately 185,000 eligible beneficiaries, 1,422 participated after two years.¹⁰
- **Idaho’s Wellness Preventive Health Assistance Program (2007 – present):** Beneficiaries receive \$10 per month for keeping well-child exams and immunizations up-to-date, which is used to pay for premiums. A quasi-experimental study found a 116 percent increase in CHIP children with up-to-date exams and immunizations, compared to a 13 percent increase among children without the incentives.¹¹
- **West Virginia’s Mountain Health Choices Program (2005 – 2014):** Provided access to an “enhanced” benefits package if beneficiaries sign and conform to an agreement with the state that they will engage in healthy behaviors. Ten percent of eligible adults enrolled in the enhanced plan. Those who enrolled were more likely than others to have more doctor visits and take their medications, and to have physicians involved in the decision to enroll.¹²
- **Wisconsin’s BadgerCare Plus Individual Incentive Pilots (2008 – 2010):** Six Medicaid health plans were awarded two-year grants to test if offering incentives would encourage enrollees to adopt healthier behaviors. None of the six projects reached their health outcomes goals.¹³

Program Spotlight: Healthy Michigan

- In 2014, Michigan became the second state after Iowa to offer lower premiums to Medicaid expansion enrollees who pursue healthy behaviors. The Healthy Michigan Plan’s Healthy Behavior Incentive Program offers a 50 percent reduction in managed care enrollees’ required contributions, or a comparably valued gift card (for members not required to make contributions), if they complete a health risk assessment and agree to address or maintain healthy behaviors.
- Michigan’s Department of Community Health worked with a behavioral economist to develop an innovative approach to encourage individuals to complete the initial assessment and agree to address/maintain healthy behaviors. Michigan may submit protocols to CMS for additional healthy behavior incentives.

Current and Emerging Medicaid Incentive Programs

CMS is supporting a variety of efforts to more effectively design, implement, and evaluate incentive programs to promote healthy behaviors. In 2011, under Section 4108 of the ACA, CMS’ Innovation Center awarded 10 states five-year grants to test healthy behavior financial incentive programs for individuals with chronic diseases. These pilot programs are addressing health goals related to: tobacco cessation, diabetes management, weight control, blood pressure, and

cholesterol. Programs include an intervention and control group, allowing evaluators to more accurately determine the intervention's effectiveness. In August 2014, CMS released a [request for information](#) to study the use of innovative programs, including incentive strategies, to increase beneficiaries' engagement in their health care.¹⁴

There is also considerable interest among state Medicaid programs in using incentive programs to promote healthy behaviors. Some states that expanded Medicaid for non-elderly adults using an §1115 waiver included healthy behavior incentives in their expansion proposals, including Iowa, Michigan, and Pennsylvania. These states are offering reduced premiums as incentives to Medicaid beneficiaries who complete a health risk assessment and/or participate in other healthy behaviors.

DESIGN CONSIDERATIONS FOR MEDICAID INCENTIVE PROGRAMS

- **Bonus or Penalty:** Given the behavioral economic theories of loss aversion and the endowment effect, penalties for poor health behaviors are likely to prove a stronger incentive to change than rewards for good behaviors. Despite this, policymakers must consider the fact that penalty programs could harm beneficiaries if the penalty involves denying them needed health services.
- **Size of Incentive:** Overall, research suggests that the larger a financial incentive is, the higher the response to the incentive.¹⁵ However, there is currently insufficient evidence available to determine optimal incentive value.
- **Incentive Type:** Research on Medicaid incentive programs does not provide clear evidence that one type of financial incentive is more effective than another; for example, that cash rewards are more effective than vouchers or gifts. However, research did conclude that individuals prefer to receive cash over other types of rewards.¹⁶
- **Targeting Simple or Complex Behaviors:** Some studies have suggested that financial incentives may be more effective in changing simple or one-time behaviors (such as receiving a vaccination) than more complex behaviors (such as smoking cessation).¹⁷ A 2014 meta-analysis, however, did not find convincing evidence that financial incentives work better for changing one-off behaviors than longer-term, more complex behaviors.¹⁸

Recommendations for Establishing Successful Medicaid Incentive Programs

Below are recommendations for states looking to establish healthy behavior incentives in their Medicaid programs. These recommendations were informed by academic research and results from past Medicaid incentive programs.

- **Heavily advertise the program and its benefits.** Past incentive programs may have enrolled fewer Medicaid beneficiaries than anticipated because individuals were not aware of the program. Simply stated, beneficiaries need to know a program exists in order to actively participate. States should use multiple information channels to advertise the program, including public service announcements, print media in health care settings, and community health worker and provider education. A survey from West Virginia's incentive program found that information provided through mailers and trusted health care workers (physicians, case managers, pharmacists) was most helpful to beneficiaries.¹⁹ Furthermore, states can use messaging strategies to convey—in the simplest manner possible—why program participation is worth the individual's time. Ideally, messaging about the program's benefits would describe both its financial rewards and its potential to improve health.

PROGRAM SPOTLIGHT: NEW MEXICO'S CENTENNIAL REWARDS PROGRAM

Centennial Rewards is an incentive program under New Mexico's §1115 waiver, Centennial Care, a managed care program for most New Mexico Medicaid beneficiaries that integrates physical health, behavioral health, and long-term services and supports through four managed care organizations (MCOs). As of September 2014, there were nearly 560,000 individuals enrolled in Centennial Care, including approximately 150,000 adults who entered Medicaid under ACA expansion.*

Centennial Rewards, which began on January 1, 2014, covers all Centennial Care enrollees. Beneficiaries can earn points for completing the following healthy activities (see below), even if they are not aware of, or actively engaged in, the program:

- Annual dental visit (adult or child);
- Prenatal program participation;
- Bone density testing;
- Medication management for schizophrenia and bipolar disorder (Rx refills);
- Asthma (inhaler refills); and/or
- Diabetes (various disease-related tests).

In order to redeem benefits after completing one of the healthy activities mentioned above, beneficiaries must register through the Centennial Rewards website or member services call center. Following registration, participants can choose a reward: an item from the [Centennial Rewards catalog](#) (such as a soccer ball, yoga mat, or first aid kit) or a Centennial Rewards debit card that can be used for limited purchases (e.g., no cigarettes or alcohol) at certain stores. For the second year of the program, the state is contemplating adding new activities and rewards. For example, points may be awarded for completion of a health risk assessment. The state is also considering adding rewards that would appeal to particular sub-populations, including New Mexico's large Native American population, pregnant women, and young mothers.

All four New Mexico MCOs contract together with the same two vendors that manage the program components, including the website, catalog, call center, and debit card implementation. The primary vendor receives a monthly enrollment file from the state and regular encounter data feeds from each of the MCOs. The MCOs make direct payments to the vendor for the administrative infrastructure and for the redeemed points. The state, in turn, has built these costs into the MCOs' monthly capitation payments, thus receiving federal matching funds for the program. A unique quality of Centennial Rewards is the program's portability across MCOs: points earned during individuals' enrollment with one MCO can carry over to another if beneficiaries switch enrollment.

Oversight of the program is accomplished through various means. State leadership has access to an administrative portal that allows near real-time monitoring of information, including points earned and redeemed, and participants registered. The MCOs are also contractually required to submit quarterly reports of their performance and their members' activities. Finally, the Centennial Rewards vendors are able to provide significant detail on an ad hoc basis comparing MCO performance. A rigorous evaluation was also built into the program. Data related to health outcomes and reduced expenditures are expected in the middle of 2015.

The success of an incentive program like Centennial Rewards hinges on engaged Medicaid beneficiaries. While New Mexico designed its Centennial Rewards program to allow individuals to earn points even when unaware of the program, the end result should be that a significant portion of the Medicaid beneficiaries will eventually be participating in their own health care. Many individuals have gotten involved in the first year – whether they know that or not – and will be more likely to fully buy into Centennial Care goals, and work to improve their own health outcomes, as they learn more about the program.

The state and its contractors are actively engaged in outreach, communication, and marketing. Currently, program information is included in MCO member materials and welcome packets; it is also mailed directly to beneficiaries. The call center is using outbound calls during non-peak hours to reach out to individuals who have accrued points but have not yet registered for reward redemption. The state is also working on a provider engagement program, as evidence suggests that the involvement of health care professionals is another positive factor in changing beneficiary behavior. A provider-specific portal is planned for later this year. Finally, a public website is now operational, allowing anyone to learn about the program without needing to register. Please visit www.centennialrewards.com for additional information.

* New Mexico's total Medicaid enrollment of about 730,000 also includes individuals who are not enrolled in managed care, such as those with partial benefits (e.g., Medicare Savings Program and family planning) and a significant number of Native Americans who have not opted into the managed care program.

- **Forge partnerships to promote and implement the program.** Medicaid programs should consider partnering with sister agencies such as public health, health plans, provider organizations, local community groups, or other entities to educate beneficiaries about the program or to help administer it.
- **Pay attention to beneficiary characteristics.** Materials should be designed to be clear and understandable for multiple levels of education and different cultural backgrounds. States should also consider how different Medicaid beneficiaries might respond to incentives. While some individuals may be willing to undergo behavioral changes in exchange for small incentives, others may not want to participate if they cannot, for example, access or pay for necessary transportation costs. Medicaid beneficiaries with low health literacy may not understand how a behavior change will benefit their long-term health and may require a relatively large financial incentive to participate.
- **Establish a simple benefit structure.** Overly complex or multi-step incentive programs can be hard to understand or perceived as not worth a beneficiary's time. Policymakers should work to design an incentive benefit structure that is as simple as possible, so it is clear what a beneficiary needs to do to qualify for the incentive and why or how the desired behavior change will improve that person's health.
- **Incorporate a rigorous evaluation component.** Data are needed to evaluate a program's effectiveness and determine whether it is worth continuing. Before a new incentive program is launched, state Medicaid programs should develop a clear evaluation plan, which is required of plans authorized by an §1115 waiver.²⁰ Where possible, states should consider initially offering the program to a sub-set of beneficiaries, then compare the results from the intervention group to a similar control group. This analysis will help program evaluators determine the intervention's true effectiveness.

Conclusion

State Medicaid programs can establish incentive programs to engage beneficiaries in their health care and promote the adoption of healthier behaviors. Incentive programs also hold political appeal, and may help a state pass a potentially contentious Medicaid expansion. While financial incentives can be powerful motivators, states are encouraged to make smart choices about program design and pay attention to the behavioral economic theories that help explain how and why people are motivated to change. Given CMS' growing knowledge of past and current incentive programs' successes and failures, it is likely to take an active role in assessing proposals' design features and working with states to develop promising strategies. After an incentive program is up and running, states should closely evaluate the programs with outcome data related to participation and health status to determine if the program is effective and worth continuing.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

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