ACHI
Arkansas Center for Health Improvement

# ISSUE BRIEF

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

## Healthy Behavior Incentives: Medicaid • February 2016

*Arkansas has some of the highest rates of risk factors for poor health in the nation with nearly 36 percent of adults considered obese, 39 percent with hypertension, and 13 percent with diabetes.[1] As a result, Arkansas's health has ranked between 44th and 49th for the last two decades and is currently ranked 48th.[2] For 2013, projected costs of chronic disease treatment and lost productivity were $26 billion.[3] By making reasonable improvements in preventing and managing chronic disease, Arkansas can make progress in disease reduction and economic improvement. Businesses and policymakers have seen the value of investing in preventive care and encouraging individuals to make better health choices related to diet, physical activity, and tobacco use. This issue brief is part of a series that discusses the components and effectiveness of healthy behavior incentive programs with recommendations for their establishment and their impact on individuals, businesses, and Medicaid.*

### HEALTHY BEHAVIOR INCENTIVE PROGRAMS

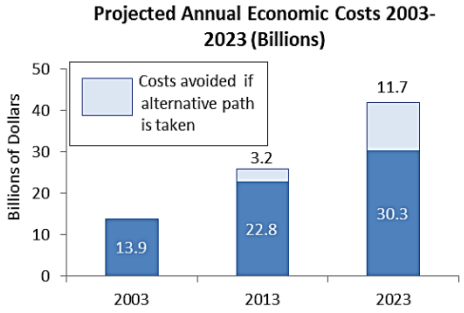
State governments and businesses have continued to face increasing healthcare costs. In addition, they have seen the financial impact of risk factors for poor health on increased employee absenteeism and decreased employee productivity at work.[4] One strategy for lowering these costs that is gaining popularity is the use of incentives to persuade program beneficiaries and employees to take greater personal responsibility for their health, use preventive care, and make healthy lifestyle choices. Behavioral changes such as eating better, exercising more, and smoking less are cost-effective strategies to contain the impact of chronic disease.[5] When offered, employees appear ready to join into the incentive programs, with 80 percent wanting incentives for wellness, 67 percent noting employers should offer a discount on health insurance for employees at a healthy weight, and 52 percent supporting rewards for adherence to chronic disease medication regimens.[6] It is important to differentiate incentive programs from comprehensive workplace wellness programs. Incentives are intended to increase engagement and encourage employees to take part in wellness programs, while the wellness programs themselves incorporate strategies to improve health, manage chronic conditions, and prevent disease.

#### The Cost of Chronic Disease in Arkansas

In 2007, the Milken Institute used data from the Medical Expenditure Panel Survey to develop cost projections related to seven common chronic diseases: cancers, diabetes, heart diseases, hypertension, stroke, mental disorders, and pulmonary conditions. They considered a "business-as-usual" scenario ("current path") of treatment and an optimistic scenario ("alternative path") that assumed improvements in health-related behavior and treatment (see Figure 1). With positive changes in weight control, improved nutrition, increased exercise, and reductions in smoking, Arkansas could see more than $11.7 billion in avoided health-related costs over a 20-year span, representing a 28 percent reduction in the economic impact of chronic disease.[3] Updating this report seven years later, the Milken Institute examined changes in their original projections. On the

positive side, national data indicated heart disease prevalence and expenditures per patient—aided by falling smoking rates—were lower than baseline projections. However, in all other diseases studied—cancer, diabetes, hypertension, and stroke—the number of people reporting a condition, actual treatment costs, and productivity losses exceeded estimates.[7] In addition, they found the increased prevalence of obesity contributed to the number of cases of most of these diseases. This led the Institute to recommend incentives for disease prevention and a renewed national commitment to achieving a healthy body weight.

**Figure 1: Economic Costs of Chronic Disease in Arkansas[3]**




Avoidable Costs in 2023 (Billions)

| | Treatment Expenditures | Lost Productivity | Total |
|---|---|---|---|
| Current Path | $7.3 | $34.7 | $42.1 |
| Alternative Path | $5.2 | $25.1 | $30.3 |
| **Costs Avoided** | **$2.1 (29%)** | **$9.6 (28%)** | **$11.7 (28%)** |

## Use of Financial Incentives

Incentives have rarely been utilized in Medicaid programs to date. However, recent waivers granted by the Centers for Medicare & Medicaid Services (CMS) have authorized states to incorporate wellness incentives. Research in the non-Medicaid population suggests financial incentives are effective at encouraging healthy behavior.[8,9] The effectiveness of incentive programs depends on how the incentives are timed, distributed, and framed. Behavioral economics suggest that the same decision-making process that contributes to poor health-related behaviors can be used to create effective incentive programs (e.g., people are more attracted to immediate than delayed benefits and are more deterred by immediate than delayed costs).[11] Incentive programs that offer small, frequent payments for a behavior that benefits the individual, such as following a medication plan, can be more effective than less-visible incentives that reduce a monthly premium or are included in a paycheck.[12]

> Behavioral economics is the study of how people actually make choices. It draws on insights from both psychology and economics.[10]
>
> *"Behavioral economics explains why we procrastinate, buy, borrow, and grab chocolate on the spur of the moment."*
>
> *–Craig Lambert, Harvard Magazine*

### *Federal and State Oversight of Incentive Programs*

The Patient Protection and Affordable Care Act of 2010 (PPACA)[13] allows employers, starting in 2014, to use up to 30 percent of the total amount of their employees' health insurance premiums to provide outcome-based wellness incentives. If the wellness activity aims to help someone reduce or quit smoking, the incentive can be higher—up to 50 percent of the plan's cost. The regulations consider the variability of medical conditions that might make achievement of a particular health standard "medically inadvisable" or "unreasonably difficult." For people with such conditions, the regulations require that plans offer a "reasonable alternative standard." There is limited guidance as to how these terms may be interpreted.[14] However, a number of state and federal laws and regulations impose limits on the use of financial incentives in wellness programs such as group

health plans and self-insured group health plans to protect beneficiaries. Regulations under the Public Health Service Act,[15] the Employee Retirement Income Security Act of 1974 (ERISA),[16] the Americans with Disabilities Act of 1990 (ADA),[17] the Health Insurance Portability and Accountability Act of 1996 (HIPAA),[16] the Genetic Information Nondiscrimination Act of 2008 (GINA),[18] and the Internal Revenue Code[19] impact the design and administration of these programs.

### *Medicaid Incentive Programs – What We Know*

Medicaid incentive initiatives focus on program beneficiaries and emphasize the importance of personal choices in determining health. The initiatives to date look to improve adherence to prescribed drug regimens, enhance participation in programs, encourage preventive care (e.g., vaccinations and mammography), and promote wellness and healthy behaviors. The incentives generally are financial or cash equivalents (e.g., gift cards as well as credits or vouchers redeemable for health related products and services, gym memberships, and weight loss programs).[20] In general, because of the unique circumstances and limited financial resources of Medicaid beneficiaries, states and the federal government have not been permitted to employ financial penalties.

States are able to operate their incentive programs under various authorities. Ten states utilize the Center for Medicare and Medicaid Innovation's Medicaid Incentives for Prevention of Chronic Disease (MIPCD) grant program. Three states have state plan amendments under the Deficit Reduction Act of 2005 (DRA), while other states use Section 1115 Medicaid demonstration waivers, Section 1915(b) waivers, and Medicaid managed care organizations.[21]

Medicaid program policies that are focused on encouraging beneficiaries to be active participants in their health and health care fall into three general areas: cost sharing through copayments and premiums, health savings accounts (HSAs), and healthy behavior incentives and rewards.[21,22] Six states—Arkansas, Iowa, Michigan, New Hampshire, Pennsylvania, and West Virginia—have incorporated copayments and/or premium adjustments into their Medicaid expansion models. Arkansas, Indiana, and Michigan have established HSAs.

> Seven states are using cost sharing through copayments, premium adjustments, and/or establishing health savings accounts.

A part of the Arkansas Health Care Independence Program (HCIP), Health Independence Accounts offered cost avoidance of copayments for those individuals with incomes greater than 100 percent of the federal poverty level (FPL) if they participated in monthly premium payments.[23] Through 2014, The Stephen Group (TSG) examined the state's Medicaid plan and made recommendations in its report to the Arkansas Health Reform Task Force identifying personal responsibility and accountability through wellness, prevention, and appropriate use of healthcare services. In this proposal, Medicaid beneficiaries would be held accountable for specific healthcare actions as outlined in a Membership Agreement. In addition, a wellness scorecard would be used to track health factors such as preventive care. Potential vision and dental care benefits would be lost, and copayments and premiums would be charged to those individuals who do not meet the wellness standards.[24] These recommendations are under review by the General Assembly and Executive Branch.

States target a variety of healthy behaviors with their incentive programs. The states funded by the MIPCD address at least one of the following specified prevention goals: tobacco cessation, weight

control, lowering cholesterol, lowering blood pressure, and preventing or controlling diabetes. Table 1 summarizes the behavior, type of incentive, and program authority of current Medicaid programs.[20]

**Table 1. Healthy Behaviors, Consumer Incentive, and Authority[20]**

| State | Healthy Behaviors | Incentive | Authority |
|---|---|---|---|
| CA, CT | Tobacco cessation | Financial | MIPCD |
| FL | Preventive care | Redeemable credits | Section 1115 waiver |
| HI | Diabetes | Financial | MIPCD |
| ID | Tobacco and weight control | Vouchers for health-related services | DRA |
| | Well-child exams and immunizations | Medicaid premium coverage | Children's Health Insurance Program |
| KY | Disease management | Redeemable health-related services | DRA |
| MN | Diabetes and weight control | Financial | MIPCD |
| MT | Diabetes, weight control, high cholesterol, high blood pressure | Financial | MIPCD |
| NV | Diabetes, weight control, high cholesterol, high blood pressure | Redeemable points | MIPCD |
| NH | Tobacco and weight control | Vouchers for health-related services | MIPCD |
| NM | Healthy behaviors | Redeemable points | Section 1115 waiver |
| NY | Tobacco, diabetes, high blood pressure | Financial | MIPCD |
| TX | Tobacco, diabetes, weight control, high blood pressure, high cholesterol | Flexible Wellness Account for specific health goals | MIPCD |
| WV | Healthy behaviors | "Enhanced" benefits package | DRA |
| WI | Tobacco | Financial | MIPCD |
| | Healthy behaviors | Various incentives | Medicaid Managed Care |

### *Lessons Learned from Existing Programs-State Medicaid Programs*

There is limited evidence about the impact of financial incentives within the Medicaid program. Florida, Idaho, and West Virginia began their programs during 2006, 2007, and 2006, respectively. Though all programs had the same goal of improving the health of their program participants, they had unique approaches and, except for the Idaho child wellness program, little is known of their effectiveness. A summary of each program follows:[25]

- Florida enrolled all participants into their incentive program. Credits as cash equivalents were awarded for having: annual physical examinations; immunizations; cancer screenings; following medication regimens; and participating in tobacco cessation, weight loss, and/or diabetes programs. Only 54 percent of participants earned credits, and only 52 percent of those were redeemed. The majority of credits were earned for childhood preventive care or adult/child office visits, with less than 1 percent of credits earned for behavior change programs.
- Idaho focused on providing vouchers to adults to attend tobacco cessation and weight loss programs and providing premium assistance for well-child visits. Well-child visits increased from 23 to 49 percent, while less than 1 percent of adults participated in the behavioral programs.

- West Virginia established a two-tier program that offered enrollees the option of an "enhanced" or a "basic" health plan. Only 10 percent of eligible adults enrolled in the enhanced plan, which required adherence to agreements and physician-patient contracts while providing unlimited prescriptions, diabetes, weight management, and tobacco cessation programs. Low levels of health literacy and plan understanding may have contributed to the low enrollment.

The interim evaluation of the ten states funded by the MIPCD was only able to provide an overview of the programs' enrollment and status. The states had experienced administrative delays; difficulty with provider recruitment, participation, and management; problems determining participant eligibility; and impediments running the incentive component. From these challenges, the states modified timelines and beneficiary recruitment, enrollment, and incentives as well as provider recruitment, training, and incentives.[26]

### *Recommendations for Establishing a Healthy Behavior Incentive Program*

Insights gained from academic research,[9,11,12] private businesses,[6,27] and Medicaid incentive programs[20,25,28,29] provide guidance for the establishment of healthy behavior incentive programs.

- Program beneficiaries need to be aware of the existence of these programs as well as the criteria for active participation. Outreach and education using multiple channels to engage beneficiaries in these programs is crucial.[28,29]
- Simple messages should describe a program's health and financial benefits so that people at all education and health literacy levels will be able to understand them. The benefit structure should be clear about what is included in the program and how individuals qualify for it.
- Rewards for behavior change should be immediate, visible, and sufficient to motivate change.
- Targets for clinical improvement should be individually achievable relative goals to support engagement rather than absolute goals (e.g., a 5 percent[30] – 10 percent[31,32] weight loss achievement [relative goal] versus a normal weight achievement [absolute goal]).
- Partnerships among businesses, health plans, community groups, state agencies, and healthcare providers can enhance education and program participation.
- Potential administrative infrastructure complexities need to be addressed in advance, such as how to measure health behavior changes, provide incentive payments, and expedite incentive distributions.
- An evaluation component should be included to assess relative effectiveness and assist with ongoing program improvement over time.

## CONCLUSION

An investment in good health is an investment in economic opportunities. Providing people with the opportunities and incentives to take control of lifestyle behaviors that impact their health helps them, their families, and their employers, as well as the state. A well-designed incentive program is likely to increase the level of participation in wellness programs and increase positive behavior changes, thus leading to healthier individuals with lower healthcare costs and less worker

absenteeism. Given the burden of chronic disease in Arkansas and the opportunity to improve health and lower healthcare costs, it is worthwhile for Medicaid to explore the potential of adding a healthy behavior incentive program to its benefits structure.

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