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Beneficiary Understanding of Incentives: Evidence from Interim Demonstration Evaluation Reports in Indiana, Iowa, and Michigan

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Executive summary

Indiana, Iowa, and Michigan used section 1115 authority to implement beneficiary engagement programs as part of their Medicaid expansions, seeking to help Medicaid beneficiaries become more active participants in their health care. Indiana's Healthy Indiana Plan (HIP) 2.0, Iowa's Health and Wellness Plan (IHAWP), and Michigan's Healthy Michigan Plan (HMP) each incentivize behaviors with rewards and penalties to encourage beneficiaries to engage in their health and health care, use regular preventive care, and/or make cost-conscious decisions when accessing care. This brief synthesizes findings from beneficiary survey data presented in interim demonstration evaluation reports to assess beneficiary understanding of each state's incentive program.

Most available survey data reflect only the first year of demonstration operations, and at this stage beneficiary understanding of many policies is still developing. For example, less than 10 percent of surveyed HIP 2.0 beneficiaries knew that they receive preventive care at no cost, and less than 30 percent of surveyed IHAWP beneficiaries knew that completing a health risk assessment (HRA) and wellness visit waives required monthly payments in the next enrollment year. There are a few notable exceptions, however. For instance, 97 percent of HIP 2.0 beneficiaries who would be subject to disenrollment for nonpayment of required monthly contributions were aware of the disenrollment policy, and 67 percent of HMP beneficiaries reported reviewing their MI Health Account statements closely to find out how much they owe.

Although all three states and their contracted health plans conduct outreach and education to communicate with beneficiaries about the incentive programs (Contreary and Miller 2017), these early findings suggest that states and health plans may need to continue working to help beneficiaries understand demonstration policies. Thorough understanding of the incentives and penalties is a precursor to effective implementation of states' beneficiary engagement strategies and to achieving these demonstrations' policy goals. However, state evaluation findings also raise the possibility that beneficiaries might be engaging in incentivized behaviors even without a strong understanding of program details. For example, 74 percent of HIP 2.0 beneficiaries enrolled for at least 10 months received a qualifying preventive service, despite the fact that 52 percent of surveyed HIP Plus beneficiaries and 35 percent of HIP Basic beneficiaries understood rollover incentives for preventive care. Further investigation of the reasons for changing behaviors—such as whether changes are driven by program incentives, closer relationships with primary care providers, or specific communications from health plans—would help with the interpretation of program outcomes and could inform decisions about future policy design.

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.

Introduction

Indiana, Iowa, and Michigan have expanded Medicaid to adults with incomes up to 133 percent of the federal poverty level (FPL) using section 1115 authority to test beneficiary engagement strategies.[1] All three states seek to engage beneficiaries in their health care by providing financial rewards for completing certain health behaviors, such as the use of preventive care and completion of an HRA. Indiana and Michigan have also designed incentives to encourage beneficiaries to make cost-conscious decisions when accessing care. All three states reduce beneficiaries' monthly payments or point-of-service cost-sharing obligations for completing certain behaviors or provide other financial rewards, such as gift cards. Indiana and Iowa also provide rewards in the form of enhanced benefits. (See Byrd, Colby, and Bradley [2017] for a detailed discussion of these policies and their design, and the appendix for a high-level summary.)

The degree to which incentives influence beneficiaries' behavior depends on how well beneficiaries understand their incentives. The state Medicaid agencies and contracted health plans in Indiana, Iowa, and Michigan have devoted considerable effort to communication strategies designed to educate beneficiaries about encouraged behaviors and associated rewards and penalties. As we discuss in a separate issue brief, contracted health plans provide the majority of beneficiary education, in the form of welcome packets, member handbooks, and calls to members from call centers (Contreary and Miller 2017). Beneficiaries can also receive information about incentivized behaviors through conversations with enrollment brokers, health care providers, or materials distributed directly by the state Medicaid agency.

To assess beneficiaries' experiences in these demonstrations, state evaluators in Indiana, Iowa, and Michigan conducted beneficiary surveys and reported the results in interim demonstration evaluation reports to the Centers for Medicare & Medicaid Services (CMS). This brief synthesizes the data from states' interim reports regarding beneficiary understanding of the behavior-incentive programs. Because states' incentives and survey methods differ, most results cannot be directly compared across states. As context, the following section provides information on data-collection timing and methods in each state. We then discuss survey findings specific to key policies in each state and note implications for evaluation and demonstration design.

Data sources

All three states fielded at least one survey before submitting interim demonstration evaluation reports to CMS, which asked currently enrolled beneficiaries about encouraged behaviors, rewards, and penalties. Although all three states required surveyed beneficiaries to be enrolled for at least 6 months, evaluators fielded surveys between 9 and 21 months after the beginning of the demonstration period, depending on the state (Table 1). At the time of the surveys, most beneficiaries in Indiana and Iowa had not experienced key program features, such as the HIP 2.0 Personal Wellness and Responsibility (POWER) Account rollover incentive[2] or the IHAWP monthly payment requirement in the second enrollment year[3] (see the appendix for a summary of demonstration features and incentives). Subsequent beneficiary surveys that occur after these rewards have accrued might reflect a higher level of beneficiary understanding, although understanding of incentives within the first enrollment year is necessary to maximize beneficiaries' engagement and potential rewards in both the first and second enrollment years. Nevertheless, the available survey data yield valuable information about beneficiary understanding of behavior incentives in the early demonstration implementation period. Each state's approach for conducting its beneficiary surveys provides important context for the findings.

Indiana. Indiana's evaluators surveyed current beneficiaries in December 2015, 11 months after implementation of the demonstration, using separate survey instruments for beneficiaries enrolled in the two benefit plans: HIP Plus and HIP Basic.[4] Overall, survey respondents were reasonably well aligned with the universe of HIP 2.0 beneficiaries based on age, gender, and income level, suggesting that survey responses were representative of all HIP 2.0 enrollees. The full target sample of 600 beneficiaries was reached, and responses reported in the interim evaluation report are weighted to match the HIP 2.0 population; the response rate was not reported. The main limitation of the survey data is that responses reflect beneficiary experiences over 10 or fewer months of enrollment, which means respondents had not yet completed the annual reenrollment process or earned rewards for incentivized behaviors that accrue after renewal.

Iowa. Iowa's evaluators surveyed enrolled beneficiaries in a 2014 survey of IHAWP members and a 2015 Dental Wellness Plan (DWP) member survey.[5] Evaluators also conducted interviews with IHAWP beneficiaries in 2015. Overall, available information on beneficiary understanding of encouraged behaviors and associated rewards in Iowa is limited for several reasons. First, the IHAWP and DWP surveys had low response rates of about 30 percent. Although data reported from the IHAWP survey were weighted, evaluators noted that respondents and nonrespondents for both surveys differed on characteristics such as age and race, raising concerns about the generalizability of results. The data reported from the DWP survey were not weighted. The IHAWP member survey, which is the main survey we analyze in this brief, was fielded about nine months after the demonstration began, although some respondents had been enrolled for as little as six months. Finally, none of the surveys included questions about the HRA incentive.

Michigan. Michigan evaluators conducted the Healthy Michigan Voices beneficiary survey beginning in January 2016, 21 months after the implementation of the demonstration. Evaluators drew monthly samples until they reached the target sample population of 4,050 respondents in November 2016. Considering responses through June 2016—the last month of data included in the state's interim evaluation report—the distribution of income levels and geographical regions among respondents closely matched the target sampling plan, suggesting that survey respondents provide a representative sample of the HMP beneficiary population so far. However, responses reported in the state's interim evaluation report are preliminary, as they are not based on a complete sample and are unweighted. All respondents were enrolled for at least one year at the time they were surveyed, which is longer than the minimum respondent enrollment periods in the HIP 2.0 and IHAWP surveys. Therefore, HMP survey respondents likely had more experience with program features than most respondents in Indiana and Iowa. However, the available data on beneficiary incentives are limited because the state's interim survey report does not distinguish between respondents above and below 100 percent of the FPL, for whom healthy behavior incentives and rewards differ.

Table 1. Beneficiary survey methods, timing, and sample sizes

State	Evaluation report	Methods and timing of beneficiary survey or interviews	Length of time after demonstration implementation	Final sample size	Response rate
Indiana	Healthy Indiana Plan (HIP) 2.0: Interim Evaluation Report, July 2016	The HIP 2.0 survey of current members was administered in December 2015 and January 2016. HIP Plus and Basic beneficiaries received different surveys to capture the unique features of each program. The statistical power of the survey was 80 percent, which was sufficiently large to detect differences across groups of beneficiaries (that is, HIP Plus versus HIP Basic).	11 months	600 surveys were completed (420 HIP Plus beneficiary surveys and 180 HIP Basic)	Number of sample members with contact attempts not reported so response rate cannot be calculated
Iowa	Evaluation of the Iowa Health and Wellness Plan (IHAWP) Member Experiences in the First Year, April 2015	Surveys were mailed to a stratified random sample of IHAWP members who had been enrolled in their current plan for at least the previous six months. The survey was fielded in fall 2014. Statistical power was not discussed.	About nine months	1,792 (1,101 Wellness Plan [WP] and 691 Marketplace Choice [MPC])[a]	30 percent (32 percent WP; 28 percent MPC)
	Dental Wellness Plan (DWP) Evaluation Interim Report, March 2016	Surveys were administered to a random sample of DWP members in spring 2015. Beneficiaries were eligible for the survey if they had been enrolled for 7–10 months with only one month of ineligibility or less. The survey was insufficiently powered to detect differences among groups of beneficiaries.	About 15 months	1,260 DWP members	30 percent
	Health Behaviors Incentive Program Evaluation Interim Report, March 2016	Due to a low response rate in the fall 2014 member survey, evaluators also conducted beneficiary interviews. Interviews were conducted with a sample of IHAWP enrollees ages 19 to 64 as of August 14, 2015, with a valid telephone number and mailing address, who had been enrolled for at least six months. The sample was stratified by four groups: those who had completed only a health risk assessment, those who had completed only a wellness exam, those who had completed both, and those who had completed neither.	About 20 months	152 interviews (of which 146 were coded and reported)[b]	46 percent
Michigan	Healthy Michigan Voices Beneficiary Survey Interim Report, September 2016	Monthly samples were drawn beginning in January 2016; data reported were current as of June 2016. At the time of monthly sample selection, beneficiaries must have been initially enrolled in the Healthy Michigan Plan at least 12 months prior, with only 2 or fewer months of ineligibility. Statistical power was not discussed.	At least 21 months	2,059 at the time of the report (total sample size of 4,050 reached by the end of 2016;	Not specified—survey was not complete when the interim report was released

[a] Marketplace Choice (MPC), the state's original demonstration that provided care for beneficiaries with incomes above 100 percent of the federal poverty level through qualified health plans, closed at the end of 2015. MPC beneficiaries have since transitioned to the Wellness Plan (WP), the state's Medicaid plan that originally covered only IHAWP beneficiaries with incomes at or below 100 percent of the federal poverty level.

[b] The remaining interviews were conducted in Spanish and were not coded.

What do we know about beneficiary understanding of behavior incentives so far?

The following findings represent experience in the first one to two years of these demonstrations. They are early findings, and over time reported rates may change due to demonstration maturation and increased beneficiary experience. Although it is difficult to compare incentives across demonstrations, about one-third to one-half of beneficiaries in each state report understanding relevant incentive policies. Beneficiary understanding of Indiana's disenrollment policy for nonpayment of monthly POWER Account contributions is much higher, and is a notable exception to overall understanding levels. In this section we discuss beneficiary understanding of state-specific behavior incentives, note a few instances in which beneficiary understanding seems to be higher than average, and, when possible, draw comparisons across states with similar incentive policies.

Indiana

HIP 2.0 aims to engage beneficiaries in their health and health care and to encourage them to consider the costs of the care they receive. The demonstration incentivizes regular monthly payments into and management of the POWER Account, as well as regular receipt of preventive care. The POWER Account, which is modeled after a health savings account, is the foundation for all beneficiary engagement policies in HIP 2.0, although behavior incentives, rewards, and penalties vary between the HIP Plus and HIP Basic plans.

Monthly POWER Account payments. HIP Plus beneficiaries must make regular monthly payments of no more than 2 percent of their income into their POWER Accounts to maintain enrollment in the program or their level of benefits, depending on income level.[6] HIP Plus beneficiaries with incomes above 100 percent of the FPL can be disenrolled for nonpayment, which results in a six-month exclusion from re-enrollment.[7] HIP Plus beneficiaries with incomes at or below 100 percent of the FPL cannot be disenrolled for nonpayment. Instead, they are moved to HIP Basic, which requires point-of-service copayments and offers more limited benefits.

Among surveyed HIP Plus beneficiaries with incomes greater than 100 percent of the FPL, 97 percent reported being aware of the disenrollment policy and inability to re-enroll for six months, although the number surveyed was relatively small (n=69). Among HIP Plus beneficiaries with incomes below 100 percent of the FPL (n=351), 78 percent were aware that failure to make regular monthly payments could result in reduced benefits and assessment of co-payments for all services. Awareness of the nonpayment penalty is consistent with the high rate of compliance with the monthly payments; more than 90 percent of beneficiaries both above and below 100 percent of the FPL who were ever enrolled in HIP Plus made the monthly payments necessary to stay in HIP Plus during the first demonstration year.

POWER Account management and cost-conscious consumption of care. The POWER Account incorporates a rollover incentive to encourage beneficiaries to make cost-conscious decisions about accessing care. HIP 2.0 beneficiaries use POWER Accounts to pay for the first $2,500 of their annual medical expenses, similar to a deductible, except for the cost of preventive care, which is not deducted from the account. HIP Plus beneficiaries fund part of this amount through monthly contributions; for HIP Basic beneficiaries, the state provides the entire amount. Beneficiaries have an incentive to spend POWER Account funds judiciously because they can be eligible to roll over a portion of any funds remaining at the end of an enrollment year into their account for the next year, thereby reducing or even eliminating their required monthly contributions in the next year.[8]

Although POWER Accounts are an integral part of HIP 2.0, survey results suggest that many beneficiaries do not actively monitor their POWER Accounts by checking their balances regularly. All beneficiaries have a POWER Account, and 66 percent of HIP Plus and 46 percent of HIP Basic beneficiaries reported ever hearing of the POWER Account. Of those who had heard of the account, 72 percent of HIP Plus and 76 percent of HIP Basic beneficiaries reported knowing they had an account. Of those who reported knowing they had an account, 51 percent of HIP Plus and 57 percent of HIP Basic beneficiaries reported checking their account balances every few months or more frequently. Thus, about 24 percent of HIP Plus and 18 percent of HIP Basic beneficiaries surveyed reported knowing they had a POWER Account and checking its balance at least every few months.[9]

Likewise, 27 percent of all surveyed HIP Plus beneficiaries responded affirmatively to a question about whether, when they need to access care, they ask their provider how much the care will cost. Although "cost" could refer to any type of cost, since HIP Plus beneficiaries have no out-of-pocket medical costs[10] the main costs beneficiaries would need to be aware of are deductions from the POWER Account to cover the costs of care they receive. These findings suggest that the POWER Account might not motivate many HIP Plus beneficiaries to consider the cost of care they receive. The HIP Basic member survey did not ask this question.

Receipt of preventive care. HIP 2.0 incentivizes the receipt of preventive care in two ways. First, HIP Plus beneficiaries who obtain recommended preventive care and have a balance remaining in their POWER Accounts earn a doubled account rollover at the end of the enrollment year. About half (52 percent) of all surveyed 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. HIP Basic beneficiaries who receive recommended preventive care can also roll over a portion of their POWER Account funds, but only if they have a remaining account balance and agree to start making monthly contributions and move to HIP Plus. About a third (35 percent) of all surveyed HIP Basic beneficiaries understood that if they agreed to move up to HIP Plus and they did not receive a preventive service in the past year then their remaining account balance would not be rolled over.

To further encourage receipt of preventive care, the costs of preventive services are not deducted from POWER Accounts. Survey findings revealed that 52 percent of all respondents enrolled in HIP Plus and 51 percent of all respondents enrolled in HIP Basic stated (incorrectly) that the cost of preventive care would be deducted from their POWER Account; an additional 39 percent of surveyed HIP Plus beneficiaries and 40 percent of surveyed HIP Basic beneficiaries responded "don't know." Therefore, 9 percent of surveyed HIP Plus and 7 percent of surveyed HIP Basic beneficiaries correctly identified that there is no cost for preventive care.

Overall, the proportion of beneficiaries who actually received preventive care was higher than the proportion indicating they understand 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. Thus, the majority of beneficiaries obtained preventive services even though smaller proportions reported understanding the rewards associated with this behavior. These findings suggest that the POWER Accounts and related communications might have been less important as a motivator for seeking preventive care during the first enrollment year, for some beneficiaries, than intrinsic motivation or prompts from care providers. Future surveys will be important for understanding whether beneficiaries become more aware of the account-related incentives over time and, therefore, whether the incentive structures can be credited with changing observed behaviors.

Iowa

IHAWP aims to engage beneficiaries in their health and health care by encouraging beneficiaries to complete an annual HRA and a wellness exam.[11] IHAWP also incentivizes the use of regular dental care by providing beneficiaries with enhanced dental benefits if they use regular dental care. These policies have been in effect since the program's inception, although the state has since changed program structures. Marketplace Choice (MPC), the state's original demonstration that provided care for beneficiaries with incomes above 100 percent of the FPL through qualified health plans, closed at the end of 2015. MPC beneficiaries have since transitioned to the Wellness Plan (WP), the state's Medicaid plan that originally covered only IHAWP beneficiaries with incomes at or below 100 percent of the FPL.[12] However, the beneficiary surveys discussed here were fielded when MPC was still operating, and we present some survey responses from MPC and WP members separately. The available data on beneficiary understanding are very limited due to the limited scope of the survey and interview questions.

Monthly payments. After one year of enrollment, IHAWP beneficiaries with incomes at or above 50 percent of the FPL who do not complete a wellness visit and HRA must start making monthly payments. At the time of the beneficiary survey in 2014, no respondents had reached their second enrollment year and the survey did not ask about experience with monthly payments. Additional interviews conducted in fall 2015 indicate that beneficiary understanding of the monthly payment policy might be low, but there is not enough information to support this conclusion. For example, of the 105 interviewed IHAWP beneficiaries who said they never received an invoice for a monthly payment, 30 (29 percent) did not know why they did not receive an invoice, 19 (18 percent) stated this was due to their low income, and 16 (15 percent) reasoned that they did not receive an invoice because their insurance plan did not require a monthly payment.[13] The report does not distinguish between answers from beneficiaries who were and were not subject to monthly payments due to income or completion of encouraged health behaviors.

HRA and wellness exam. IHAWP rewards beneficiaries who complete the annual HRA and wellness visit by waiving monthly payments in the successive enrollment year. Iowa's fall 2014 survey found that 29 percent of WP and 18 percent of MPC beneficiaries were aware of the wellness visit incentive. The survey did not ask beneficiaries about the HRA incentive. This level of beneficiary awareness could reflect the relatively short time that respondents had been enrolled in the program (some as little as six months) when this survey took place, because no surveyed beneficiaries had experienced reenrollment or the opportunity to avoid monthly payments in their second year. However, beneficiaries interviewed during fall 2015 reported similar levels of awareness: 7 of 35 MPC respondents (20 percent) and 34 of 111 WP respondents (31 percent) appeared to be aware of the wellness exam and HRA policies.

Dental wellness. IHAWP incentivizes dental care in two ways. First, a dental exam can fulfill the program's annual wellness visit requirement. Second, beneficiaries who obtain regular dental care receive progressively higher levels of dental coverage through an earned benefits structure, beginning with "Core" services and proceeding to "Enhanced" and "Enhanced Plus" services if beneficiaries return for regular dental exams

every 6 to 12 months. Sixty-nine percent of surveyed IHAWP beneficiaries did not know about the tiered dental coverage structure and thus were unaware that they could become eligible for enhanced levels of dental coverage based on their continued receipt of preventive dental care. Of the 31 percent of respondents who were aware of the tiered levels of coverage, 71 percent knew their current benefit level. About two-thirds of beneficiaries who knew their current benefit level (66 percent) reported that they learned about the levels of coverage through materials received from their health plan, and dentists were a source of information for 31 percent. When asked whether they would return for regular dental checkups as a result of the tiered coverage levels, 76 percent of surveyed beneficiaries responded that they would definitely or probably return, suggesting that greater awareness of the earned benefits incentive can result in the desired beneficiary response of consistent dental care.

Michigan

The Healthy Michigan Plan incentivizes healthy behaviors by encouraging beneficiaries to complete an HRA and make a commitment to personally meaningful healthy behaviors. The demonstration also sensitizes beneficiaries to the cost of their care by providing all beneficiaries with a MI Health Account, which serves as a $1,000 deductible. Beneficiaries and health plans share responsibility for funding the accounts. The MI Health Account generates quarterly statements that track service costs and acts as a repository for monthly payments, which partially fund the deductible. Monthly payments are required for beneficiaries with incomes greater than 100 percent of the FPL. Beneficiaries at all income levels also pay copayments into the MI Health Account, but copayments are redistributed to the health plans and do not accrue in the account. Preventive services and care for chronic conditions are exempt from beneficiary cost-sharing. The Healthy Michigan Voices survey included several items designed to reveal beneficiary awareness of these policies.

Monthly MI Health Account payments. HMP beneficiaries with incomes above 100 percent of the FPL are required to make monthly payments of 2 percent of their income into their MI Health Accounts, and beneficiaries at all income levels are required to pay copayments, but most beneficiaries are unaware of the details of this policy. Although monthly payments are required, the state does not disenroll beneficiaries from the program for nonpayment (unlike in Indiana).[14] About half (52 percent) of all respondents did not know whether beneficiaries could be disenrolled for not making payments, and another 33 percent incorrectly believed that they would be disenrolled for nonpayment, meaning that 15 percent of beneficiaries knew that they could not be disenrolled for nonpayment of copayments or monthly payments.

MI Health Account management and cost-conscious consumption of care. The purpose of the MI Health Account is to help beneficiaries track their health care use and spending by documenting the costs of care received, cost-sharing amounts owed, and the accrued account balance for beneficiaries with incomes above 100 percent of the FPL who are required to make monthly payments into the account. Beneficiaries at all income levels receive quarterly statements showing the copayments they owe based on their previous service use and, for beneficiaries with income above 100 percent of the FPL, their monthly payment amounts (see Miller and Contreary [2017] for a detailed discussion on the account statements).[15] Beneficiaries who make monthly account payments and do not use high levels of care may have a remaining balance in their account that they can use to purchase other health insurance coverage after exiting HMP.

Awareness of the MI Health Account and the account statement is higher than awareness of other HMP beneficiary engagement policies. Seventy-five percent of survey respondents reported receiving a MI Health Account statement; of these, 89 percent agreed or strongly agreed that they carefully review each statement to see how much they owe, and 88 percent agreed or strongly agreed that the statements make them more aware of the cost of health care. Seventy-two percent of all survey respondents reported being somewhat or very likely to find out how much they might have to pay for a health service before receiving it, and 67 percent reported being somewhat or very likely to talk with their doctors about how much different health care options would cost. In contrast, 27 percent of HIP Plus beneficiaries in Indiana reported asking their doctors about the cost of care before they receive it.

However, further research is needed to examine whether MI Health Account statements lead to changes in beneficiaries' behavior: 29 percent of beneficiaries agreed or strongly agreed that the information in the MI Health account statement led them to change some of their health care decisions. Further research is also needed to understand what types of health care decisions beneficiaries were prompted to reconsider, and what conditions—such as advance information about health care costs or the ability to consult with a provider—were necessary to enable those decisions.

Health risk assessment and healthy behavior attestation. HMP incentivizes beneficiaries to complete an HRA and attest to improving or maintaining a healthy behavior of their choice; however, additional research is needed to understand whether beneficiaries are engaging in these activities because of the incentives. Beneficiaries who complete an HRA with a provider and commit to improving one or more health behaviors receive credits in their MI Health Accounts that reduce the amount of monthly payments they owe in the future (if they

have incomes above 100 percent of the FPL) or a $50 gift card (if they have incomes at or below 100 percent of the FPL). Of the 53 percent of survey respondents who remembered completing the HRA, the most common reasons for doing so were because a primary care provider suggested it (46 percent) or they received the HRA in the mail (34 percent). Much smaller proportions reported that incentive rewards motivated completion: 3 percent reported that the "gift card/money/reward" was a reason for completion, and less than 1 percent reported doing so to save money on copayments or their monthly payments in the future. Similarly, 29 percent of beneficiaries correctly identified that they can receive a reduction in their monthly payment amounts if they complete an HRA. Consistent with the level of beneficiary understanding of the HRA-linked incentive, 15 percent of beneficiaries had received credit for completing the encouraged behaviors as of December 2015.[16] However, 40 percent of beneficiaries responded that information about the incentives led them to do something they "might not have done otherwise," suggesting that incentives can positively affect beneficiaries' behavior even if they do not fully understand them.

Receipt of preventive care. HMP makes preventive services and services to manage chronic conditions available to beneficiaries with no associated cost-sharing. More than three-fourths (78 percent) of survey respondents correctly identified that some kinds of visits, tests, and prescriptions have no copayments; however, the survey did not specify the kinds of visits, tests, and prescriptions. These data points suggest that beneficiaries know that certain types of care are incentivized and free of charge, but it is not clear whether they know what kind of care or for what reason.

Implications for states' education efforts and incentive design

Survey data described in the interim demonstration evaluation reports for Indiana, Iowa, and Michigan provide valuable insights into beneficiaries' understanding of encouraged behaviors and associated incentives in each state. Though the survey questions differ among states, and most responses cannot be compared directly across states, the available data from all three states show that about one-third to one-half of beneficiaries understand key features of beneficiary incentive programs. However, there are notable exceptions to general awareness levels, such as high awareness of the penalties for nonpayment of POWER Account contributions in HIP 2.0 and high rates of use of MI Health Account statements in Michigan.

Uneven understanding among beneficiaries of many encouraged behaviors and incentives suggest that states might have to do more to explain incentive programs to beneficiaries. One clear example of this is in Iowa, where 31 percent of beneficiaries were aware of the earned dental benefits structure, but 76 percent of beneficiaries said they would likely use regular dental care to obtain enhanced benefits when they learned about the benefits structure. These data suggest that greater awareness of the incentive could result in the desired beneficiary response of consistent dental care. All three states and their contracted health plans report conducting outreach and initiatives to educate beneficiaries about incentivized behaviors (Contreary and Miller 2017). Even though the survey results described here are preliminary, individual states should consider how the findings from the beneficiary surveys could inform ongoing efforts to improve beneficiary education.

Notably, the level of understanding of incentives might not accurately predict beneficiaries' outcomes related to receiving incentivized care or adopting certain health care-related behaviors, because many factors might influence beneficiaries' decisions to engage in the incentivized activities. For example, in Indiana about three-quarters of HIP 2.0 beneficiaries enrolled for 10 to 12 months received preventive care services despite limited understanding among surveyed beneficiaries of the program incentives that encourage preventive service use. These findings suggest that other factors—such as intrinsic beneficiary motivation or prompts from care providers—might have been equally important during the first demonstration year in motivating beneficiaries to seek preventive services.

Some features of beneficiary engagement programs not related to incentives have higher levels of beneficiary understanding. For example, about 88 percent of HMP beneficiaries reported that

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.

the MI Health Account statement helped them learn more about the cost of care. As noted above, 72 percent of surveyed HMP beneficiaries reported being somewhat or very likely to find out how much they might have to pay for a health service before receiving it, and 67 percent reported being somewhat or very likely to talk with their doctors about how much different health care options would cost. Investigating the factors that influence the choices beneficiaries make in obtaining care and the information they receive about health and health care from diverse sources might help states better understand what motivates them to act in certain ways, and to design incentives that reinforce the factors most likely to motivate behavior change.

If additional survey data indicate that beneficiary understanding of behavior incentive design features has not increased with implementation experience, changing the implementation of incentive programs may be warranted—or states might find that some desired outcomes can be achieved without significant incentives. Simple changes could include involving providers more heavily as education partners or making rewards more immediate (Contreary and Miller 2017). As additional survey data become available, states and their evaluators should assess beneficiary understanding together with behavior completion rates to determine whether it makes sense to simplify or otherwise change incentive programs at demonstration renewal. States could also consider a more nuanced approach to some incentives that recognizes that different subpopulations respond to incentives in different ways. In particular, future surveys that assess beneficiary understanding of and response to incentives that accrue after annual coverage renewal (for example, the POWER Account rollover in Indiana and owing monthly payments in Iowa) will provide important insights, because the interim demonstration evaluations analyzed in this brief primarily reported data from surveys conducted within the first implementation year. Such information will also be valuable to other states considering implementation of new beneficiary incentive programs and to their federal partners at CMS.

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 here.

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Table A.1. Healthy behaviors programs in Indiana, Michigan, and Iowa

	Indiana: Healthy Indiana Plan (HIP) 2.0 (includes HIP Plus and HIP Basic)	Iowa: Iowa Health and Wellness Plan (IHAWP) (includes Iowa Wellness Plan [WP] and Marketplace Choice [MPC])	Michigan: Healthy Michigan Plan (HMP)
Implementation Date	February 1, 2015	January 1, 2014	April 1, 2014
Incentivized health behaviors			
Receipt of preventive care	Beneficiaries who receive a preventive care service recommended for their age and sex are eligible for a doubling of their POWER Account rollover. Preventive care services have no beneficiary cost-sharing.	Receipt of regular dental care earns beneficiaries enhanced dental coverage	Preventive care services have no beneficiary cost-sharing
Health risk assessment (HRA)	The state requires plans to use an HRA[a]	HRA completion is one of two behaviors required to earn a monthly payment exemption in the second enrollment year	HRA completion is one of two behaviors required to earn MI Health Account credits that reduce monthly payments and cost-sharing in the current enrollment year, or a $50 gift card, depending on income level. Beneficiaries must complete the HRA with a primary care provider. When completing an HRA, beneficiaries agree to address or maintain one healthy behavior.
Wellness visits	None	A wellness visit is one of two healthy behaviors required to earn a monthly payment exemption in the second enrollment year. Qualifying wellness visits include an annual physical, a dental wellness visit, and a sick visit if it includes wellness visit components.	To earn monthly payment and cost-sharing reductions in the current enrollment year, or a $50 gift card, beneficiaries must complete the HRA with a primary care provider
Consider the cost of health care received	Monthly POWER Account statements show cost of services received, including no beneficiary cost-sharing for receipt of preventive services 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	None	Quarterly MI Health Account statements show cost of services received, including no beneficiary cost-sharing for receipt of preventive services and care for chronic conditions

(continued)

	Indiana: Healthy Indiana Plan (HIP) 2.0 (includes HIP Plus and HIP Basic)	Iowa: Iowa Health and Wellness Plan (IHAWP) (includes Iowa Wellness Plan [WP] and Marketplace Choice [MPC])	Michigan: Healthy Michigan Plan (HMP)
Demonstration features			
Monthly payments	For HIP Plus beneficiaries: 0–5% FPL: $1 6–100% FPL: 2% of income, equivalent to $1–$20[b] >100–133% FPL: 2% of income, equivalent to $20–$26 HIP Basic beneficiaries do not make monthly payments	0–49% FPL: $0 50–100% FPL: $5 >100–133% FPL: $10[c]	0-100% FPL: $0 >100–133% FPL: 2% of income, equivalent to $20–$26
Copayments	>100% FPL: no point-of-service copayments 0–100% FPL: not enrolled in HIP Plus: point-of-service copayments for all services except preventive care All beneficiaries: $8 for first non-emergent ED visit, $25 for additional ED visits	$8 for non-emergent ED visit[d]	Copayments are required for all services except preventive care and management of chronic conditions. Beneficiaries make delayed copayments directly into the MI Health Account rather than at the point of service.
Penalty for non-payment	>100% FPL: disenrollment and 6-month exclusion from re-enrollment 0–100% FPL: enrollment in HIP Basic	>100% FPL: disenrollment but may reenroll at any time 0–100% FPL: cannot be disenrolled	Cannot be disenrolled State can garnish beneficiaries' state tax returns and lottery winnings (if applicable) to recover the unpaid amount
Health account	Monthly payments are made into POWER Accounts for HIP Plus beneficiaries. Monthly payments are mandatory for beneficiaries above 100% FPL. The account tracks accrual of services used for all beneficiaries and debits individual account value as services are received. Preventive service use does not reduce the account value.	None	MI Health Accounts for individuals above 100% FPL. The account tracks receipt of copayments, accrual of monthly payments, and credits earned for completing incentivized behaviors for all beneficiaries. The accounts debit service cost for beneficiaries with incomes above 100% FPL. Preventive service use and chronic care management services do not reduce the account value.

[a] Plans provide beneficiaries with rewards for completion (for example, $10–$30 gift cards).

[b] This dollar estimate is calculated for a family of one using 2016 FPL ($11,880/year, or about $990 per month).

[c] The $8 copayment policy for non-emergent ED visits has never been enforced in Iowa.

[d] Dental benefits for beneficiaries age 21 and older are limited to treatment of acute pain or infection.

ED = emergency department; FPL = federal poverty level; HIP = Healthy Indiana Plan; HMP = Healthy Michigan Plan; IHAWP = Iowa Health and Wellness Plan; POWER = Personal Wellness and Responsibility; ED = emergency department.

Notes

[1] 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.

[2] Some HIP 2.0 beneficiaries were previously enrolled in HIP 1.0, the Medicaid program that preceded HIP 2.0, which had POWER Accounts and rollovers similar to those in HIP 2.0. Therefore, a portion of HIP 2.0 beneficiaries would have experienced similar program features under HIP 1.0 and could potentially have drawn on that experience when responding to the HIP 2.0 survey.

[3] All incentivized behaviors in the Healthy Michigan Plan earn rewards in the same enrollment year they are completed. In addition, the Michigan survey was conducted long enough after program inception that all respondents would have experienced all key program features.

[4] Beneficiaries who make monthly payments into their Personal Wellness and Responsibility Accounts are enrolled in HIP Plus, which offers enhanced benefits and no point-of-service copayments except for a copayment for non-emergent use of the emergency department. Beneficiaries with income less than 100 percent of the FPL who do not make monthly payments are moved to HIP Basic, which offers no enhanced benefits and requires point-of-service copayments. Beneficiaries with income at or above 100 percent of the FPL who do not make payments are disenrolled and cannot reenroll in the program for six months.

[5] IHAWP beneficiaries receive dental benefits through a dental-specific health plan that operates separately from beneficiaries' regular health plans, although both dental and non-dental health benefits are provided as part of the IHAWP program.

[6] The monthly payment amount for beneficiaries with incomes at or below 5 percent of the FPL is $1. For all other beneficiaries, the payment amount is 2 percent of monthly income.

[7] The disenrollment policy does not apply to individuals above 100 percent of the FPL who are pregnant, medically frail, or Native Americans. Individuals can also apply for a waiver from the six-month disenrollment period due to a qualifying event, such as obtaining and subsequently losing private insurance coverage or being a victim of domestic violence.

[8] HIP Plus and HIP Basic beneficiaries are both eligible for the account rollover, but the size of the rollover varies across these two components of the program. For HIP Plus beneficiaries, the rollover amount is doubled if they meet the preventive service requirement. However, HIP Basic beneficiaries face more requirements. To receive any rollover, they must have obtained at least one recommended preventive service for their age and gender, and they must agree to move up to HIP Plus and start paying monthly payments. The rollover for HIP Basic beneficiaries also cannot reduce payment amounts in the next enrollment year by more than 50 percent.

[9] The state's evaluators note that low understanding of program features could be due in part to the relatively short time beneficiaries had been enrolled at the time of the initial HIP 2.0 survey. Although we agree that understanding likely accrues with increased program experience, we also note that to take advantage of the rollover incentives, beneficiaries have to be aware of the accounts and related incentives before the enrollment year ends. Beneficiary understanding of program features may also be influenced by the proportion of sample members who were previously enrolled in HIP 1.0. As this information was not provided in the interim report, we cannot judge whether levels of beneficiary understanding might be higher or lower if more or fewer members of the survey sample had been in HIP 1.0.

[10] All beneficiaries, including those in HIP Plus, are subject to the copayment for non-emergent use of the emergency department.

[11] Initially, only a comprehensive annual physical counted as a wellness exam. Over time, Iowa has accepted routine medical exams, physician office visits for acute care, and dental wellness visits.

[12] Incentives were the same for both WP and MPC beneficiaries, although some operational details were different across these demonstrations.

[13] The report's wording of this last response category is "sixteen stated it was because of the insurance plan they were covered by." The remaining 40 beneficiary responses were not categorized.

[14] In the case of nonpayment, the state can garnish beneficiaries' state tax returns and lottery winnings (if applicable).

[15] Michigan uses quarterly account statements, but beneficiaries usually pay copayments and, if applicable, premiums in three equal monthly installments using monthly payment coupons provided in the statements, although beneficiaries can pay the entire statement amount in one lump sum payment if they prefer. Beneficiaries begin receiving statements in their third quarter of enrollment (months 7–9), which include the costs of care received in the first quarter of enrollment (months 1–3).

[16] Providers' lack of knowledge might also contribute. Other research has found that providers frequently do not realize that for beneficiaries to receive credit for completing the behavior, the provider must submit the completed HRA to the beneficiary's health plan. For more information about providers' understanding of the HRA incentive and other aspects of the HMP, see Contreary and Miller (2017) and Dorr Goold et al. (2016).