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Are Medicaid Incentives an Effective Way to Improve Health Outcomes?

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State Medicaid programs are testing a number of approaches to improve beneficiaries’ health outcomes by encouraging them to engage in healthy behaviors and to use the health care system more efficiently. While states may be tempted to offer incentives or penalties to increase primary care and reduce emergency room visits, the evidence shows that these programs are unlikely to achieve their goals. Improving access to care through coordination and transportation are more likely to improve Medicaid beneficiaries’ health and offer states a return on their investment.

Some states impose penalties, such as levying cost-sharing charges or limiting access to certain benefits such as adult dental and vision services, for beneficiaries who don’t pay premiums or complete certain activities such as health assessments or preventive care visits. Two programs operating in this manner — programs in West Virginia and Indiana — have produced disappointing results. These programs have led to increases in emergency department (ED) visits among people whose access to primary care was limited under these programs.

Various other states provide rewards ranging from gift certificates to deposits in health savings accounts (HSAs) for healthy behaviors and high-value health care spending. These approaches have produced mixed results. Short-term incentives provided at the point of service are most likely to be effective in increasing the likelihood that an individual keeps an appointment with a health provider or attends a diabetes prevention class, for example. There is less evidence to support long-term incentives that reward individuals for quitting smoking or maintaining weight loss, or for other incentives provided after the fact.1

The evidence is increasingly clear that restricting coverage or access to services as a penalty for failing to complete healthy behaviors or pay premiums can negatively affect patient care and lead to increased use of emergency services. Studies have also shown that Medicaid beneficiaries generally use appropriate services if those services are accessible. Given states’ limited Medicaid resources, they should consider investing in strategies to improve access to appropriate health services, better

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coordinate care, and better integrate health and social services, rather than implementing complex penalties that can be challenging and costly to administer and yield counter-productive results.

Some behavior rewards may prove to have benefits for short-term behaviors, yet a longer-term investment in supporting access to timely, appropriate care for beneficiaries likely would provide greater returns. If states choose to test behavior incentives, they should consider offering targeted rewards to individuals who aren’t otherwise likely to take up needed services, and should avoid penalties likely to drive up emergency room use.

**Incentives Can Take Form of Rewards or Penalties**

Incentive programs in both Medicaid and the private sector offer different types of incentives for a wide range of activities.

- **Rewards for one-time activities or behaviors** aim to incentivize people to keep primary care appointments or call a tobacco cessation hotline, participate in cancer screenings, or meet a health benchmark such as reducing high blood pressure. Rewards can be cash, a gift certificate, a health-related reward such as a soccer ball or yoga mat, a contribution to an HSA, or access to a service such as a dental appointment.

- **Rewards for long-term behaviors** aim to incentivize ongoing behaviors such as participating in weight management classes or achieving health goals such as lowering blood sugar to mitigate diabetes. Rewards are usually similar to rewards for one-time activities, although there are frequently caps on the number or amount of rewards per year.

- **Penalties** such as cost-sharing, premiums, or limits on benefits are imposed on people who don’t get preventive care or other necessary services or use services inappropriately, such as visiting the ED for a condition that could have been treated in a primary care setting.

**Rewards Can Be Effective in Encouraging Short-Term Behaviors**

While the evidence is limited, evidence from private-sector worksite wellness programs suggests that small financial incentives such as cash or gift cards can change some health behaviors. Financial incentives appear to increase participation in healthy activities such as preventive screenings, obesity and diabetes prevention programs, routine vaccinations, and tobacco cessation.²

In Medicaid, financial rewards have been effective incentives for one-time or short-term activities, such as showing up for a specific preventive health service.³ Some studies have shown that offering as little as $5 or $10 can incentivize healthy behaviors.⁴ However, the evidence is mixed as to whether incentives can be effective in changing long-term behaviors that require ongoing engagement, such as sustained weight loss or smoking cessation.

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The Medicaid Incentives for Prevention of Chronic Disease (MIPCD) program aimed to test incentive programs in ten state Medicaid programs over five years beginning in 2011. It provided $85 million in grants to states for program incentives and administration. Rewards included gift cards, cash, points redeemable for health-related services or items, and reduced premiums or cost-sharing. Some rewards were awarded at the time of participation while others were redeemable later, such as in the form of reduced cost-sharing in the following year.

Participating states had to target at least one health prevention goal such as tobacco cessation or controlling diabetes; several states targeted multiple behaviors or conditions. Their interventions and incentives varied widely:

- California established a smoking-cessation counseling hotline and gave participants a $20 gift card to pharmacies or grocery stores.
- Federally qualified health centers in Hawaii provided diabetes testing and education and self-management programs for high-risk individuals, allowing the clinic to determine the incentive for participation (such as cash or a gift card).
- Texas offered flexible spending accounts for beneficiaries with mental health or substance use disorders who developed individual wellness plans with personal health goals.
- Minnesota offered diabetes prevention and self-management training to individuals dually enrolled in Medicare and Medicaid, with cash rewards for attending the first session, attaining weight loss goals, and attending follow-up visits. The program also provided child care, meals, and transportation to and from sessions.

The Department of Health and Human Services (HHS) is still evaluating these programs; its final report to Congress is due in April 2017. In a 2016 interim report, HHS noted that states faced administrative challenges in setting up their programs and recruiting participants and providers. Collaboration with providers, clinics, and managed care organizations was important in identifying eligible participants and providing referrals to appropriate programs. Preliminary data, available from only a few states, did not show significant differences in hospitalization or ED use for program participants. However, California did report that participants in its tobacco cessation program (which included nicotine replacement therapy and cash incentives) were more likely than a control group to abstain from smoking for 30 days.

HHS’ interim evaluation stated that participants in focus groups reported satisfaction with the programs. They characterized the incentives as a “kick start” to enroll and remain in the programs, noting that the incentives had the strongest impact in encouraging them to enroll and became less important later, when improving their health was a stronger incentive. This is consistent with

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5 The program was enacted as part of the health reform law in section 4108 of the Affordable Care Act.


previous studies showing that incentives were more effective in motivating participants to attend a diabetes prevention class than to encourage long-term behaviors such as sustained weight loss.\textsuperscript{9} Immediate incentives such as gift cards were more effective than those provided later.\textsuperscript{10}

**Penalties Have Not Improved Health Outcomes**

**West Virginia: Emergency Visits Rose After State Limited Access to Benefits**

West Virginia’s Mountain Health Choices program launched in 2007 with the primary goal of reducing unnecessary ED use. Beneficiaries could choose an “enhanced plan” that offered more comprehensive benefits by committing to program rules such as relying on a medical home for services and keeping appointments with providers. Alternatively, they could choose or default into a “basic plan” that limited them to four prescriptions per month and restricted access to services such as behavioral health care, tobacco cessation programs, and podiatry services.\textsuperscript{11}

An evaluation conducted after the program’s termination in 2010 found that Mountain Health Choices actually raised unnecessary ED use. Individuals in the basic plan used the ED more, both overall and for non-emergency visits, than those in the enhanced plan and those in a county that didn’t offer Mountain Health Choices. Although ED use fell slightly for those in the enhanced plan, the decline was overwhelmed by the increase in ED use among those in the basic plan.

Among all Medicaid beneficiaries in the counties offering the program, the likelihood that an individual would go to the ED rose by an average of 6 percent, and the likelihood that they would go to the ED for a non-emergency rose by 12 percent. Limiting access to benefits for individuals in the basic plan ended up increasing their ED use, both for conditions that could have been treated in a primary care setting and for mental health and substance use.\textsuperscript{12}

**Indiana: Increased Cost-Sharing Associated With Higher ED Use**

Indiana expanded Medicaid in February 2015 following federal approval of its demonstration project, the Healthy Indiana Plan (HIP) 2.0.\textsuperscript{13} HIP 2.0 includes two types of coverage: HIP Plus and HIP Basic. HIP Basic has significantly narrower coverage — for example, it excludes dental and vision care — and charges co-pays for many services. Beneficiaries may keep HIP Plus only if they pay premiums; otherwise they are moved to HIP Basic or lose coverage altogether, depending

\textsuperscript{9} Op cit., Vleet and Rubinowitz 2014.

\textsuperscript{10} Karen J. Blumenthal \textit{et al.}, “Medicaid Incentive Programs to Encourage Healthy Behavior Show Mixed Results to Date and Should Be Studied and Improved,” \textit{Health Affairs}, March 2013; Pat Redmond, Judith Solomon, and Mark Lin, “Can Incentives for Healthy Behavior Improve Health and Hold Down Medicaid Costs?” Center on Budget and Policy Priorities, June 2007.


\textsuperscript{12} Ibid.

on their income level. All HIP 2.0 enrollees have an HSA, which contains both state contributions and deposits from beneficiaries who pay premiums. After the first year of enrollment, enrollees in HIP Plus can use a portion of the funds remaining in their HSAs to reduce their premiums for the following year. The amount they can roll over is doubled if they get preventive care services recommended for their age and gender.

An interim evaluation of HIP 2.0 found that Plus enrollees used more preventive, primary, and specialty care and prescription drugs than Basic enrollees. Basic enrollees were more likely to use the emergency room — including for non-emergencies — and less likely to use primary care and preventive care. These facts suggest that they were more likely to lack adequate access to ordinary health care, probably due in part to the co-pays charged in Basic.

Basic members also were less likely to adhere to their prescription drug regimens for certain chronic conditions such as asthma, arthritis, and heart disease. This isn’t surprising, because Basic members must refill their prescriptions every month and make a co-payment, while Plus members can obtain a 90-day supply of maintenance medications with no co-pay. This is of particular concern because access to maintenance medications can affect health outcomes. It’s also of particular concern to African Americans in Indiana, who are more likely than other groups to be in the Basic plan; fully half of African Americans enrolled in HIP 2.0 are in Basic rather than Plus.

Similar to West Virginia’s, Indiana’s experience shows that making it harder to obtain needed routine care likely increases ED use. Cost-sharing and limiting benefits may reduce health care use and costs in the short term but likely lead to worse health outcomes over time.

**Kentucky: Waiver Proposal Would Penalize People With Significant Health Care Needs**

Kentucky has proposed major changes in its Medicaid expansion modeled on Indiana’s HIP 2.0. Like Indiana, Kentucky proposes to charge premiums, and beneficiaries with incomes above the poverty line who miss premium payments would lose their coverage and couldn’t re-enroll for six months. The plan would also provide beneficiaries with HSAs to fund a $1,000 annual deductible. Members with money left in their accounts at year’s end could use up to half of it in the following year for services that Medicaid doesn’t cover, such as adult dental and vision services.

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14 People with incomes above the poverty line must pay premiums and enroll in HIP Plus.


Kentucky’s model would discriminate against less healthy individuals, who would need to use their accounts to pay for their health care and wouldn’t have funds remaining in their accounts to pay for dental and vision care. It could also discourage people from for using needed health care if they wanted to save money in their accounts so they could roll funds over.

**Beneficiaries’ Confusion, Lack of Knowledge Weaken Incentive Programs**

Iowa and Michigan included incentive programs for preventive care in their Medicaid expansion programs, but early evidence shows that few beneficiaries were aware of the programs. In Michigan, newly enrolled adult beneficiaries had to pay co-payments for most services, but their cost-sharing was reduced if they completed a health risk assessment and agreed to participate in certain activities. A state analysis found that only 14.9 percent of beneficiaries enrolled in a health plan for at least six months completed the assessment. Most beneficiaries weren’t aware the incentive existed.\(^\text{19}\)

Iowa was the first state granted permission to charge premiums to beneficiaries with incomes below the poverty line. Enrollees don’t have to pay premiums in the first year they are enrolled and premiums are waived in later years if enrollees complete a health risk assessment and get a wellness exam. An interim evaluation found that in 2015, just 17 percent of beneficiaries with incomes below the poverty line and 8 percent with incomes above it qualified for a premium waiver. Some 90 percent of beneficiaries surveyed didn’t know they could get their premiums waived if they got a wellness exam.\(^\text{20}\)

Indiana’s experience also shows that beneficiaries need to be aware of and understand incentives if these programs are to succeed. As noted, enrollees in both HIP Basic and HIP Plus who receive preventive care can lower their premiums after the first year by rolling over funds remaining in their HSAs. The rollover does not appear to be working effectively as an incentive for a large share of enrollees, however, because they evidently lack basic knowledge about the accounts and how they work. Only 60 percent of respondents to a survey conducted as part of the HIP 2.0 evaluation had heard of the accounts, and fewer than half of enrollees knew they had one.\(^\text{21}\)

Beneficiaries’ lack of understanding of these programs indicates that the complexity of the incentive programs limits their impact and creates a need for substantial outreach and education.

**Medicaid Programs Face Challenges in Implementing Incentive Programs**

Administrative challenges are common among Medicaid reward programs. Providers’ engagement and participation can be particularly difficult given their large patient loads and low reimbursement rates. Providers in West Virginia’s program felt that the state failed to adequately


educate them as to their role in reporting whether patients completed healthy behaviors. A recent evaluation of Iowa’s incentive program found that although providers were compensated for completing health risk assessments with their patients, the majority of providers interviewed “either had a vague idea about the program or knew nothing about it.” Most “reported that they did not hear about this program from anyone.”

Identifying and engaging beneficiaries to participate can also be challenging due to inaccurate contact information, changes in beneficiaries’ eligibility or health status, and difficulties identifying eligible individuals. Establishing the infrastructure to offer and provide the incentive can also be technically challenging. Moreover, behavioral economics research shows that people are more likely to change their behavior in response to immediate rewards or costs, so delays in providing a reward due to lack of adequate program infrastructure could minimize programs’ effectiveness in changing behavior.

In addition, states tend to incur significant costs in implementing and administering these programs. Rewards above and beyond the cost of services can be costly to provide, and offering them requires up-front funds and staff time. In the interim evaluation of the Medical Incentives for the Prevention of Chronic Disease program, HHS reported that administrative costs for the incentive programs accounted for about 25 percent of overall expenditures during the program’s first three years. Penalties such as premiums and cost-sharing can also be complex to administer, and their administrative costs generally exceed the revenue they collect from beneficiaries.

**Behavioral Incentives Not Likely to Be the Best Way to Improve Health Outcomes**

States implement incentive programs to reduce costs and improve health outcomes. However, strong evidence demonstrates that eliminating access to services increases use of emergency services. While reward programs may increase participation in some short-term healthy behaviors without negatively affecting care, there is little evidence that they facilitate long-term changes in behavior and better health outcomes. Many individuals who engage in the rewarded behaviors would likely have done so without the reward. This lack of targeting, combined with reward programs’ administrative costs, suggests they generally offer a low return on investment.

Reward programs are premised on the assumption that Medicaid beneficiaries often don’t make the healthiest choices available to them, and that this can raise Medicaid costs especially when it

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results in more ED visits. Studies show, however, that while Medicaid beneficiaries do use the ED more often than privately insured individuals, they also are in poorer health than the general population and the majority of ED visits by non-elderly Medicaid beneficiaries are appropriate.28 An analysis of the 2013 and 2014 National Health Interview Survey results reported that of all adults who visited the ED, Medicaid beneficiaries were the most likely to report that their visit was due to the severity of their condition. Adults with private insurance were the most likely to report visiting the ED because their primary care provider’s office was closed.29

Rather than investing scarce financial and administrative resources in offering rewards or imposing penalties for individuals to make healthy choices, states may be better served by investing in improved access to appropriate health services, better care coordination, and increased integration of health and social services. Providing transportation, for example, can enable more beneficiaries to keep appointments.30

Similarly, various ED diversion and care coordination initiatives have been found to promote healthy behaviors and save states money. Successful programs in states including Georgia, Indiana, Minnesota, New Mexico, Oregon, Washington, and Wisconsin show that states can reduce ED use by expanding access to primary care services and targeting interventions to populations that use the ED frequently. For example, a recent evaluation of Oregon’s Coordinated Care Organizations — integrated, community-run organizations responsible for providing all medical, mental health, and dental care services for their members — showed that they have reduced ED utilization by 50 percent since 2011, while increasing enrollment in patient-centered primary care homes that coordinate beneficiaries’ physical and behavioral health care.31

Thus, while behavior rewards may prove to have some benefits for short-term behaviors, a longer-term investment in improving Medicaid beneficiaries’ access to timely and appropriate care is likely to provide greater returns.

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