

## HEALTHY BEHAVIORS CLAIMS-BASED REPORT #3 AND HRA COMPLETION REPORT #3

Final Draft

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## CONTENTS

List of Measures.....	3
List of figures.....	3
List of tables.....	3
Executive Summary.....	4
Overview of Iowa’s Healthy Behaviors Incentive (HBI) Program.....	6
Methodology.....	8
Results.....	10
Comparing Annual Rates 2014 to 2016.....	14
Conclusions.....	17

## LIST OF MEASURES

Measure 1 Proportion of IHAWP members who had a preventive care visit . . . . .	10
Measure 2 Proportion of IHAWP members completing HRA . . . . .	11
Measure 3 Whether an IHAWP member completed both healthy behaviors . . . . .	12

## LIST OF FIGURES

Figure 1. Wellness Exam Completion Rates Using DHS Data, 2014 – 2016 . . . . .	11
Figure 2. HRA Completion Rates Using DHS Data, 2014 – 2016 . . . . .	12
Figure 3. Completion Rates of Both Activities Using DHS Data, 2014 – 2016 . . . . .	13
Figure 4. Members Enrolled for Full Calendar Year Who Received a Wellness Exam as Identified by DHS Data, by Program and Year 2014 – 2016 . . . . .	14
Figure 5. Members Enrolled for Full Calendar Year Who Completed an HRA as Identified by DHS Data, by Program and Year 2014 – 2016 . . . . .	15
Figure 6. Members Enrolled for Full Calendar Year Who Completed Both a Wellness Exam and an HRA as Identified by DHS Data, by Program and Year 2014 – 2016 . . . . .	16

## LIST OF TABLES

Table 1. Descriptive Statistics of Population of Interest, 2014 – 2016 . . . . .	10
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## EXECUTIVE SUMMARY

On January 1, 2014 Iowa implemented the Iowa Health and Wellness Plan (IHAWP). IHAWP expands coverage for low income Iowans through two new programs: the Marketplace Choice and the Wellness Plan.

The **Wellness Plan** provides coverage for adults aged 19–64 years with income up to and including 100 percent of the Federal Poverty Level (FPL). It is administered by the Iowa Medicaid Enterprise (IME). Members have access to the Medicaid provider network established for this program.

**Marketplace Choice** provided coverage for adults aged 19–64 years with income from 101–133 percent of the Federal Poverty Level (FPL). Marketplace Choice allows members to choose certain commercial health plans available on the health insurance marketplace, with Medicaid paying the member’s commercial health plan premiums. Due to the absence of a qualified health plan, the Marketplace Choice plan was phased out and members were transitioned to the Wellness Plan as of January 1, 2016.

IHAWP replaces the IowaCare program with plans that cover more services, offer a broader provider network, and expand coverage to other low-income adults in Iowa who were not previously enrolled in IowaCare.

The Marketplace Choice Plan ended on January 1, 2016, and all of these members were transitioned to the Wellness Plan. Then, starting April 1, 2016, all Wellness Plan members were enrolled into Medicaid managed care.

A component of IHAWP called the Healthy Behavior Incentive (HBI) Program, encourages members to complete several healthy behaviors in an attempt to encourage prevention and reduce longer term costs. Members are incentivized to complete a wellness exam (annual physical or dental exam) and a health risk assessment (HRA), in exchange for having their monthly \$5 or \$10 premium waived. This evaluation report provides updated completion rates for wellness exams, HRAs, and/or both activities among IHAWP during the first three years of the program (CY 2014 – 2016). Because of program changes over time (e.g., the elimination of the Marketplace Choice Plan and the transition to managed care), we do not report separate results for Wellness Plan and Marketplace Choice members. Instead, we assign individuals to a lower-income group ( $\leq 100\%$  FPL) and a higher-income group (101 – 133% FPL), because we can do this in all years, and analyses of program compliance by income level remain meaningful. Below are highlights of our key findings:

### GENERAL FINDINGS

- After two years of the program, the proportion of members completing their HRA or Wellness Exam was low.
  - Approximately 87% of lower-income members and 86% of higher-income members failed to complete both required activities from 2014 to 2016. ([Figure 3](#))
  - With the exception of Wellness Plan members with incomes below 50% FPL, these members should have been subject to paying premiums in 2015, 2016, and/or 2017 based on their rates of compliance and time of enrollment.

### COMPLETED WELLNESS EXAM

- Across all years, Iowa Department of Human Services (DHS) data—which, also include dental wellness visits and members who self-report completion of an activity via telephone—indicate that 43% of lower-income members and 44% of higher-income members completed a wellness exam. ([Figure 1](#))
- From 2014 to 2016, receipt of a wellness exam increased from 39% to 46% of lower-income members, and from 34% to 52% of higher-income members. ([Figure 4](#))

### COMPLETED HRA

- Across all years, 29% of lower-income members and 27% of higher-income members completed an HRA according to DHS data. ([Figure 2](#))
- From 2014 to 2016, HRA completion rates increased from 36% to 42% among lower-income members, and from 18% to 47% among higher-income members. ([Figure 5](#))

### COMPLETED BOTH ACTIVITIES

- 
- Across all years, approximately 13% of lower-income members and 14% of higher-income members completed both activities according to DHS data. ([Figure 3](#))
  - From 2014 to 2016, completion of both activities increased from 13% to 24% among lower-income members, and from 6% to 31% among higher-income members. ([Figure 6](#))

## OVERVIEW OF IOWA'S HEALTHY BEHAVIORS INCENTIVE (HBI) PROGRAM

Members are encouraged to participate in an HBI program involving three components: 1) a wellness exam and health risk assessment (HRA), 2) provider incentives, and 3) healthy behaviors. This program is designed to:

- Empower members to make healthy behavior changes.
- Establish future members' healthy behaviors and rewards.
- Begin to integrate HRA data with providers for clinical decisions at or near the point of care.
- Encourage members to take specific proactive steps in managing their own health and provide educational support.

Encourage providers to engage members in completion of the healthy behaviors by offering incentive payments.

Starting in 2015, a small monthly contribution by the member was required depending on family income, although there are no copayments for health care services and prescriptions under the plan. Members with incomes between 50 – 100% FPL (\$5,835 – \$11,670 per year for an individual, or \$7,865 – \$15,730 for a family of 2) will contribute \$5 per month, while higher-income members (up to 133% FPL) will contribute \$10 per month. IHAWP members who complete the wellness exam and the HRA will not be responsible for a monthly contribution.

Members earning over 49% of the FPL are given a 30-day grace period after the enrollment year to complete the healthy behaviors in order to have the contribution waived. If members do not complete the behaviors after the grace period has ended, members will receive a billing statement and a request for a hardship exemption form. For members of the Wellness Plan with incomes between 50 – 100% FPL, all unpaid contributions will be considered a debt owed to the State of Iowa but will not, however, result in termination from the Wellness Plan. If, at the time of reenrollment, the member does not reapply for or is no longer eligible for Medicaid coverage and has no claims for services after the last premium payment, the member's debt will be forgiven. For members with incomes between 101 – 133% FPL, unpaid contributions after 90 days result in the termination of the member's enrollment status. The member's outstanding contributions will be considered a collectable debt and subject to recovery. A member whose benefits are terminated for nonpayment of monthly contributions must reapply for Medicaid coverage. The IME will permit the member to reapply at any time; however, the member's outstanding contribution payments will remain subject to recovery.

### WELLNESS EXAM

The wellness exam is an annual preventive wellness exam (New Patient CPT Codes: 99385 18-39 years of age, 99386 40-64 years of age; Established Patient CPT Codes: 99395 18-39 years of age, 99396 40-64 years of age) from any plan-enrolled physician, Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC) or Advanced Registered Nurse Practitioner (ARNP). The exams are part of the preventive services covered by the plans and therefore do not cost the member anything out-of-pocket. A 'sick visit' can count towards the requirement of the preventive exam, if wellness visit components are included and the billing code modifier 25 is used. Starting in January of 2015, members could also complete a preventive dental exam to fulfill this requirement. The following dental codes were included: D0120 periodic oral evaluation, D0140 limited oral examination, D0150 comprehensive oral examination, and D0180 comprehensive periodontal exam.

### HEALTH RISK ASSESSMENT

A health risk assessment (HRA) is a survey tool that can be used by members and providers to evaluate a member's health. IME has identified Assess My Health as one such tool, although providers can select their own tool if it asks similar questions. Assess My Health is an online form that takes members between 15 and 40 minutes to complete on the computer. HRA information can be used by providers to develop plans addressing member needs related to health risk determinants. The HRA could be completed online at any location, including the health care provider's office. Some clinics may have contacted patients to fill out the HRA over the phone, with the clinic inputting the data into the online system.

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## **PROVIDER INCENTIVES**

Providers also have incentives available to them, so that they encourage and support their patients in completing the wellness exam and HRA. Providers should be assisting members with the HRA before or during their wellness exam. For every Wellness Plan member who completes the HRA with the assistance of the provider, the provider will receive \$25.00. The only HRA which qualifies for this incentive is the Assess My Health tool.

## **FURTHER BEHAVIOR INCENTIVES**

Based on research indicating incentives can be used to change behavior, a program of incentives will be developed to encourage behavior change among enrollees. To participate in this part of the program, the member must have completed the wellness exam and the HRA, unless they are below 50% of the FPL or are Medically Exempt status. This part of the program was not implemented during CY2014-2015.

## METHODOLOGY

### DATA SOURCES

Data for the current quantitative analysis of the Healthy Behaviors Evaluation were derived from two sources: Medicaid enrollment data from January 2014 to December 2016, and Iowa Department of Human Services (DHS) records on completion of wellness exams and HRAs in CY 2014 through 2016. While prior versions of this report relied on claims data and DHS records, we rely solely on DHS records in the current report. This is done to permit analysis of 2016 data. The MCOs began operation on April 1, 2016. During the period April-September 2016 encounter data provided by the MCOs is incomplete with data missing in key fields such as the DRG code and discharge date for hospitalizations. The proportion of encounters with missing data vary by MCO. As of the fourth quarter of 2016, data is more complete, however key components such as discharge date, are still missing on a significant proportion of claims. Therefore, we do not use 2016 claims data here.

### STUDY POPULATION

As discussed in the evaluation proposal, the focus of this evaluation is to examine outcomes among Wellness and Marketplace Choice members.

The **Wellness Plan** provides coverage for adults aged 19–64 years with income up to and including 100 percent of the Federal Poverty Level (FPL). It is administered by IME. Members will have access to the Medicaid provider network established for this program. Depending on their county of residence, Wellness Plan members were historically eligible to be enrolled in one of three programs: fee-for-service, HMO, or Wellness Plan PCP. Now, however, they are enrolled in Medicaid managed care.

**Marketplace Choice** provided coverage for adults aged 19–64 years and members enrolled via three methods: 1) approximately 6,700 people previously enrolled in IowaCare who had incomes from 101 to 133% FPL, 2) people who have been enrolled in Medicaid but due to increased income are now eligible for Marketplace Choice, and 3) those who have never been in a public insurance program but meet the income eligibility for Marketplace Choice (101–133% FPL). However, because the Marketplace Choice program ended and members were transitioned into the Wellness Plan on January 1, 2016, we track both groups over time using the members' income level, rather than the specific program.

### ASSIGNING MEDICAID PLAN MEMBERS TO PROGRAMS

Before proceeding with analyses, we assigned Medicaid plan members to 1 of 2 groups on the basis of their income. Starting with monthly data, we used a rolling cohort method to attribute members to an income-based group if they were enrolled exclusively in either the Wellness Plan or the Marketplace Choice Plan (when applicable) **for 12 consecutive months**. We then assigned members as being in either the lower-income group ( $\leq 100\%$  FPL) or the higher-income group (101 – 133% FPL), which approximate the historic Wellness Plan and Marketplace Choice Plan, even after Marketplace Choice was discontinued and those members were rolled into the Wellness Plan. This allows for meaningful comparisons over time despite programmatic changes. Next, we collapsed the data to provide one observation per person per cohort. This method ensures that we retain as many Medicaid members in our sample as possible, while also ensuring that all members in our sample are exposed to a full year of the program to which they are assigned, providing them equal opportunity to engage in HBI program activities, and corresponding to the period of time they have to complete activities before being charged a premium (excluding the additional 30-day grace period).

### UNIVARIATE ANALYSES AND SUMMARY STATISTICS

First, we generated summary statistics for our sample, stratified by income group. Next, using all cohorts spanning 2014 – 2016, we examined the completion rate for wellness exams, HRAs, and both activities among lower-income and higher-income members. T-tests were used to compare the mean completion rates between income groups. Then, using only cohorts that do not span calendar years, we examined the completion rate for wellness exams, HRAs, and both activities among lower-income and higher-income members in 2014, 2015, and 2016. T-tests were used to compare the means between income groups in a given year, and within an income group between years.



## DEVIATIONS FROM PROPOSED METHODS

Originally, we proposed to determine the proportion of members who completed at least 1 additional behavior incentive, hypothesizing that it would exceed 50%. However, to date, no additional healthy behaviors or incentives have been identified beyond the completion of the wellness exam and the HRA. Since completion of both activities is required to avoid being charged premiums, we modified this part of the evaluation to instead determine the proportion of members who completed both activities (wellness exam and HRA). In this report, we no longer include the IowaCare data, as we chose to focus on more recent 2014 – 2016 data—our earlier report already examined historical IowaCare data. Similarly, we do not report data on Medicaid State Plan members, as we do not have adequate claims data for 2016, and DHS records do not track healthy behavior activity among this population. Moreover, we do not present updated multivariate analyses to address the question of which characteristics are associated with completing healthy behaviors here, as the most recent available claims data (through CY 2015) are presented in the prior version of this report (Healthy Behaviors Claims-Based Report #2 and HRA Completion Report #2).

## RESULTS

Descriptive statistics for lower-income and higher-income members are shown in Table 1. While the two groups are remarkably similar, we do note that there are disproportionately more women enrolled in the higher-income group.

**Table 1. Descriptive Statistics of Population of Interest, 2014 – 2016**

	Lower-Income Group N=157,378		Higher-Income Group N=45,782	
	Value*	Std. Dev.	Value*	Std. Dev.
Average Age	38.2	13.2	38.1	12.6
% Male	73.8	44.0	67.4	46.9
% White	65.2	47.6	68.1	46.6
% Black	8.8	28.3	5.7	23.1
% Hispanic	4.7	21.2	5.8	23.3
% Other Race	5.0	21.8	6.0	23.7
% Unknown Race	17.0	37.5	15.4	36.1
% Metropolitan	61.1	48.7	59.7	49.0
% Nonmetropolitan Urban	34.9	47.7	35.7	47.9
% Nonmetropolitan Rural	4.6	20.9	5.1	22.0
Number of Moves	0.4	1.4	0.3	1.2

\*Note: Values for average age, and number of moves are means within each income group. Values for all other variables are proportions of the member population in that income group with a given characteristic. For example, in the above table, 65.2% of lower-income members are white, 8.8% are black, and so forth, such that the race proportions sum to 100% within the lower-income column (with differences due to rounding).

The remainder of our results are organized by the questions and hypotheses as outlined in the original evaluation proposal.

### **Question 1 : Which activities do members complete?**

#### **HYPOTHESIS 1.1**

The proportion of IHAWP members who complete a wellness exam is greater than the proportion of Medicaid State Plan (MSP) members.

#### **Measure 1 Proportion of IHAWP members who had a preventive care visit**

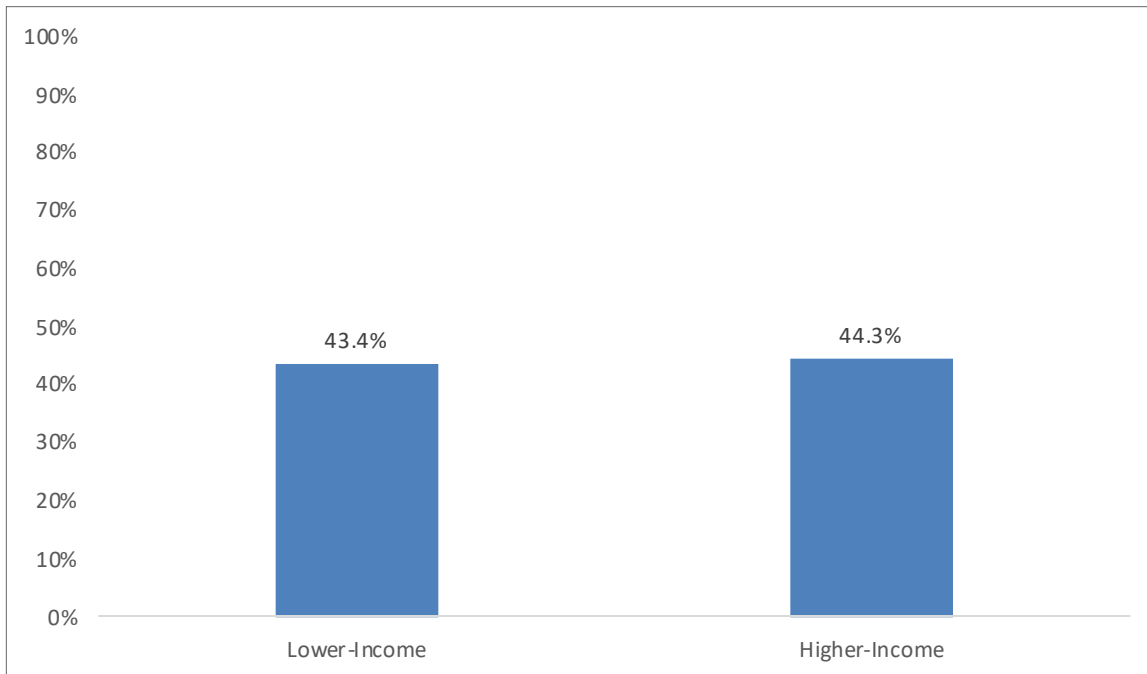
Protocol-NCQA HEDIS AAP

Data source-Administrative

Analyses-Means tests between IHAWP members and two comparison groups before and after implementation

We documented the proportion of members completing a wellness exam from 2014 to 2016 using DHS data. We are unable to test hypothesis 1.1, as we do not have 2016 claims data for MSP members. As Figure 1 shows, the proportion of lower-income members completing a wellness exam was 43.4%. The corresponding figure among higher-income members was 44.3%. This difference, while small, is statistically significant.

**Figure 1. Wellness Exam Completion Rates Using DHS Data, 2014 – 2016**



Note: Significantly different at  $P < 0.001$ .

## **HYPOTHESIS 1.2**

The proportion of IHAWP members who complete an HRA is greater than 50%.

### **Measure 2 Proportion of IHAWP members completing HRA**

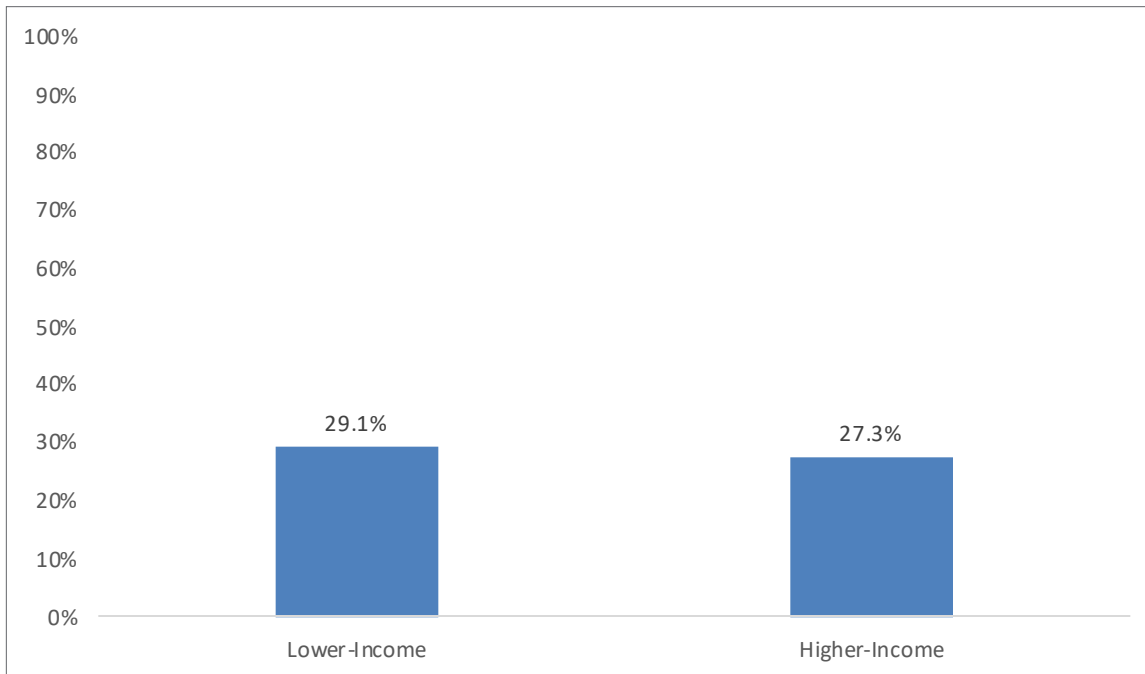
Protocol-Original

Data source-Administrative

Analyses- Descriptives regarding the rate of completion for IHAWP members

As Figure 2 shows, our hypothesis 1.2 is not supported. We find that only 29.1% of lower-income members and 27.3% of higher-income members completed an HRA according to DHS data. As we previously documented in our interim report from March 2016, it is important to note that Iowa DHS records report significantly higher completion rates for both Wellness Exams and HRAs than do claims data. This is likely due to the fact that members may call IME to report completion of these activities. We report results using the DHS data, because they will be used to determine program compliance, the charging of premiums, and potential disenrollment from the program.

**Figure 2. HRA Completion Rates Using DHS Data, 2014 – 2016**



Note: Significantly different at  $P < 0.001$ .

### **HYPOTHESIS 1.3**

The proportion of IHAWP members who are eligible to participate and complete both activities is greater than 50%.

#### **Measure 3 Whether an IHAWP member completed both healthy behaviors**

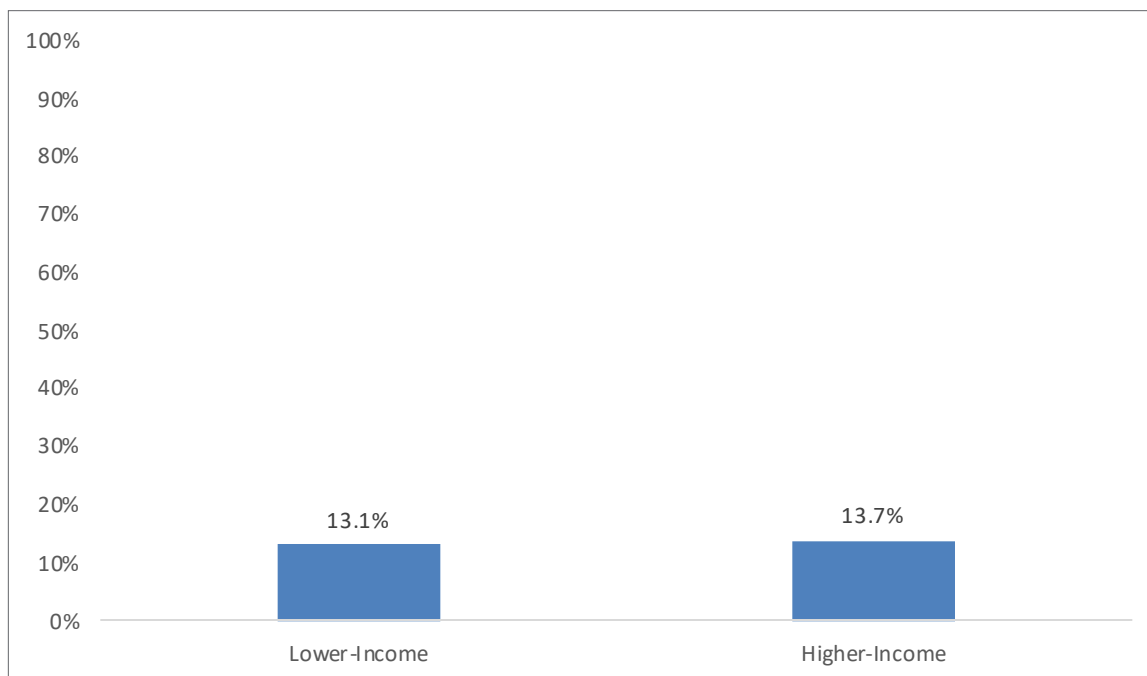
Protocol-Original

Data source-Administrative

Analyses-Descriptives regarding the rate of completion for IHAWP members

Using the data collected by Iowa DHS, we determined the proportion of lower-income and higher-income IHAWP members who completed both a wellness exam and an HRA from 2014 to 2016. As expected, these figures are lower than the figures for completion of each activity when considered independently, and our hypothesis 1.3 was not supported. As shown in Figure 3, we find that 13.1% of lower-income members completed both activities, compared to 13.7% of higher-income members. These figures are especially important as they indicate the proportion of members who have completed the activities required to avoid being charged a monthly premium in the following year. Clearly, based on these results, the overwhelming majority of members will have been subject to a monthly premium in 2015, 2016, and/or 2017 (depending on their cohort).

**Figure 3. Completion Rates of Both Activities Using DHS Data, 2014 – 2016**



Note: Significantly different at  $P < 0.001$ .

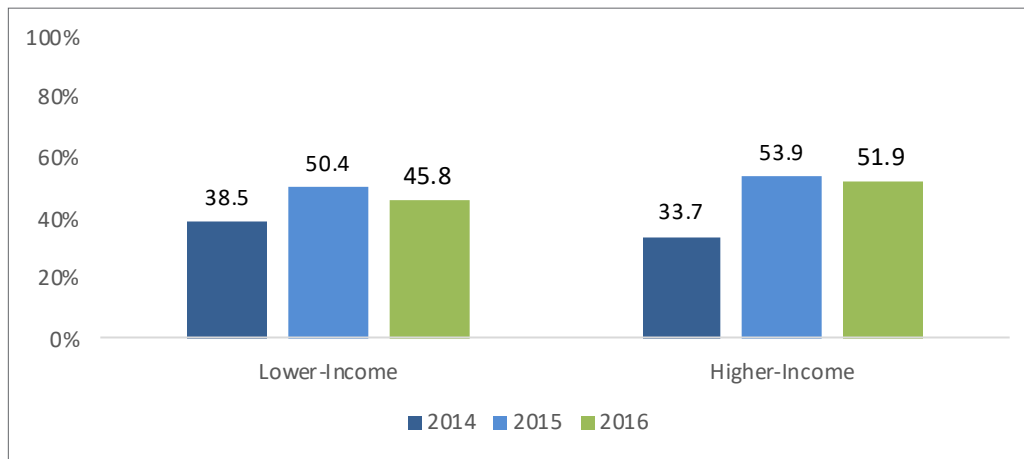
## COMPARING ANNUAL RATES 2014 TO 2016

In this section, we look specifically at those members who were enrolled for all 12 months of 2014, 2015, and/or 2016. This allows us to repeat several of our analyses and compare results of the program from year to year, by excluding members in our cohort-based sample whose data spanned calendar years. While this section generally follows the questions, hypotheses, and measures presented earlier in this report, we have streamlined the text for ease of reading.

### **Proportion of members who had a preventive care visit, 2014 – 2016**

We documented the proportion of members completing a wellness exam in 2014, 2015, and 2016 using DHS data. As Figure 4 shows, the proportion of lower-income members completing a wellness exam increased from 38.5% to 45.8% between 2014 and 2016, although the rate peaked in 2015 at 50.4%. Similarly, there was an increase in the completion rate among higher-income members, from 33.7% to 51.9%, with a rate peak in 2015 at 53.9%.

**Figure 4. Members Enrolled for Full Calendar Year Who Received a Wellness Exam as Identified by DHS Data, by Program and Year 2014 – 2016**

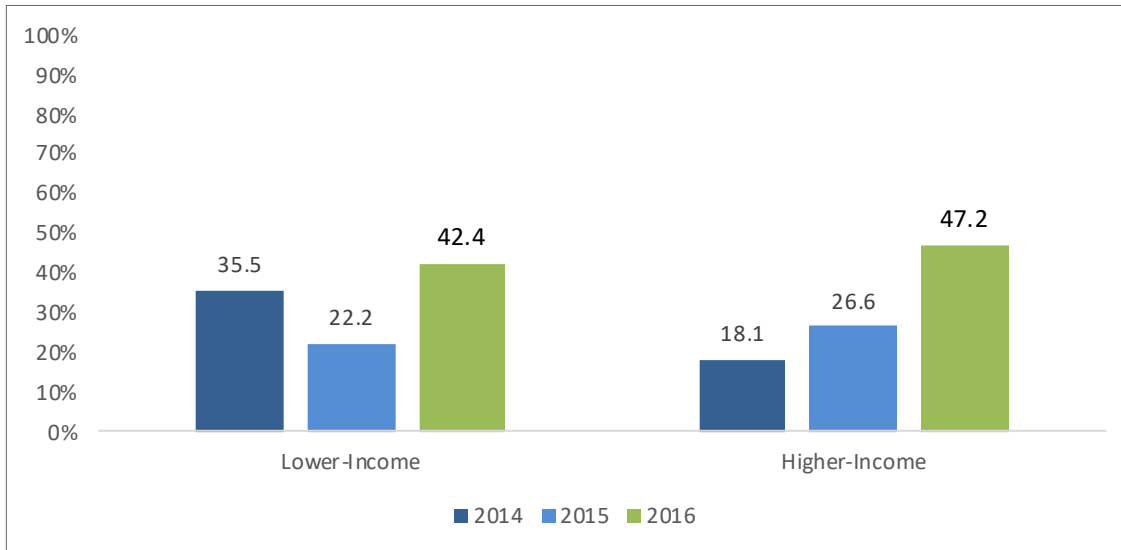


Note: Both the differences between income groups within years and the differences between years within income groups are statistically significant ( $P < 0.001$ ), with the exception of years 2015 and 2016 of the higher-income group ( $P = 0.10$ ).

### **Proportion of IHAWP members completing HRA, 2014 – 2016**

As Figure 5 shows, Health Risk Assessment completion rates among lower-income members decreased from 35.5% in 2014 to 22.2% in 2015 before increasing to 42.4% in 2016. Among higher-income members, the HRA completion rate increased steadily from 18.1% in 2014 to 47.2% in 2016.

**Figure 5. Members Enrolled for Full Calendar Year Who Completed an HRA as Identified by DHS Data, by Program and Year 2014 – 2016**

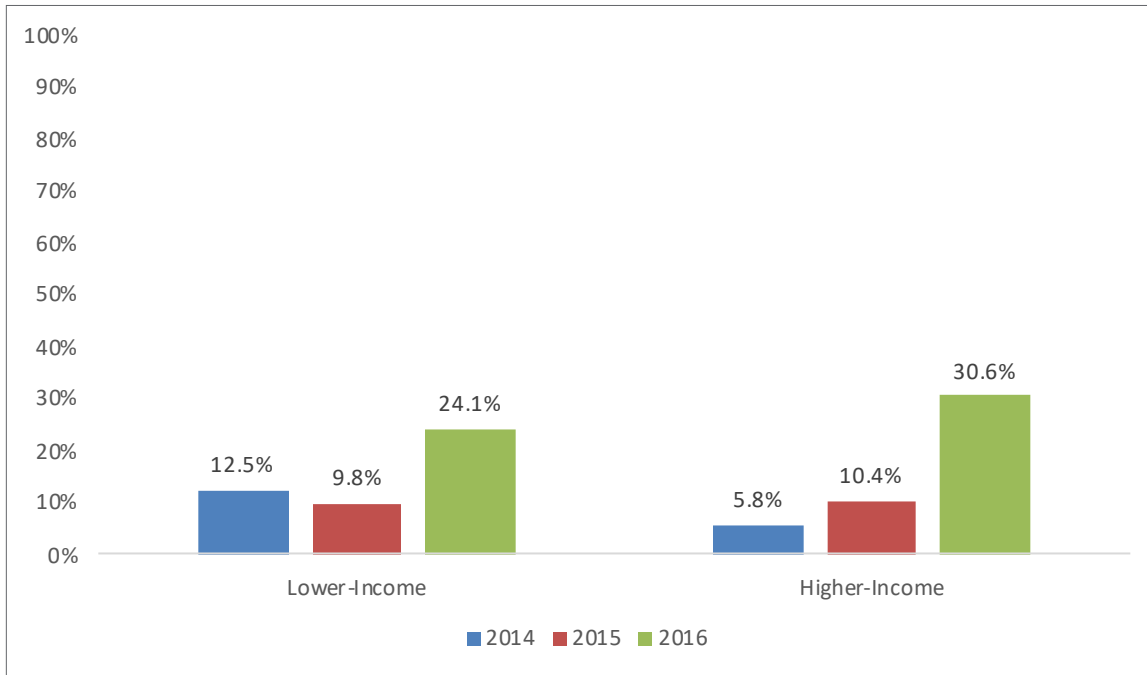


Note: Both the differences between income groups within years and the differences between years within income groups are statistically significant ( $P < 0.001$ ).

#### ***Whether an IHAWP member completed both healthy behaviors, 2014 – 2016***

Using the data collected by Iowa DHS, we determined the proportion of members in both the lower-income and higher-income groups who completed both a wellness exam and an HRA in 2014, 2015, and 2016. As expected, these figures are lower than the figures for completion of each activity when considered independently. As shown in Figure 6, we find that 12.5% of lower-income members completed both activities in 2014, but that this figure dropped to 9.8% in 2015, before increasing to 24.1% in 2016. By comparison, 5.8% of higher-income members completed both activities in 2014, and this figure increased steadily to 10.4% in 2015, and 30.6% in 2016. These figures are especially important as they indicate the proportion of members who have completed the activities required to avoid being charged a monthly premium in the following year.

**Figure 6. Members Enrolled for Full Calendar Year Who Completed Both a Wellness Exam and an HRA as Identified by DHS Data, by Program and Year 2014 – 2016**



Note: Both the differences between income groups within years and the differences between years within income groups are statistically significant ( $P < 0.001$ ).



## CONCLUSIONS

The HBI program is designed to encourage members of the Iowa Health and Wellness Plan, Iowa's Medicaid Expansion Program, to take an active part in maintaining their health and to promote accountability among enrollees. According to our findings, approximately 87% of lower-income members and 86% of higher-income members failed to complete required Healthy Behaviors in the first three years of the program (CY2014 – 2016), and with the exception of certain low-income Wellness Plan members, should have been subject to paying premiums in 2015, 2016, and/or 2017 based on their rates of compliance and time of enrollment. However, it appears that completion rates are improving over time.

In our year-by-year analysis, we observe a particularly strong uptick in completion rates in 2016, which we speculate is attributable to efforts on the part of the MCOs. This is encouraging. However, even with these increased rates of compliance, we find that no more than half of members (regardless of income level) are completing their HRA or Wellness Exam, and fewer than one-third of members complete both activities, which is required to avoid paying a monthly premium in the following year.

As we know from information presented in our interim report, the combination of a general lack of awareness and understanding about the program at the enrollee and provider level have stunted the program's ability to achieve significant participation in the first phase. The updated completion rates we present here demonstrate that these challenges may or may not persist, and the extent to which improvements in trends will continue are unknown.