

INITIAL REVIEW DRAFT

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Healthy Behaviors Program Evaluation Interim Summative Report

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Background

The Iowa Health and Wellness Plan (IHAWP) is Iowa's version of the Medicaid expansion, approved by the federal government under a Section 1115 Demonstration waiver. Enrollment into IHAWP began on January 1, 2014. The IHAWP replaced IowaCare, a limited coverage program for adults age 19-64 with incomes from 0-200% Federal Poverty Level (FPL) who were not categorically eligible for Medicaid, expanding health care service coverage while reducing the upper end of the eligibility spectrum from 200% to 138% FPL (133% with a 5% income disregard). Originally, the IHAWP included two separate plans: 1) the Wellness Plan (WP) and the Marketplace Choice Plan (MPC). The WP was a more traditional, Medicaid-like program for adults with incomes from 0-100% of the Federal Poverty Level (FPL) who were not eligible for Medicaid through a categorical program such as Family Medical Assistance Plan (FMAP) or Medicaid for Employed People with Disabilities (MEPD). In MPC, individuals with incomes from 101-138% FPL selected a Qualified Health Plan (QHP) from eligible private plans in Iowa's Health Insurance Marketplace, and Medicaid paid the premiums.

One feature of the IHAWP that is unique for a Medicaid plan is the healthy behaviors incentive program (HBP). IHAWP members can avoid paying a premium for their insurance after their first year of coverage by participating in the HBP. The HBP requires members to have a yearly medical or dental exam (a wellness visit) and complete a health risk assessment (HRA) in order to avoid paying a premium in the following year. If the member does not complete these requirements during their first year of coverage, they may be required to pay a monthly premium (\$5 or \$10, depending on income). Due to a lack of participating insurers in Iowa's Health Insurance Marketplace, MPC members were transitioned to the WP in 2015 and the 1115 waiver for the MPC program was not renewed. The transition to the three Medicaid Managed Care Organizations (MCOs) was implemented on April 1, 2016.

Introduction

This summative report on the Healthy Behaviors Program (HBP) provides an outline of the analyses and results that have been conducted as of April 1, 2019.

The Healthy Behaviors Program

As a part of both the **Wellness Plan** and the **Marketplace Choice Plan**, enrollees are encouraged to participate in the HBP which originally involved 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 may be required depending on family income, although there are no copayments for health care services and prescriptions under the plan. Members with incomes between 51

– 100% FPL would contribute \$5 per month, while members with incomes between 101 – 138% FPL would contribute \$10 per month. Members with individual earnings less than 51 percent of the Federal Poverty Level (\$6,191 per year for an individual, or \$8,395 for a family of 2 in 2018) would not have monthly contributions. IHAWP members who completed the wellness exam and the HRA would not be responsible for a monthly contribution. Additionally, members could claim a financial hardship to avoid paying a contribution. This hardship must be claimed on a monthly basis. Communication efforts to inform members and providers about the healthy behaviors program included mailings to members, toolkits for providers, and a website.

Members earning over 50% of the FPL are given a 30-day grace period after the enrollment year to complete the healthy behaviors (wellness exam and HRA) in order to have the contribution waived. If members do not complete the behaviors after the grace period has ended, members would receive a billing statement and a request for a hardship exemption form. For members with incomes at or below 100% FPL, all unpaid contributions would be considered a debt owed to the State of Iowa, but would not result in termination from the program. If, at the time of reenrollment, the member did not reapply for or was no longer eligible for Medicaid coverage and had no claims for services after the last premium payment, the member's debt would be forgiven. For members with incomes between 101 – 138% FPL, unpaid contributions after 90 days would result in the termination of the member's enrollment status. The member's outstanding contributions would be considered a collectable debt and subject to recovery. A member whose Medicaid benefits were terminated for nonpayment of monthly contributions must reapply for Medicaid coverage. Iowa's established and federally approved Medicaid waiver policy allows 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 visit (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' or chronic care visit could count towards the requirement of the preventive exam, if wellness visit components were included and the billing code modifier 25 was 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 identified Assess My Health as one such tool, although providers could select their own tool if it asked similar questions. Assess My Health is an online form that takes members between 15 and 40 minutes to complete. HRA information could be used by providers to develop plans addressing member needs related to health risks. The HRA could be completed online at any location, including the health care provider's office. Clinics could contact patients to fill out the HRA over the phone, with the clinic inputting the data into the online system. After the transition to statewide managed care, each managed care organization (MCO) was able to use their own health risk assessment or screening, as the MCOs referred to them.

Provider Incentives

Providers also had incentives available to them, so that they could encourage and support their patients in completing the wellness exam and HRA. Providers should have been 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 would receive \$25.00. The only HRA which qualified for this incentive was the Assess My Health tool. Provider incentives were not part of the contractual agreements with the MCOs.

Further Behavior Incentives

A program of incentives was to 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 were below 50% of the FPL or were Medically Exempt status. This program was not implemented.

Factors influencing the evaluation of the Healthy Behaviors Program

The table below outlines factors that have influenced the evaluation of the program. It is important to understand these factors as they impact the evaluation. First, some evaluation activities were eliminated or altered to respond to these factors and second these factors provide the reader with a lens to interpret evaluation findings.

Table 1. Factors influencing the evaluation of the Healthy Behaviors Program

Planned implementation	Actual implementation
Wellness exam was defined as CPT codes 99385, 99386, 99395, and 99396 or a “sick visit” with a modifier code of 25.	Additionally, members could report having a wellness exam without documentation. Beginning in year 2 a preventive dental exam also fulfilled the requirement.
Members needed to complete the Assess My Health HRA tool. The data would be available to IME, providers, and members.	This information is not shared with the providers or the members. Each MCO has a different screening or risk assessment tool. This information is not shared with IME, the providers or the members.
A communication campaign would ensure members, providers, and clinic staff awareness and knowledge of the program.	There were limited communication efforts, which resulted in low levels of awareness and knowledge.
The Marketplace Choice plan would provide members with insurers from which to select.	The MPC members were converted to the Wellness Plan when both QHPs were no longer participating in the IHAWP.
Members were to be disenrolled for non-payment of contribution and not completing the HRA and wellness exam.	Systems were not in place to make disenrollment possible until the 4 th quarter of the 2 nd year.
Intended to contract with vendor was supposed to implement a program to incentivize members to complete other behaviors.	A Request for Proposal was issued, but no suitable vendor was found. Following the transition to statewide managed care, the MCOs offered “value added benefits,” such as rewards programs that served the purpose of incentivizing members to complete behaviors.
Providers were to receive incentives to encourage patients to complete HBP.	MCOs were not contractually required to implement a provider incentive program related to completion of the HBP.
Members could complete HRA online with/out provider.	Members could report having completed an HRA without documentation. Some health systems helped members complete the HRA over the telephone.
Members were supposed to complete the wellness exam and the HRA to be eligible for the additional incentivized behaviors.	Any MCO member can participate in the MCO’s rewards program.

Operationalization of Research Questions and Hypotheses

Understanding the effects of new programs on the access to health care, utilization of health care, and outcomes of health care is a complex undertaking requiring a variety of methods and analytical approaches. This evaluation incorporates population-based outcomes as well as individual assessments in an attempt to provide a balanced evaluation. The evaluation design has evolved to be responsive to changes in program implementation and data availability. The table below outlines all the originally proposed research questions, hypotheses, and measures (Table 2). We have indicated if these data will be presented in the final report. If the data will not be available for the final report, we have outlined reasons for deviating from the original proposal. A version of the table with the protocols, data sources, and analyses for each measure is provided in the appendix.

Table 2. A comparison of proposed research questions, hypotheses, and measures with data available for summative report

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
1. Which activities do enrollees complete?			
1.1: The proportion of Wellness Plan (WP) members and Marketplace Choice (MPC) members who complete a wellness exam is greater than the proportion of Medicaid State Plan (MSP) or IowaCare members who complete an exam.	Measure 1: Proportion of members who had a preventive care visit	We presented DHS data on the proportion of members with a “well visit” that qualified for the HBP. We examined the differences between IHAWP members based on income level and do not make comparisons between IHAWP members and MSP or IowaCare.	We also included data on the proportion of members who complete both HBP behaviors (well exam and HRA) and compare those proportions by income level. We had to move from examining the differences between WP/MPC to income levels, because the programs merged, and we do not make comparisons to MSP and IowaCare, because DHS does not track wellness exams or HRAs in those groups
1.2: The proportion of WP/MPC members who complete a Health Risk Assessment is greater than 50%.	Measure 2: Proportion of WP/MPC members completing HRA	We presented data on the proportion of members completing the HRA and compare the members by income level.	We had to move from examining the differences between WP/MPC to income levels, because the programs merged.

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
1.3: The proportion of WP/MPC members who are eligible to participate complete at least one behavior incentive is greater than 50%.	Measure 3: Whether a WP/MPC member completed a healthy behavior	We are currently not able to present these data because we do not have data on additional healthy behaviors. This part of the program was delayed in implementation. The MCO data related to value added/rewards behavior has not been provided to us.	While it is our understanding that the MCOs are now operating incentive programs, we do not have data on these. Thus, we examined the proportion of WP and MPC members who completed both activities (wellness exam and HRA).
1.4: Members (WP/MPC) are most likely to complete the behaviors that require the least amount of effort.	Measure 4: Respondent report of how easy it is for them to obtain a yearly physical exam	We provided this information.	
1.5: Members (WP/MPC) will be least likely to complete incentivized behaviors requiring sustained participation.	Measure 5: Completion of healthy behavior by perceived sustained effort	We are unable to complete this because we have no data on additional healthy behaviors.	We had self-report data from the member survey, but there were not enough people who have completed the behaviors to examine specific behaviors. The MCO programs also do not incentivize for the same behaviors, so comparisons are not possible.
1.6: Member (WP/MPC) will be most likely to complete incentivized behaviors with the largest real or perceived value.	Measure 6: Completion of healthy behavior by value of behavior Measure 7: Completion of healthy behavior by value of incentive	We are not able to assess perceived value on additional behaviors because we do not have information about specific behaviors. We do not have specific information about incentives available through the MCOs.	We collected data on perceived value of a well exam and an HRA and reported on these perceptions.

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
2. What personal characteristics are predictive of completing at least one behavior incentive, and the number (or extent) of behavior incentives completed?			
2.1: Members (WP/MPC) who have heard of the program from their health care provider are more likely to complete at least 1 behavior.	Measure 8: Reported completion of healthy behavior by source of information	We have reported on this.	
2.2: Members (WP/MPC) who are young, white, female, and/or live in metro areas are more likely to complete at least 1 behavior.	Measure 9: Completion of healthy behavior by demographic characteristics	We presented these data.	
2.3: Members (WP/MPC) with poorer health status are less likely to complete behaviors compared to members with better health status.	Measure 10: Health Status by completion of healthy behavior	We presented these data using #Rx, #ED visits and count of chronic conditions as measure of health status.	
2.4: Members who do not pay a contribution (WP members less than 50% FPL) are least likely to complete behaviors compared to those who pay a contribution.	Measure 11: Proportion of members who complete the healthy behaviors prior to the application of the premium payment	We did not present these data on completion of the behaviors after application of the premium payment, because we are not aware of who is not required to pay the premium because of a hardship.	
	Measure 12: Proportion of members who complete the healthy behaviors only after the application of the premium payment		
	Measure 13: Proportion of members who are		

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
	disenrolled due to the application of a premium payment as a result of not completing the healthy behaviors		
2.5: Members (WP/MPC) receiving care at federally qualified health centers, rural health clinics, and public hospitals will be more likely to participate in the incentive programs than enrollees receiving care in other settings.	Measure 14: Completion of healthy behavior by type of provider	Medicaid claims data received from IME are missing a significant amount of data in the provider type and provider specialty fields needed to identify site of care. Therefore, we did not conduct claims-based analyses to predict completion of wellness exams, HRAs, and both, and thus, do not present this outcome.	We reported data from the member telephone survey asking about the use of FQHCs.
3. Is engaging in behavior incentives associated with improved access to care and health outcomes?			
3.1: The program will improve WP/MPC members' access to health care.	Measure 15: Adults access to primary care	We presented measure 15A, 20A, 21A, and 23 as proposed and 15B, 20B, and 21B using a DID approach.	We did not report on measures 15B, 20B, or 21B using RDD because RDD is not an appropriate analysis based on the outcome and the data.
	15A Percent of members who had an ambulatory care visit		
	15B Whether a member had an ambulatory or preventive care visit		We used the member survey to report measures 17, 18 and 24. However, we will not conduct quantitative analyses of these measures (beyond descriptive statistics), because of concerns about collinearity (i.e., participating in the HBP requires completion of the wellness exam which means by definition
	Measure 16: Access to and unmet need for urgent care		
	Measure 17: Access to and unmet need for routine care		

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
	Measure 18: Getting timely appointments, care, and information		members will have access to primary care, have a preventive visit, etc.).
	Measure 19: Prescription medication, access to and unmet need for prescription medication		
	Measure 20: Comprehensive diabetes care: Hemoglobin A1c		
	20A Percent of members with type 1 or type 2 diabetes who had Hemoglobin A1c testing		
	20B Whether a member with type 1 or type 2 diabetes had Hemoglobin A1c testing		
	Measure 21: Comprehensive diabetes care: LDL-C screening		
	21A Percent of members with type 1 or type 2 diabetes who had LDL-C screening		
	21B Whether a member with type 1 or type 2 diabetes had LDL-C screening		
	Measure 22: Preventive care		

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
	<p>Access to and unmet need for preventive care</p> <p>Measure 23 Ambulatory Care</p> <p>Measure 24 Regular source of care – Personal Doctor</p> <p>The percent who respond that they currently have a personal doctor</p>		
<p>3.2: Health outcomes of WP/MPC members will be positively impacted by completing the healthy behaviors.</p>	<p>Measure 25: Non-emergent ED use</p> <p>25A Number of non-emergent ED visits per 1,000 member months</p> <p>25B Whether member had a non-emergent ED visit</p> <p>Measure 26: Follow-up ED visits</p> <p>26A Percent of members with ED visit within the first 30 days after index ED visit</p> <p>26B Whether member had an ED visit within the first 30 days after index ED visit</p>	<p>We reported measures 25A, 26A, 26B, 30, 31, and 32 as proposed, and measure 25B using a DID approach.</p>	<p>We did not report on measure 25B using RDD because RDD is not an appropriate analysis based on the outcome and the data.</p> <p>We did not report on measures 27, 28A, 28B, 29A, or 29B due to a lack of admissions for these conditions.</p>

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
	<p>Measure 27: Admission rate for diabetes short-term complications, and asthma</p> <p>The number of discharges for short-term complications from diabetes or asthma per 100,000 Medicaid members</p>		
	<p>Measure 28: Admission rate for diabetes short-term complications</p>		
	<p>28A Number of discharges for diabetes short-term complications per 100,000 Medicaid members</p>		
	<p>28B Whether member had an admission for diabetes short-term complications</p>		
	<p>Measure 29: Admission rate for asthma</p>		
	<p>29A Number of discharges for asthma per 100,000 Medicaid members</p>		
	<p>29B Whether member had an admission for asthma</p>		
	<p>Measure: 30 Inpatient utilization-general hospital/acute care</p>		

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
	<p>This measure summarizes utilization of acute inpatient care and services in the following categories: total inpatient, surgery and medicine using number of discharges per 1000 member months, number of days stay per 1000 member months and average length of stay for all members who were enrolled for at least 1 month during the measurement year</p>		
	<p>Measure 31: Plan “all cause” hospital readmissions</p> <p>For members age 19-64 years who were enrolled for at least on month during the measurement year, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission</p>		
	<p>Measure 32: Rate of 30 day hospital readmissions</p> <p>30 day readmissions reported in last 6 months</p>		
4. What are the effects of the program on health care providers?			
4.1 Providers use the information from the Health Risk Assessment	Measure 33: Provider reported use of HRA	We were unable to present these data due to the very low awareness of the program.	In-depth interviews with clinic managers (the person in the practice most likely to know about the program)

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
	<p>33A Percent of providers who report using HRA</p> <p>33B How providers use the HRA</p>		<p>indicated very low levels of awareness and high levels of confusion. It was not possible to design a survey to ask responses about a program that providers were unaware of.</p>
<p>4.2 Providers are encouraging patients to participate in the behavior incentive program</p>	<p>Measure 34: Percent of providers reporting encouraging patients to participate</p> <p>Measure 35: Enrollees report providers encouraging them to participate</p> <p>Measure 35A Percent of enrollees who report provider encouraged participation</p> <p>Measure 35B Percent of enrollees who reported participation</p>	<p>We were unable to report all these data, because the provider survey was not possible.</p> <p>We reported on the enrollee survey about where they heard about the program.</p>	
<p>4.3 Providers are receiving their additional reimbursement</p>	<p>Measure 36: Percent of providers reporting reimbursement</p>	<p>We did not report on these data because the provider survey was not possible.</p>	
<p>4.4 Providers are more likely to use the HRA with Wellness Plan members compared to Marketplace Choice Plan members</p>	<p>Measure 37: Provider reporting using HRA</p> <p>Measure 37A Percent of providers who use HRA with Wellness Plan and Marketplace Choice Plan members</p> <p>Measure 37B Providers reporting on using HRA</p>	<p>We did not report on the percent of providers using the HRA because the lack of awareness made the survey impossible to field.</p>	<p>In-depth interviews indicate that the HRA were not being used by providers.</p>

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
4.5 The HRA changes communication between the provider and patient	Measure 38: Providers reported changes in communication with patients	We did not report on these because a provider survey was not possible.	
4.6 The HRA changes provider treatment plans	Measure 39: Provider reported changes in treatment plans due to HRA	We did not report on these because a provider survey was not possible.	
4.7 There are barriers to providers using the HRA information	Measure 40: Provider reported barriers to using the HRA information.	We were unable to report on these data because we did not identify providers or practices that use the HRA information.	
5. What are the effects of HBI on Medicaid costs?			
5.1 Costs of the program do not exceed the savings	Measure 41: Compare PMPM costs for those who have and have not completed the healthy behaviors in the Iowa Health and Wellness Plan and those in the Medicaid State Plan	We do not report these data.	Due to the move to Medicaid managed care, the State determined that these analyses would no longer be conducted as part of this evaluation.
6. What are the implications of disenrollment?			
6.1 Disenrolled members do not understand the disenrollment process	Measure 42: Disenrolled member reported understanding disenrollment process	We reported on these data.	
6.2 Disenrolled members do not understand premiums.	Measure 43: Disenrolled members reported understanding premiums	We reported on these data.	
6.3 Disenrolled members do not understand the HBP	Measure 44: Disenrolled members do not understand the HBP	We reported on these data.	

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
6.4 Disenrolled members find it difficult to meet their health needs	Measure 45: Disenrolled member ability to meet health needs.	We reported on these data.	
6.5 Disenrolled members are unable to re-enroll due to administration issues	Measure 46: Disenrolled member reporting of challenges related to re-enrollment	We reported on these data.	
7. What are members' knowledge and perceptions of the HBP?			
7.1 Members (WP/MPC) will value incentives offered to complete the healthy behaviors.	Measure 47: Members assigned value of the program and behaviors	We reported on these data.	We were limited by the few enrollees who actually completed the behaviors.
7.2 Members (WP/MPC) will be most willing to complete behaviors that have lower costs/barriers compared to those with higher benefits and relevance.	Measure 48: Members assessment of costs, barriers and benefits to program participation.	We reported on these data.	We were limited by the small number of program participants.
	Measure 48A Members indicate cost		
	Measure 48B Members indicate barriers		
	Measure 48C Members indicate benefits		
7.3 Members (WP/MPC) with a greater sense of locus of control will be more willing to participate.	Measure 49: Members' perceived locus of control	We reported on these data.	We were unable to use a full-validated scale to measure locus of control due to survey length and respondent burden. We used one question. Additionally, we have used this measure in the in-depth interviews and found high levels of locus of control, which might make it difficult to

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
			have the variation we need.
7.4 Members (WP/MPC) understand the logistics (for example—payment, payment options, requirements of the program, ...) of the HBP	Measure 50: Members' knowledge of program requirement Measure 51: Members' knowledge of payment process	We reported on these data.	
7.5 Members (WP/MPC) understand the purpose of the HBP and how it is supposed to influence their behavior.	Measure 52: Members' knowledge of the purpose of HBP Measure 53: Members' understanding of how the program influences behavior.	We reported on these data	
7.6 Members (WP/MPC) do not report difficulties paying premiums related to payment form accepted by IME	Measure 54: Members' experience with premium payment mechanism	We reported on these data	
8. What are the experiences of the ACOs related to the HBP?			
8.1 ACOs experience barriers to reaching targets for wellness exams and HRA	Measure 55: Type and number of barriers to reaching targets for wellness exams and HRA	We did not have these data.	With the move to managed care, ACOs would not play a significant role in the program.
8.2 ACOs promote the HBP	Measure 56: Type and level of promotion	We did not have these data.	With the move to managed care, ACOs would not play a significant role in the program.

Hypothesis	Measures	Inclusion in final report	Reasons for modifying original plan
8.3 ACOs experience advantages and success from the HBP.	Measure 57: Advantages and successes reported from the HBP	We did not have these data.	With the move to managed care, ACOs would not play a significant role in the program.

Methods

The original evaluation proposal included 8 research questions encompassing 34 hypotheses operationalized by 69 measures. General descriptions of the methods used to analyze these questions are listed below. Technical descriptions of the methods used to date may be found in individual reports at <http://ppc.uiowa.edu/publications/healthy-behaviors-incentive-program-evaluation>.

Data Sources and data collection

Administrative data

The Iowa evaluation provides a unique opportunity to optimize several sources of data to assess the effects of innovative coverage options. The Public Policy Center is home to a Medicaid Data Repository encompassing over 100 million claims, encounter, and eligibility records for all Iowa Medicaid enrollees for the period January 2000 through the present. Data are assimilated into the repository on a monthly basis. The database allows members to be followed for long periods of time over both consecutive enrollment months and periods before and after gaps in coverage. When the enrollment database was started in 1965, Iowa made a commitment to retain a member number for at least 3 years and to never reuse the same Medicaid ID number. This allows long term linkage of member information including enrollment, cost and utilization. We also maximize the use of outcome measures derived through administrative data manipulation using nationally recognized protocols from the National Quality Forum (NQF) and National Committee on Quality Assurance (NCQA) HEDIS.

Healthy behavior data

While some data on the completion of the wellness exam are available to the team through the Medicaid administrative claims database, the fact that members could call in to report receipt of a wellness exam and/or completion of an HRA led us to rely exclusively on data from IME to determine if a wellness exam was received and/or a Health Risk Assessment was completed. We do not have access to the MCO value added/rewards data, which would indicate if someone had participated in behaviors in addition to the wellness exam or HRA. The use of these data also means that we were unable to compare healthy behavior completion rates among members of IowaCare or the Medicaid State Plan.

Qualitative and quantitative consumer data

The guiding framework for the consumer data is understanding how consumers weigh the costs and benefits of participation in the incentive program. The Health Belief Model provides a systematic way to examine health behavior decision-making (Becker, 1974). The model suggests that individuals weigh the perceived benefits, barriers, and self-efficacy to performing a behavior, as well as the perceived susceptibility and severity of the negative health outcome which could result from not performing the behavior. This model will be used to inform the qualitative and quantitative data collection and analysis for the consumer data.

Qualitative data collection enables us to capture member and clinic experiences for an in-depth examination of program implementation. The interviews explored enrollees' knowledge, perception and experience with the healthy behavior incentive program. Enrollees were sent a recruitment letter asking them to participate in an in-depth telephone interview. Interviews were transcribed and coded to distill the information relevant to the evaluation.

Interviews were conducted with enrollees (n = 152), in 2015. We invited 468 enrollees to participate. The sample was stratified by gender, age, income, and race/ethnicity to ensure the data included the widest range of experiences. Clinic managers (n = 52) were interviewed in 2015. Clinic managers were selected to interview in place of providers because clinic managers were more likely to know about insurance, Medicaid and other programs. They were also more likely to

have received the communication from IME about the program. We interviewed members who were disenrolled during the first disenrollment period and members who had been more recently disenrolled. We invited all members who had been disenrolled 3 months prior and had a telephone number to participate in the interviews. Members (n = 37) who had been disenrolled in late 2015/early 2016 were interviewed. Members (n = 34) who had been disenrolled in early 2017 were interviewed. We did not conduct interviews with ACOs because of the transition to managed care. With many unknowns about the HBP during the transition, the data gathered would not have been useful to understanding the HBP.

Survey data

To inform the development of the survey items, qualitative data collection was conducted before each survey was designed. The qualitative data provided information about experiences, perceptions, barriers, and motivators needed in order to ensure the survey items and response categories reflect the enrollees’ experiences. The surveys include CAHPS measures and supplemental items. The supplemental items address issues specific to the healthy behaviors. We assess enrollees’ awareness of the program and its components, including their overall perceptions of the program. Barriers and motivators to completing the specific behaviors will be documented. We include several demographic and self-reported health items to be used as adjustment variables in the analyses.

2017 Disenrollment Survey

The 2017 IWP Disenrollment Survey was conducted between June and December of 2017. Surveys were mailed on a rolling monthly basis to members who were disenrolled from the IWP program for non-payment in the prior three months. For example, surveys mailed in June were sent to members who had been disenrolled on March 1.

The monthly samples were drawn from Medicaid enrollment data. Individuals who had participated in previous evaluations were excluded from the sample. Individuals who had been disenrolled for failure to pay the IWP premium were identified through discontinuance data provided monthly and matched back to enrollment data to provide names and mailing addresses. In some cases, surveys were sent to multiple members in one household. The monthly groups varied in size as the monthly number of disenrolled members changed (Table 3).

Table 3. Sample Size for 2017 Disenrollment Survey by Survey Month & Disenrollment Month

Survey Month (Disenrollment Month)	n
June (March)	130
July (April)	150
August (May)	2
September (June)	338
October (July)	229
Total	849

Survey packets were initially mailed to each group on the second Wednesday of the month. The packets included the survey and a cover letter, which described the survey, stated that participation was completely voluntary, and provided a phone number to ask questions or opt out of the study. Respondents were given the option to complete the survey on paper or online by entering a unique access code. To maximize response rates for the survey, both a premium and an incentive were used: each initial packet included a \$2 bill, and respondents who returned a completed the survey were sent a \$20 Wal-Mart gift card.

One week after the initial survey packets were mailed, a postcard reminder was sent. Four weeks after the initial mailing, a reminder survey packet was sent to those who had not returned a completed survey.

2017 Enrollee Survey

The 2017 Survey of IHAWP members was conducted between July and September 2017 using computer assisted telephone interviewing. The purpose of the survey was to document member awareness of the HBP, knowledge of the program, perceptions of the program, and experiences with completing the behaviors and paying premiums.

The sample was drawn from Medicaid enrollment data current as of July 2017. The stratified random sample of IHAWP members included individuals who had been in their current plan for at least the previous fourteen months, June 2016 to July 2017. Individuals who had participated in previous evaluations and individuals without valid telephone numbers were excluded from the sample. Only one person was selected per household to reduce the relatedness of the responses and respondent burden. The sample was first stratified by completion of healthy behaviors (completed none, completed HRA, completed wellness exam, and completed both), then by FPL (0-50%, 51-100%, and 101-133%) and finally by MCO. The final sample was comprised of 6,000 IHAWP members: 2,000 from each of the three MCOs with equal numbers of members in the stratification groups (completion healthy behaviors and FPL).

Letters introducing the study were mailed to potential respondents. The introductory letter described the evaluation, stated why the respondent was being invited to participate, and ensured the participants of the anonymity of their responses. The letter stated that participation was completely voluntary, that refusal would not lead to any penalty or lost benefits, and provided a telephone number to ask questions, update their contact information, or opt out of the study. In an effort to maximize response rates for the survey, both a premium and an incentive were used: each introductory letter included a \$2 bill, and respondents who completed the survey when contacted over the telephone were sent a \$10 Wal-Mart gift card.

Interviews were conducted by the Iowa Social Science Research Center at The University of Iowa. All interviewers were trained on the purpose of the evaluation, human subjects research protections, and the survey instrument. Following the training, telephone calls were made to each sampled IHAWP member, the evaluation was introduced, the confidentiality of all responses and voluntary nature of participation was explained, informed consent was obtained, and either the interview was conducted or an alternate time to complete the interview was arranged. The survey consisted of 66 questions and took approximately twenty minutes to complete.

There were 1,375 IHAWP members who responded to the survey. The AAPOR standard Response Rate 3 (an industry standard for best practices in calculating response rates for telephone data collection projects of this nature) was 32.3%.

2018 Enrollee Survey

The 2018 Survey of IWP members was conducted between September and October 2018 using computer-assisted telephone interviewing to document member awareness of the HBP, knowledge of program specifics, perceptions of the program, and experiences with completing the activities and/or paying premiums. The sample was drawn from members who had completed the 2017 survey of IWP members. Of the 1375 respondents to the 2017 survey, the research team identified 1102 individuals who maintained IWP enrollment in 2018, had complete information for both periods, and were otherwise eligible. Results from this type of sampling provides a unique look into program experiences over time for one group of members, it does not indicate the experiences of all members or provide for comparisons within the program across time generally.

Letters introducing the study were mailed to potential respondents. To maximize survey response rates, both a premium and an incentive were used: each introductory letter included a \$2 bill, and respondents who completed the survey were sent a \$10 Wal-Mart gift card.

Interviews were conducted by the Iowa Social Science Research Center at The University of Iowa. All interviewers were trained on the purpose of the evaluation, human subjects research protections, and the survey instrument. Following the training, telephone calls were made to each sampled IWP member, the evaluation was introduced, the confidentiality of all responses and voluntary nature of participation was explained, informed consent was obtained, and the interview was either conducted then or scheduled for an alternate time. The survey consisted of 48 questions and took approximately twenty minutes to complete.

There were 641 IWP members who responded to the survey and had complete interviews. There was one IWP member who completed partial interviews, 56 who refused or broke off the interview, 303 who could not be contacted or were unable to complete the interview for other reasons, 9 who were not eligible, and 92 who had problem telephone numbers. Based on this, the AAPOR standard Response Rate 3 (an industry standard for best practices in calculating response rates for telephone data collection projects of this nature) was 64%. For more information on how the response rate was calculated, see [https://www.aapor.org/Standards-Ethics/Standard-Definitions-\(1\).aspx](https://www.aapor.org/Standards-Ethics/Standard-Definitions-(1).aspx).

Linking of survey data to claims data

The team will continue to explore the possibilities of linking survey data with claims data.

Research Design

This evaluation employs multiple levels of analyses, using quantitative and qualitative data. First, where data permit, univariate and bivariate analyses are used to compare descriptive characteristics. Second, simple rate comparisons are computed for population-based outcomes, to demonstrate differences in trends between groups. Finally, for hypotheses related to utilization, we utilize more sophisticated analytic approaches including difference-in-differences estimation (DID). While Iowa is very fortunate to have more comparable data and comparison populations over time than many other states (e.g., IowaCare), there are still limitations to the comparability across populations due to income, categorical eligibility, and health status. Unfortunately, while we had proposed an analysis that leveraged two comparison groups— IowaCare and Medicaid State Plan members—we learned as we undertook the evaluation that critical data for these groups were either entirely unavailable or had exceedingly high levels of missingness. Therefore, we opted to focus exclusively on the IHAWP population, using them as their own controls when possible. Additionally, we analyze IHAWP members by income level. We do this, rather than comparing Wellness Plan and Marketplace Choice Plan (MCP) members, because over the course of our longitudinal evaluation, the MCP was ended and those individuals were merged into the Wellness Plan, however the income levels continued to remain an important part of the IHAWP program, with respect to the amount of potential premiums members owe.

Study Population: Iowa Wellness & Marketplace Choice Plans

The focus of this evaluation is the examination of outcomes among IHAWP members, stratified by income level.

Process measures

Process measures are designed to describe the state of the program or some aspect of the program, but do not lend themselves to testing. Process measures include frequencies and descriptive statistics.

Means testing

Many of the outcome measures are population based making it unnecessary to model the outcomes and their predictors. For these population measures, means testing for the groups before and after implementation will provide us with an understanding of the programmatic effects.

Multivariate modelling

Measures from the Medicaid Adult Core Set, NCQA HEDIS, and annual CAHPS survey may be modelled using logistic regression and DID. While we originally proposed use of a regression discontinuity design (RDD), we lack a continuous variable that we could identify as assigning someone to treatment, which in this case is considered the completion of one or more healthy behaviors. As indicated in earlier reports, we have determined that they cannot be conducted. Many of our outcomes are population based, however through modification of the protocols they will also be measured as individual outcomes most often through a dichotomous variable indicating whether or not the member had a service (e.g., person with type 1 or type 2 diabetes receiving a Hemoglobin A1c) or experienced an outcome (e.g., asthma exacerbation).

Qualitative data

Interviews were transcribed and coded to distill the information relevant to the evaluation. The codebook was produced based on the research questions and hypotheses. Trained teams of coders established intercoder reliability before coding all transcripts.

Survey data

The survey data will be analyzed using descriptive and bivariate statistics.

Limitations

As with all evaluations, there are limitations to the interpretation of the results and the potential for bias. For example, the quantitative analyses are limited in three ways. First, the definition of our sample and the treatment variable, as well as the use of propensity score matching—while necessary to cleanly model the relationship between the Healthy Behaviors Program and our outcomes of interest using a quasi-experimental method—result in dropping a number of member-year observations. In turn, this raises the possibility that our results are not generalizable to other IHAWP members, to say nothing of Medicaid members writ large. Despite employing numerous analytic strategies to combat them, our regression models may be limited by unobserved factors that differ between individuals, which may bias our results. However, the direction and magnitude of any such bias cannot be well predicted. Related to this, we were unable to include the identified comparison groups (IowaCare and Medicaid State Plan) as originally intended, because data on these individuals' wellness exams and health risk assessments were not tracked by IME. However, we do include IowaCare members who transitioned to the IHAWP and HBP in our quasi-experimental approach to modeling HBP outcomes wherein members effectively serve as their own control group. Finally, administrative data are collected for billing and tracking purposes and may not always accurately reflect the service provided. For our other analyses, including survey data collection, which are based on self-reported information and the recall of the enrollee there is the potential for response bias. Non-response bias tests are conducted to determine if the characteristics of respondents differ significantly from non-respondents.

Summary of Results

We have summarized the results across the evaluation and the various evaluation data sources and analysis. More detail about the results and the methods can be found in the Appendix and the previous evaluation reports have all of the methods, analysis, and results in detail.

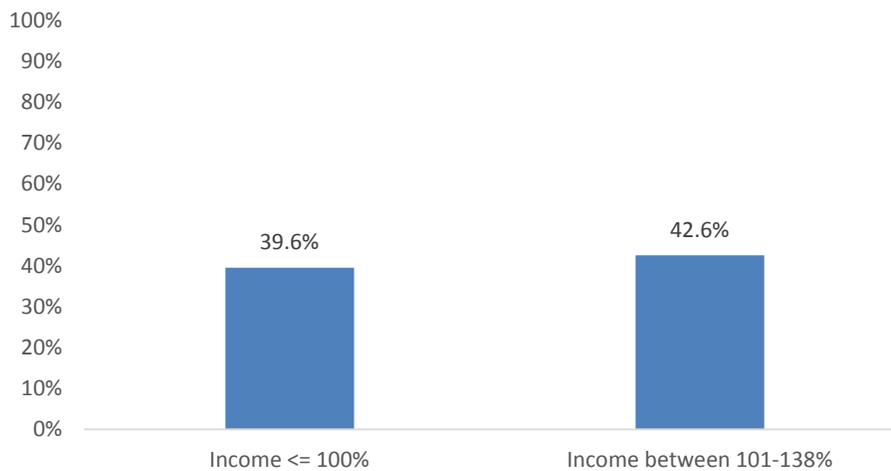
1. Which activities do enrollees complete?

1.1: The proportion of Wellness Plan (WP) members and Marketplace Choice (MPC) members who complete a wellness exam is greater than the proportion of Medicaid State Plan (MSP) or IowaCare members who complete an exam.

Data Source: HBI Completion and Outcomes Report 2018

Across all years, Iowa Department of Human Services (DHS) data—including administrative data for medical well visits and members who self-report completion of an activity via telephone—indicate that 40% of lower-income members and 43% of higher-income members completed a wellness exam

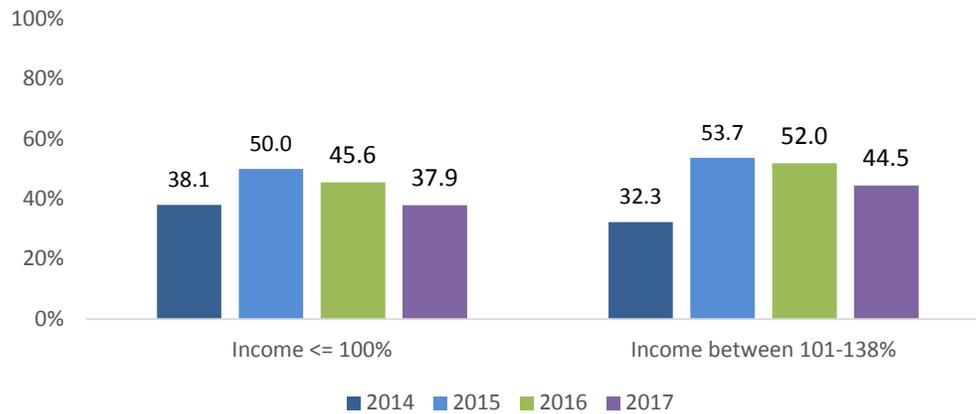
Figure 1. Wellness Exam Completion Rates Using DHS Data, 2014-2017



Note: Significantly different at $p < 0.001$.

From 2014 to 2017, receipt of a wellness exam remained at 38% among lower-income members, but increased from 32% to 45% among higher-income members.

Figure 2. Members Enrolled for Full Calendar Year Who Received a Wellness Exam as Identified by DHS Data, by Income and Year 2014 – 2017



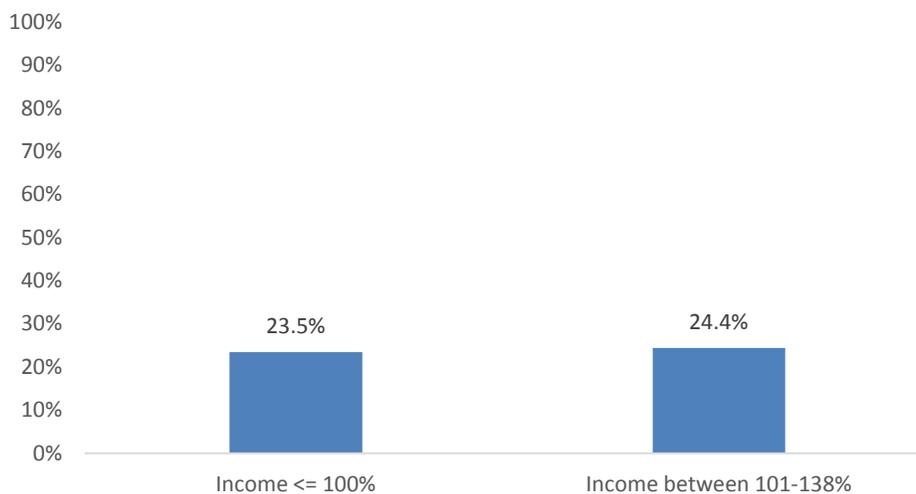
Note: Both the differences between programs within years and the differences between years within programs are statistically significant ($p < 0.001$), with the exception of years 2014 and 2017 of the income below 100% group ($p = 1.00$) and years 2015 and 2017 of the income between 101-138% group ($p = 0.854$).

1.2: The proportion of WP/MPC members who complete a Health Risk Assessment is greater than 50%.

Data Source: HBI Completion and Outcomes Report 2018

Across all years, 24% of members (regardless of income level) completed an HRA.

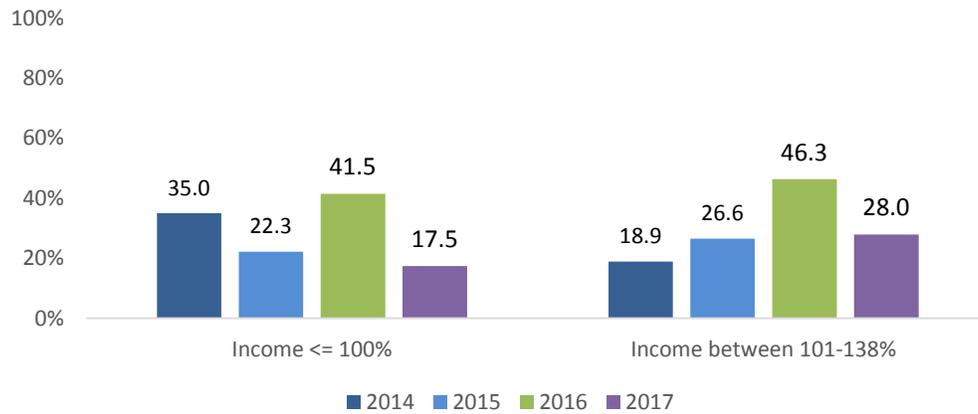
Figure 3. HRA Completion Rates Using DHS Data, 2014 – 2017



Note: Significantly different at $p < 0.001$.

From 2014 to 2017, HRA completion rates decreased from 35% to 18% among lower-income members, but increased from 19% to 28% among higher-income members.

Figure 4. Members Enrolled for Full Calendar Year Who Received an HRA as Identified by DHS Data, by Income and Year 2014 – 2017



Note: Both the differences between programs within years and the differences between years within programs are statistically significant ($p < 0.001$), with the exception of years 2015 and 2017 of the income between 101-138% group ($p = 0.937$).

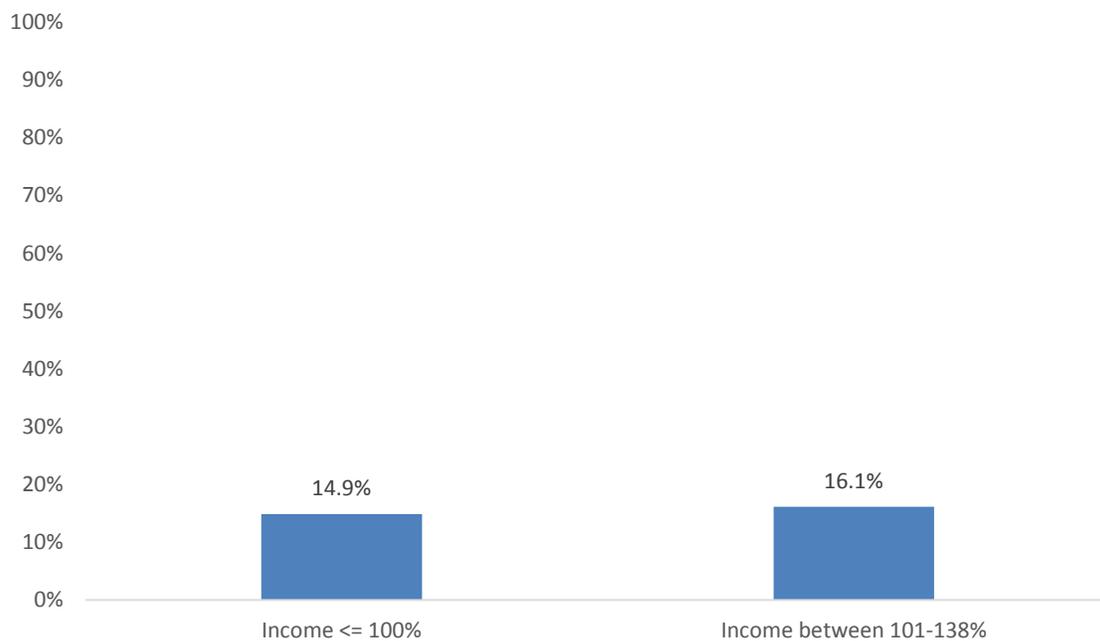
1.3: The proportion of WP/MPC members who are eligible to participate complete at least one behavior incentive is greater than 50%.

Data Source: HBI Completion and Outcomes Report 2018

We were unable to track the completion of additional behavior incentives, because this aspect of the program was not implemented initially. While it is our understanding that the MCOs are now operating incentive programs, we do not have data on these. Thus, we examined the proportion of WP and MPC members who completed both activities (wellness exam and HRA).

Across all years, approximately 15% of lower-income members and 16% of higher-income members completed both activities

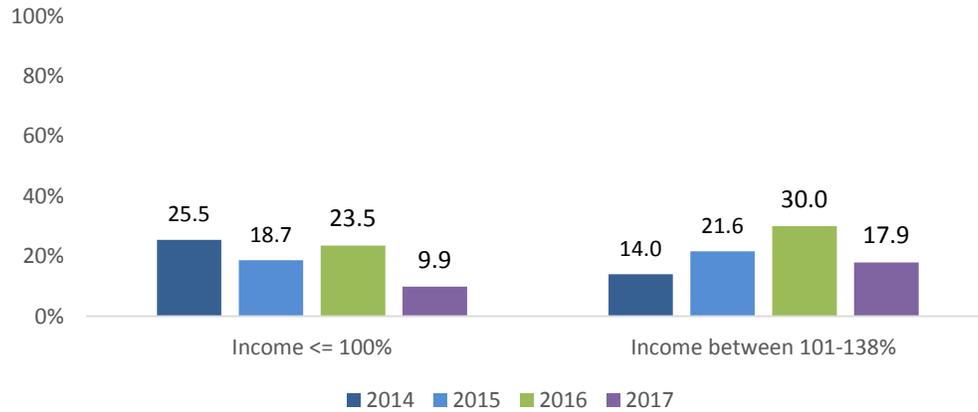
Figure 5. HRA and Wellness Exam Completion Rates Using DHS Data, 2014 – 2017



Note: Significantly different at $p < 0.001$.

From 2014 to 2017, completion of both activities decreased from 26% to 10% among lower-income members, but increased from 14% to 18% among higher-income members.

Figure 6. Members Enrolled for Full Calendar Year Who Received an HRA and Wellness Exam as Identified by DHS Data, by Income and Year 2014 – 2017



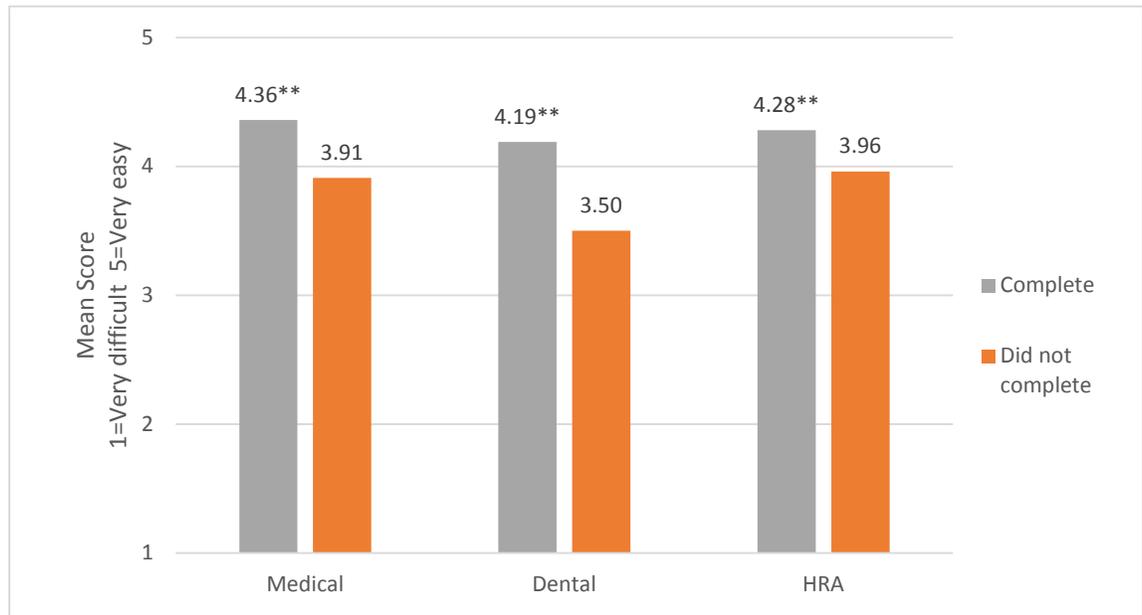
Note: Both the differences between programs within years and the differences between years within programs are statistically significant ($p < 0.001$), while slightly less significant results were seen for years 2014 and 2017 of the income between 101-138% group ($p = 0.001$) and years 2015 and 2017 of the income between 101-138% group ($p = 0.01$).

1.4: Members (WP/MPC) are most likely to complete the behaviors that require the least amount of effort.

Data Source: Enrollee Survey 2017

Respondents were asked how easy it would be for them to complete the behavior (Figure 7). Respondents who completed each individual behavior reported that it was easier to complete a wellness exam ($t=7.96$, $p<0.001$), a dental exam ($t=11.52$, $p<0.001$), and HRA ($t=6.78$, $p<0.001$) compared to those who did not complete the behavior (Figure 7).

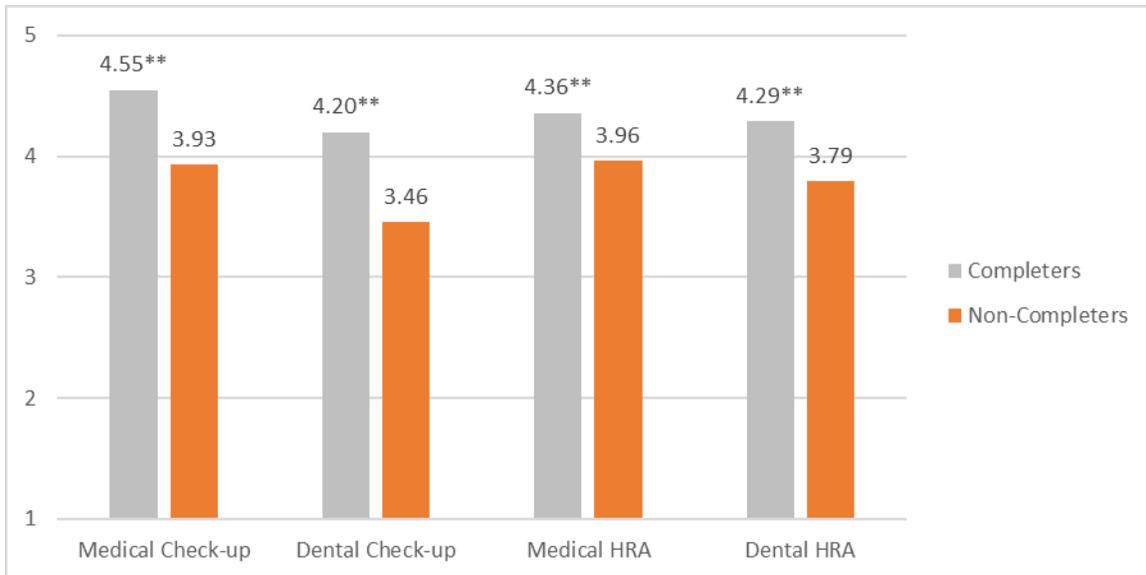
Figure 7. Respondents' perception of difficulty of completing a wellness exam, dental exam, and HRA for those who completed the behavior and those who did not complete the behavior



Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

Respondents were asked how easy it would be for them to complete each behavior (Figure 8). Respondents who completed each individual behavior reported that it was easier to complete a wellness exam ($t=5.22$, $p<0.001$), a dental exam ($t=7.50$, $p<0.001$), a medical HRA ($t=4.85$, $p<0.001$), and an oral HRA ($t=6.13$, $p<0.001$) compared to those who did not complete the behavior (Figure 8).

Figure 8. Respondents' perception of difficulty of completing a wellness exam, dental exam, medical HRA, and an oral HRA for those who completed the behavior and those who did not complete the behavior



* indicates significant difference at $p < 0.05$

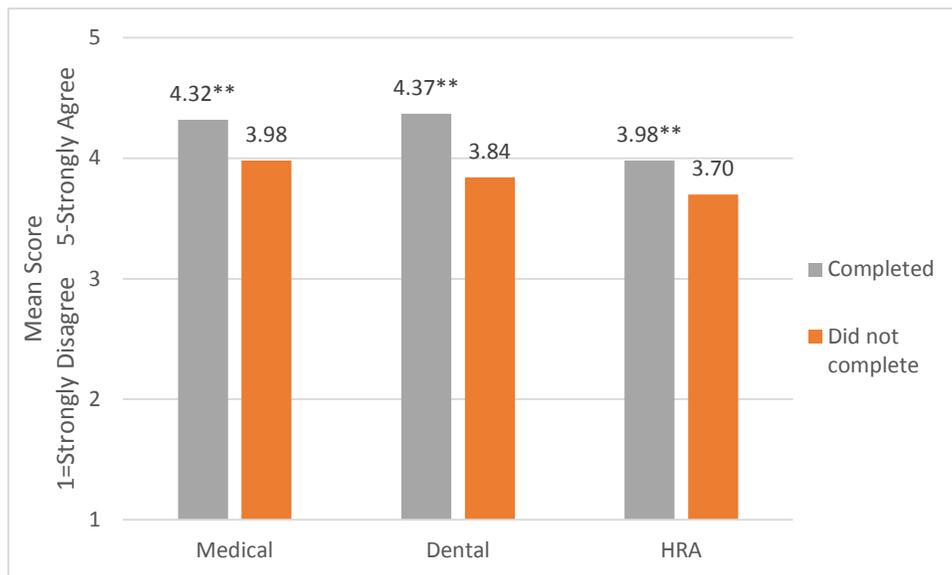
** indicates significant difference at $p < 0.001$

1.6: Member (WP/MPC) will be most likely to complete incentivized behaviors with the largest real or perceived value.

Data Source: Enrollee Survey 2017

Respondents who completed each individual behavior reported significantly higher scores for the benefit of completing a wellness exam (t=6.67, p<0.001), a dental exam (t=13.11, p<0.001), and an HRA (t=5.10, p<0.001) compared to those who did not complete the behavior (Figure 9).

Figure 9. Respondents' perception of how beneficial wellness exams, dental exams, and HRA are for those who completed the behavior and those who did not complete the behavior



* indicates significant difference at p < 0.05
** indicates significant difference at p < 0.001

There was a significant association between completing a wellness/dental exam and an HRA and whether the respondent would rather pay \$10 a month or complete a wellness/dental exam and an HRA ($\chi^2=14.3381$, $p<0.001$, Table 4). Regardless of whether a respondent has completed the behaviors, members reported preferring completing the behaviors over paying the \$10 premium.

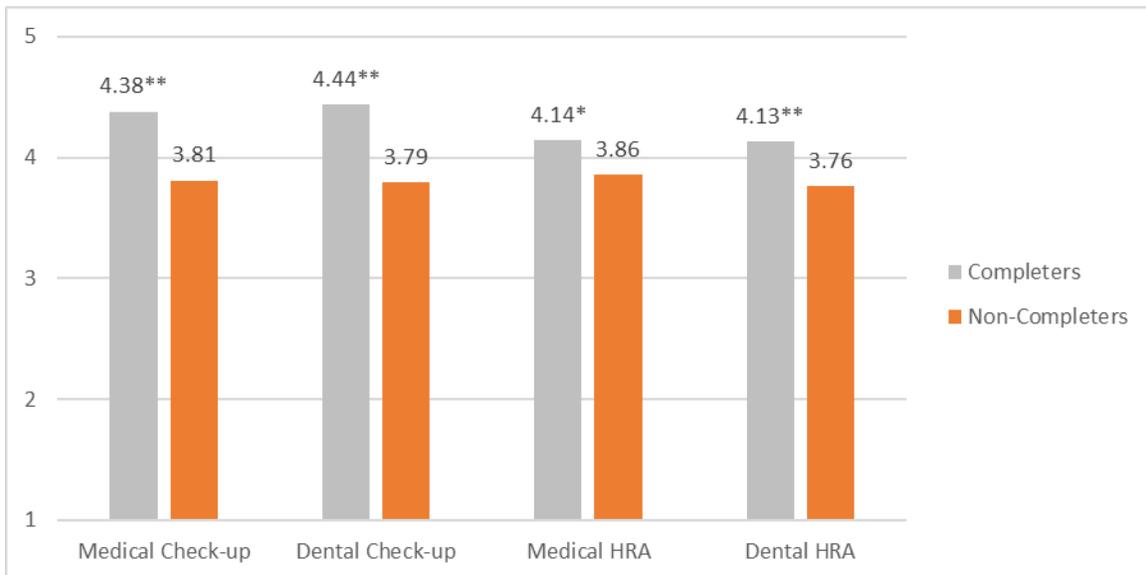
Table 4. If respondent would rather completed HBP requirements or pay \$10 by whether complete wellness/dental exam and HRA

	Complete wellness/dental exam and HRA		Total
	Yes	No	
Would rather pay \$10	58 (7.09%)	66 (13.41%)	124
Would rather complete wellness/dental exam and HRA	760 (92.91%)	426 (86.59%)	1186
Total	818 (100.00%)	492 (100.00%)	1310

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

Respondents who completed each individual behavior reported significantly higher scores for the benefit of completing a wellness exam ($t=7.51$, $p<0.001$), a dental exam ($t=10.04$, $p<0.001$), a medical HRA ($t=3.28$, $p=0.001$), and an oral HRA ($t=4.99$, $p<0.001$) compared to those who did not complete the behavior (Figure 10).

Figure 10. Respondents' perception of how beneficial wellness exams, dental exams, medical HRA, and oral HRA are for those who completed the behavior and those who did not complete the behavior



* indicates significant difference at $p < 0.05$

** indicates significant difference at $p < 0.001$

There was a significant association between completing a wellness/dental exam and a medical HRA and whether the respondent would rather pay \$10 a month or complete a wellness/dental exam and an HRA ($\chi^2=16.87$, $p<0.001$, Table 5). Regardless of whether they had completed the behaviors, respondents reported preferring completing the behaviors (89%) over paying the \$10 premium (8%).

Table 5. If respondent would rather complete HBP requirements or pay \$10 by whether completed wellness/dental exam and HRA

	Complete wellness/dental exam and HRA		Total
	Yes	No	
Would rather pay \$10	21 (4.90%)	28 (14.50%)	49
Would rather complete wellness/dental exam and HRA	407 (95.10%)	165 (85.50%)	572
Total	428 (100.00%)	193 (100.00%)	621

2. What personal characteristics are predictive of completing at least one behavior incentive, and the number (or extent) of behavior incentives completed?

Data Source: HBI Completion and Outcomes Report 2018

In general, the models find that the likelihood of completing both activities is higher among members who are older, female, white or unknown race, reside in an urban area, don't move during the year, have fewer ER visits, take more prescription drugs, and have more chronic conditions. The magnitude and direction of these results is generally consistent across both the lower-income and higher-income models, suggesting that the relationships we identify are not influenced by a person's income level. The likely reason some of the estimates in the higher-income group are not statistically significant is the smaller sample for that group of members. (HBI Completion and Outcomes Report 2018)

Table 6. Odds of Completing Both Activities by Income Groups

	Income ≤ 100%			Income between 101-138%		
	OR	95% CI		OR	95% CI	
Average Age	1.02***	1.02	1.02	1.02***	1.02	1.03
Male	0.64***	0.62	0.66	0.71***	0.68	0.75
Black	0.75***	0.72	0.79	0.73***	0.65	0.81
Hispanic	0.83***	0.78	0.89	0.85**	0.77	0.94
Other Race	0.85***	0.80	0.90	0.96	0.88	1.05
Unknown Race	1.05**	1.02	1.08	1.05	0.99	1.11
Metropolitan	1.12***	1.09	1.15	1.06*	1.01	1.11
Nonmetropolitan Urban	1.29***	1.23	1.37	1.06	0.96	1.17
Number of Moves	0.96***	0.95	0.97	1.00	0.98	1.02
Number of ER visits	0.90***	0.89	0.91	0.90***	0.88	0.92
Number of Rx drugs	1.10***	1.09	1.10	1.13***	1.11	1.14
Number of Chronic conditions	1.06***	1.05	1.07	1.04***	1.02	1.06
Constant	0.14***	0.13	0.15	0.06***	0.05	0.06

Note: Odds ratios for the cohort-specific fixed effects are not shown.

2.1: Members (WP/MPC) who have heard of the program from their health care provider are more likely to complete at least 1 behavior.

Data Source: Enrollee Survey 2017

There was a significant association between members reporting they heard about the HBP from their health care provider and completing an HRA ($\chi^2=4.985$, $p=0.026$, Table 7) and completing either a wellness exam/dental exam and completing the HRA ($\chi^2=7.752$, $p=0.0054$, Table 8). The vast majority of respondents did not hear about the program from their health care provider.

Table 7. Frequency of being aware from health care provider by whether complete HRA

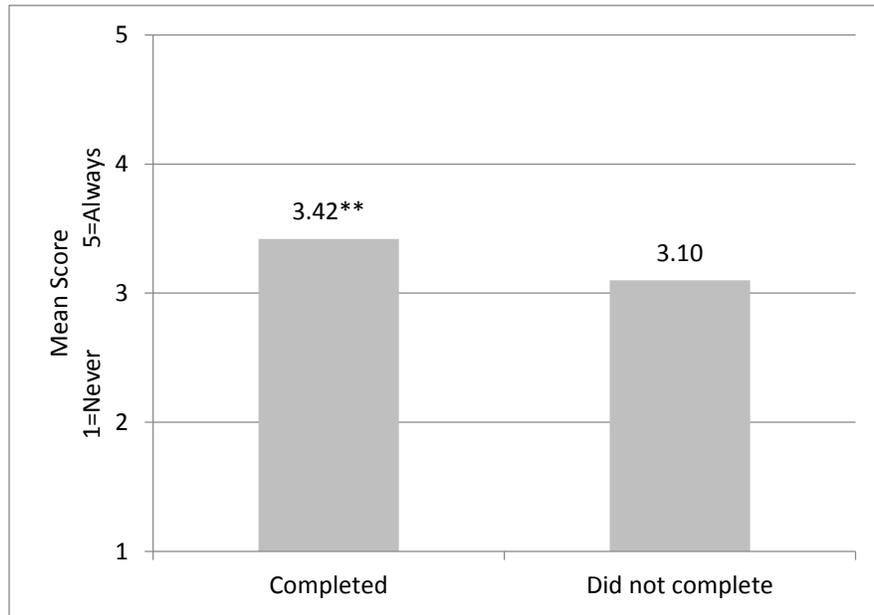
	Complete HRA		Total
	Yes	No	
Heard from provider	52 (5.84%)	9 (2.71%)	61
Did not hear from provider	839 (94.16%)	323 (97.29%)	1162
Total	891 (100.00%)	332 (100.00%)	1223

Table 8. Frequency of being aware from health care provider by whether complete wellness/dental exam and HRA

	Complete wellness or dental exam and HRA		Total
	Yes	No	
Heard from provider	51 (5.97%)	14 (2.69%)	65
Did not hear from provider	803 (94.03%)	507 (97.31%)	1310
Total	854 (100.00%)	521 (100.00%)	1375

Members who completed a wellness/dental exam and an HRA got an appointment as soon as they needed more often compared to those who did not ($t=6.36$, $p<0.001$) (Figure 11).

Figure 11. Respondents reporting receiving appointment for routine care as soon as they needed for those that completed the HBP behaviors and those that did not

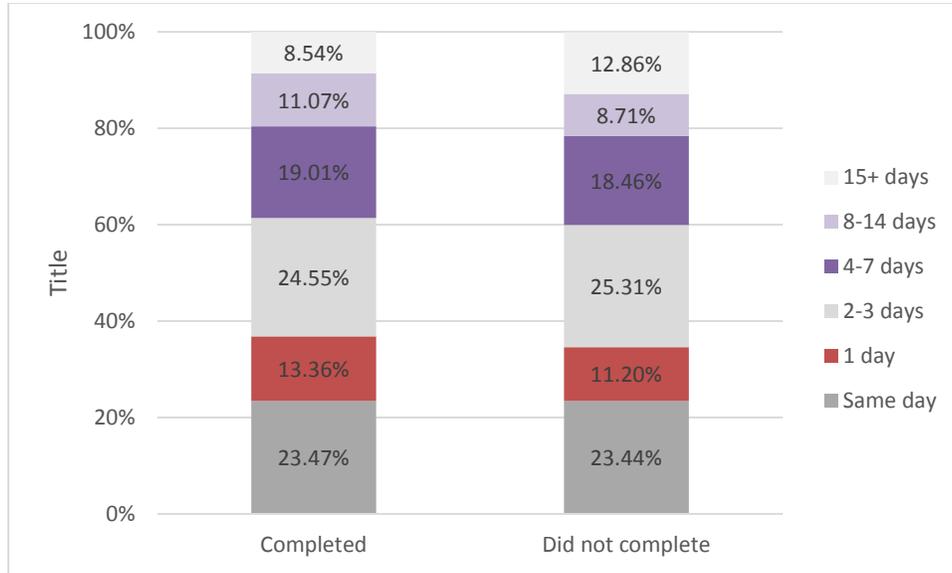


* indicates significant difference at $p < 0.05$

** indicates significant difference at $p < 0.001$

There was no significant difference between members who have completed the wellness/dental exam and HRA and those who did not in the number of days they had to wait for an appointment for a check-up or routine care (Figure 12).

Figure 12. Members’ report of the number of days they had to wait for a check-up or routine care appointment



Of the IHAWP members who responded to the survey, 1217 (88.51%) stated that they have a personal doctor when asked “A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?” There was a significant association between having a personal doctor and completing the healthy behaviors ($\chi^2=13.74$, $p=0.001$, Table 9).

Table 9. Frequency of having a personal doctor by whether complete wellness/dental exam and HRA

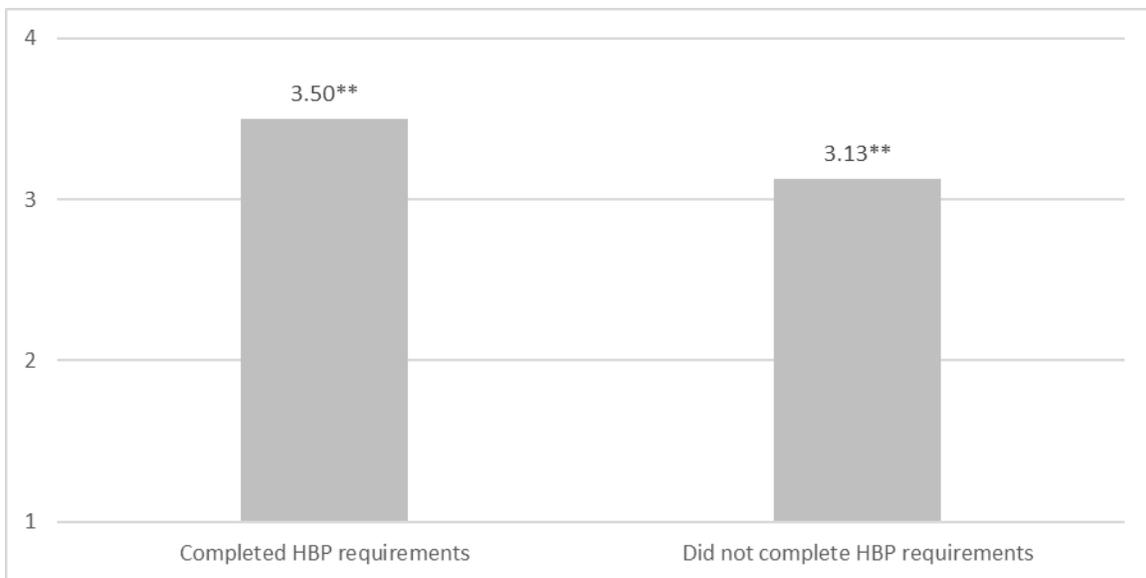
	Complete wellness/dental exam and HRA		Total
	Yes	No	
Has personal doctor	777 (91.20%)	440 (84.94%)	1217
Does not have personal doctor	75 (8.80%)	78 (15.06%)	153
Total	852 (100.00%)	518 (100.00%)	1370

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

There were no significant associations between respondents reporting they heard about the HBP from their health care provider and completing a wellness exam, dental exam, medical HRA, oral HRA, or completing either a wellness exam/dental exam and completing the HRA. The vast majority of respondents (93.8%) did not hear about the program from their health care provider

Respondents who completed a wellness/dental exam and an HRA got an appointment as soon as they needed more often compared to those who did not ($t=4.51$, $p<0.001$) (Figure 13).

Figure 13: Respondents reporting receiving appointment for routine care as soon as they needed for those that completed the HBP behaviors and those that did not



* indicates significant difference at $p < 0.05$

** indicates significant difference at $p < 0.001$

Of the IWP members who responded to the survey, 584 (91%) stated that they have a personal doctor when asked “A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?” There was a significant association between having a personal doctor and completing a medical exam ($\chi^2=27.72$, $p<0.001$, Table 10), completing a medical HRA, ($\chi^2=8.31$, $p=0.004$, Table 11), and the HBP program requirements ($\chi^2=7.41$, $p=0.006$, Table 12). Having a personal doctor was not significantly associated with completing a dental exam or oral HRA.

Table 10. Frequency of having a personal doctor by whether complete wellness exam

	Complete medical exam		Total
	Yes	No	
Has personal doctor	512 (93.8%)	64 (76.2%)	576
Does not have personal doctor	34 (6.2%)	20 (23.8%)	54
Total	546 (100.00%)	84 (100.00%)	630

Table 11. Frequency of having a personal doctor by whether complete a medical HRA

	Complete HRA		Total
	Yes	No	
Has personal doctor	424 (93.2%)	94 (84.7%)	518
Does not have personal doctor	31 (6.8%)	17 (15.3%)	48
Total	455 (100.00%)	111 (100.00%)	566

Table 12. Frequency of having a personal doctor by whether complete HBP program requirements

	Complete medical/dental exam and HRA		Total
	Yes	No	
Has personal doctor	408 (93.6%)	176 (87.1%)	584
Does not have personal doctor	28 (6.4%)	26 (12.9%)	54
Total	436 (100.00%)	202 (100.00%)	638

2.2: Members (WP/MPC) who are young, white, female, and/or live in metro areas are more likely to complete at least 1 behavior.

Data Source: HBI Completion and Outcomes Report 2018

Members who are older, female, white, and/or live in metropolitan areas are more likely to complete both behaviors.

	Income ≤ 100%			Income between 101-138%		
	OR	95% CI		OR	95% CI	
Average Age	1.02***	1.02	1.02	1.02***	1.02	1.03
Male	0.64***	0.62	0.66	0.71***	0.68	0.75
Black	0.75***	0.72	0.79	0.73***	0.65	0.81
Hispanic	0.83***	0.78	0.89	0.85**	0.77	0.94
Other Race	0.85***	0.80	0.90	0.96	0.88	1.05
Unknown Race	1.05**	1.02	1.08	1.05	0.99	1.11
Metropolitan	1.12***	1.09	1.15	1.06*	1.01	1.11
Nonmetropolitan Urban	1.29***	1.23	1.37	1.06	0.96	1.17
Number of Moves	0.96***	0.95	0.97	1.00	0.98	1.02
Number of ER visits	0.90***	0.89	0.91	0.90***	0.88	0.92
Number of Rx drugs	1.10***	1.09	1.10	1.13***	1.11	1.14
Number of Chronic conditions	1.06***	1.05	1.07	1.04***	1.02	1.06
Constant	0.14***	0.13	0.15	0.06***	0.05	0.06

2.3: Members (WP/MPC) with poorer health status are less likely to complete behaviors compared to members with better health status.

Data Source: HBI Completion and Outcomes Report 2018

Contrary to our hypothesis, we found that members with more chronic conditions (a proxy for poorer health status) were more likely to complete behaviors compared to members with fewer chronic conditions.

	Income ≤ 100%			Income between 101-138%		
	OR	95% CI		OR	95% CI	
Average Age	1.02***	1.02	1.02	1.02***	1.02	1.03
Male	0.64***	0.62	0.66	0.71***	0.68	0.75
Black	0.75***	0.72	0.79	0.73***	0.65	0.81
Hispanic	0.83***	0.78	0.89	0.85**	0.77	0.94
Other Race	0.85***	0.80	0.90	0.96	0.88	1.05
Unknown Race	1.05**	1.02	1.08	1.05	0.99	1.11
Metropolitan	1.12***	1.09	1.15	1.06*	1.01	1.11
Nonmetropolitan Urban	1.29***	1.23	1.37	1.06	0.96	1.17
Number of Moves	0.96***	0.95	0.97	1.00	0.98	1.02
Number of ER visits	0.90***	0.89	0.91	0.90***	0.88	0.92
Number of Rx drugs	1.10***	1.09	1.10	1.13***	1.11	1.14
Number of Chronic conditions	1.06***	1.05	1.07	1.04***	1.02	1.06
Constant	0.14***	0.13	0.15	0.06***	0.05	0.06

2.5: Members (WP/MPC) receiving care at federally qualified health centers, rural health clinics, and public hospitals will be more likely to participate in the incentive programs than enrollees receiving care in other settings.

Data Source: Enrollee Survey 2017

Table 13. While you were enrolled in the Iowa Health and Wellness plan, did you receive care from any of the following clinics?

	Yes n (%)	No n (%)	Don't know/ not sure. n (%)	Refused n (%)
United Community Health Center	95 (6.91)	1236 (89.89)	44 (3.20)	0 (0.00)
Community Health Centers of Southeastern Iowa, Inc	54 (3.93)	1290 (93.82)	31 (2.25)	0 (0.00)
Primary Health Care, Inc	214 (15.56)	1114 (81.02)	47 (3.42)	0 (0.00)
Community Health Centers of Southern Iowa, Inc	34 (2.47)	1314 (95.56)	27 (1.96)	0 (0.00)
Community Health Center of Fort Dodge, Inc	22 (1.60)	1340 (97.45)	13 (0.95)	0 (0.00)
Greater Sioux Community Health Center	12 (0.87)	1350 (98.18)	13 (0.95)	0 (0.00)
Linn Community Care – now called Eastern Iowa Health Center	40 (2.91)	1318 (95.85)	17 (1.24)	0 (0.00)
Community Health Care, Inc	59 (4.29)	1282 (93.24)	34 (2.47)	0 (0.00)
All Care Health Center	25 (1.82)	1331 (96.80)	19 (1.38)	0 (0.00)
Crescent Community Health Center, Inc	31 (2.25)	1327 (96.51)	17 (1.24)	0 (0.00)
River Hills Community Health Center, Inc	40 (2.91)	1321 (96.07)	14 (1.02)	0 (0.00)
Siouxland Community Health Center	50 (3.64)	1311 (95.35)	14 (1.02)	0 (0.00)
People's Community Health Clinic, Inc	44 (3.20)	1316 (95.71)	15 (1.09)	0 (0.00)

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

We did not examine completion rates by site of care, given difficulties in assigning / attributing members to a site of care, and the fact that additional incentive programs were not implemented. However, we report data from member surveys about receipt of care at Federally Qualified Health Centers.

Table 14. While you were enrolled in the Iowa Health and Wellness plan, did you receive care from any of the following clinics? (n=641)

	Yes n(%)	No n(%)	Don't know/ Not sure n(%)	Refused n(%)
United Community Health Center	40 (6.2)	570 (88.9)	30 (4.7)	1 (0.2)
Community Health Centers of Southeastern Iowa, Inc	22 (3.4)	606 (94.5)	12 (1.9)	1 (0.2)
Primary Health Care, Inc	61 (9.5)	562 (87.7)	16 (2.5)	2 (0.3)
Community Health Centers of Southern Iowa, Inc	17 (2.7)	610 (95.2)	13 (2.0)	1 (0.2)
Community Health Center of Fort Dodge, Inc	7 (1.1)	630 (98.3)	3 (0.5)	1 (0.2)
Greater Sioux Community Health Center	1 (0.2)	633 (98.8)	6 (0.9)	1 (0.2)
Linn Community Care – now called Eastern Iowa Health Center	14 (2.2)	615 (95.9)	11 (1.7)	1 (0.2)
Community Health Care, Inc	27 (4.2)	598 (93.3)	14 (2.2)	2 (0.3)
All Care Health Center	10 (1.6)	621 (96.9)	8 (1.2)	2 (0.3)
Crescent Community Health Center, Inc	16 (2.5)	619 (96.6)	4 (0.6)	2 (0.3)
River Hills Community Health Center, Inc	27 (4.2)	609 (95.0)	3 (0.5)	2 (0.3)
Siouxland Community Health Center	16 (2.5)	620 (96.7)	3 (0.5)	2 (0.3)
People's Community Health Clinic, Inc	19 (3.0)	613 (95.6)	7 (1.1)	2 (0.3)

3. Is engaging in behavior incentives associated with improved access to care and health outcomes?

Data Source: HBI Completion and Outcomes Report 2018

Percent of persons having an ambulatory care visit significantly increased if they had completed either a wellness exam and/or an HRA. We assessed access to primary care using the percentage of members who had an ambulatory care visit. Figure 14 compares both lower-income and higher-income IHAWP members, by completion of a wellness exam and/or HRA. The percent of persons having an ambulatory care visit increased significantly when they completed a wellness exam and/or HRA. We suspect that we see these differences because completion of either of these healthy behaviors likely required or resulted from an ambulatory care visit. The results are very similar regardless of income level.

3.1: The program will improve WP/MPC members' access to health care.

Data Source: HBI Completion and Outcomes Report 2018

Among lower-income and higher-income IHAWP members with diabetes, those who completed both healthy behaviors had higher rates of hemoglobin A1c testing in comparison to those who completed neither health benefit. However, this result was not statistically significant among the higher-income group.

In both lower-income and higher-income members completing both healthy behaviors showed higher rates of LDL-C Screening. However, this result was not statistically significant among the higher income group.

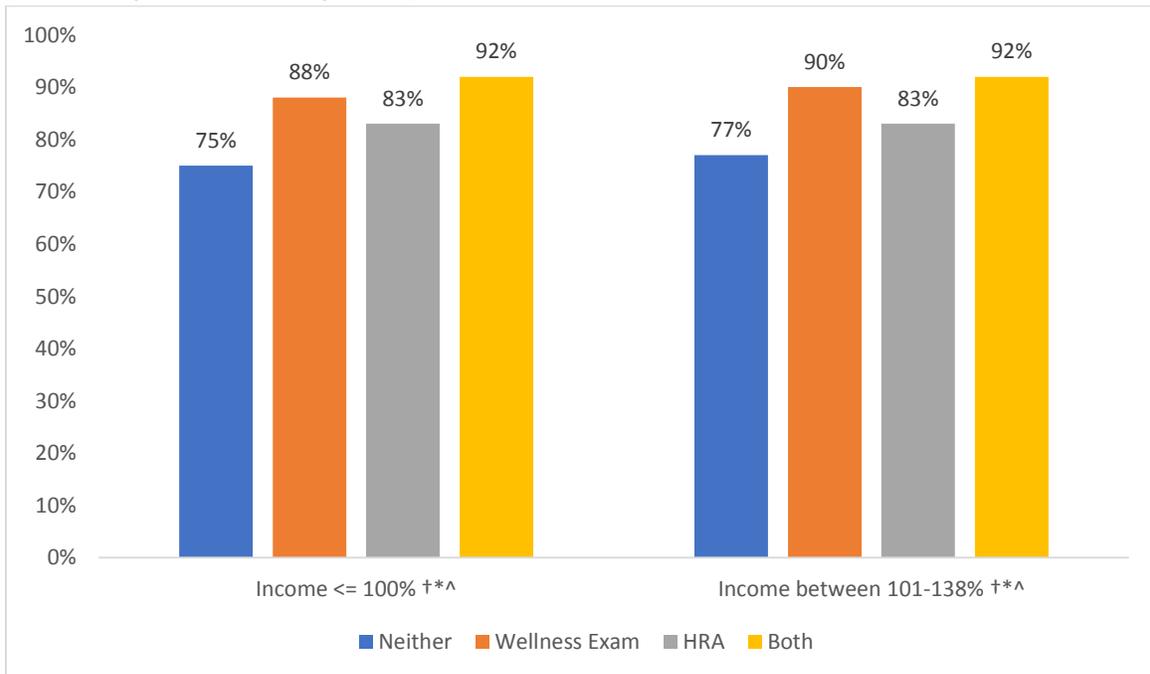
Table 15. Modeling Ambulatory/Preventive Care Visits as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Medicaid Expansion	0.048***	0.03	0.067
Treatment Group	0.169***	0.151	0.186
Post Medicaid Expansion*Treatment Group	-0.010	-0.037	0.016
Age	-0.001	-0.001	0.000
Male	-0.082***	-0.097	-0.067
Black	0.023	-0.006	-0.052
Hispanic	0.052**	0.013	0.091
Other Race	0.004	-0.038	-0.047
Unknown Race	-0.033***	-0.05	-0.015
Metropolitan	0.025**	0.009	0.042
Nonmetropolitan Rural	0.009	-0.032	0.049
Number of Relocations	-0.001	-0.007	0.006
Number of 24 Chronic Conditions	0.074***	0.07	0.078
Income between 51-100% of FPL	0.005	-0.017	0.027
Income between 101-138% of FPL	0.028	-0.003	0.058
Constant	0.695***	0.657	0.734

N = 10,202

* p<0.05, ** p<0.01, ***p<0.001

Figure 14: Percent of Members who had an Ambulatory Care Visit, by Income and Healthy Behavior Completion, 2015 - 2017



† Neither vs. wellness exam is significant at $p < 0.001$

* Neither vs. health risk assessment is significant at $p < 0.001$

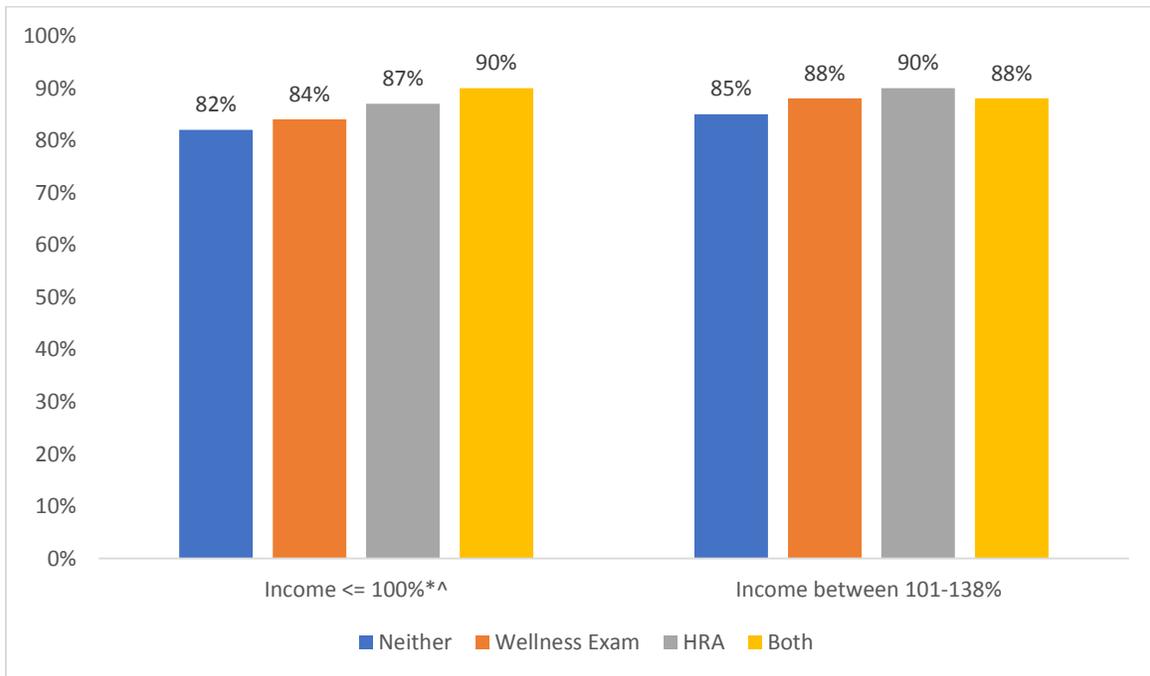
^ Neither vs. both (wellness exam and health risk assessment) is significant at $p < 0.001$

Table 16. Modeling Hemoglobin A1c Testing in Diabetic Members as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Medicaid Expansion	0.046*	0.000	0.091
Treatment Group	0.095***	0.051	0.140
Post Medicaid Expansion*Treatment Group	-0.026	-0.100	0.047
Age	0.001	-0.001	0.003
Male	-0.027	-0.063	0.009
Black	-0.018	-0.095	0.060
Hispanic	0.094**	0.037	0.151
Other Race	0.083	-0.007	0.173
Unknown Race	0.031	-0.011	0.074
Metropolitan	0.013	-0.027	0.052
Nonmetropolitan Rural	-0.069	-0.190	0.053
Number of Relocations	0.000	-0.014	0.015
Number of 24 Chronic Conditions	0.014*	0.000	0.027
Income between 51-100% of FPL	0.035	-0.014	0.084
Income between 101-138% of FPL	-0.008	-0.086	0.069
Constant	0.708***	0.578	0.838

N = 1,424* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Figure 15: Percent of Members with Diabetes Who had Hemoglobin A1c Testing, by Income and Healthy Behavior Completion



† Neither vs. wellness exam is significant at $p < 0.001$

* Neither vs. health risk assessment is significant at $p < 0.001$

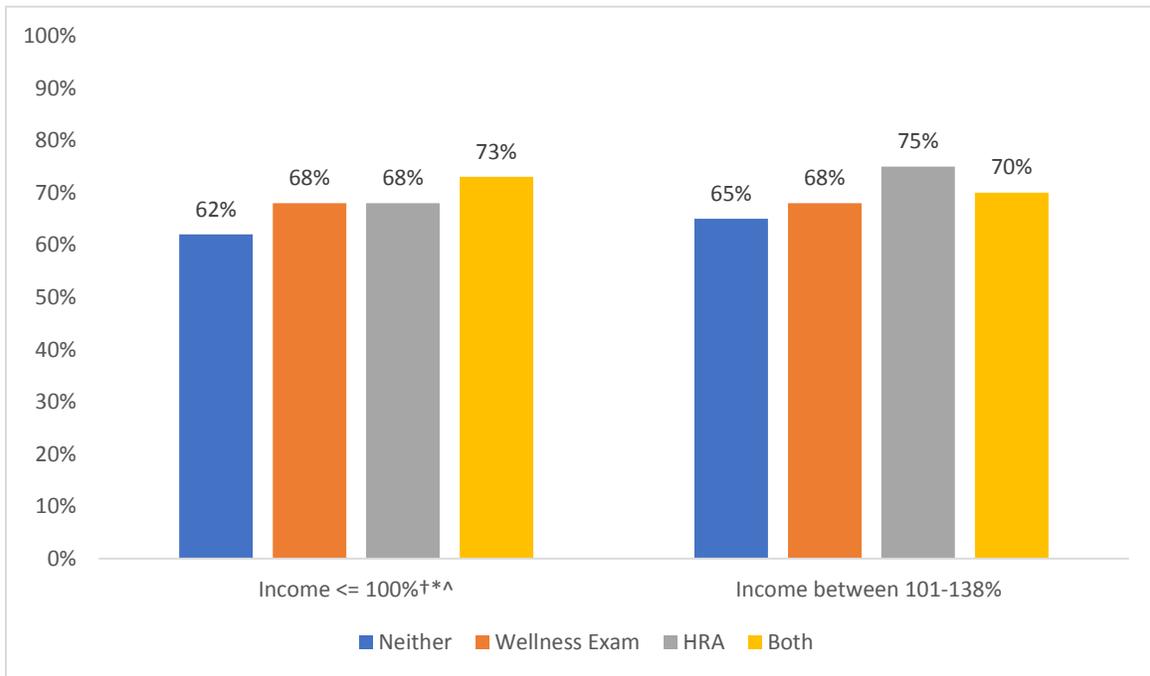
^ Neither vs. both (wellness exam and health risk assessment) is significant at $p < 0.001$

Table 17. Modeling LDL-C screenings in Diabetic Members as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Medicaid Expansion	0.165***	0.104	0.226
Treatment Group	0.094**	0.024	0.164
Post Medicaid Expansion*Treatment Group	-0.066	-0.188	0.056
Age	0.005**	0.002	0.008
Male	-0.031	-0.081	0.020
Black	0.016	-0.084	0.115
Hispanic	0.067	-0.036	0.170
Other Race	0.101	-0.039	0.242
Unknown Race	0.009	-0.050	0.068
Metropolitan	0.096***	0.040	0.151
Nonmetropolitan Rural	-0.105	-0.249	0.039
Number of Relocations	0.023*	0.003	0.042
Number of 24 Chronic Conditions	0.014	-0.003	0.030
Income between 51-100% of FPL	0.108**	0.036	0.180
Income between 101-138% of FPL	-0.030	-0.140	0.081
Constant	0.146	-0.021	0.313

N = 1,424, * p<0.05, ** p<0.01, ***p<0.001

Figure 16. Percent of Members with Diabetes Who had an LDL-C screening, by Income and Healthy Behavior Completion



† Neither vs. wellness exam is significant at p<0.001

* Neither vs. health risk assessment is significant at p<0.001

Data Source: Enrollee Survey 2017

Below are results from survey data to address H3.1. Of respondents, 88.51% reported having a personal doctor. When asked about being able to get an appointment for routine care, when they needed it 56.15% indicated “always” (Table 19). Only 5.24% reported having to wait 15-30 days for an appointment, while most indicated they could get an appointment sooner (Table 20).

Table 18. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

	n	percent
Yes	1217	88.51
No	153	11.13
Don't know/not sure	5	0.36
Refused	0	0.00

Table 19. In the last 6 months, how often did you get an appointment for a check-up or routine care at the doctor's office or clinic as soon as you needed? Would you say never, sometimes, usually, or always?

	n	percent
Never	78	5.67
Sometimes	209	15.20
Usually	281	20.44
Always	772	56.15
Don't know/not sure	30	2.18
Refused	5	0.36

Table 20. In the last 12 months, how many days did you usually have to wait for an appointment for a check-up or routine care?

	n	percent
Same day	308	22.40
1 day	165	12.00
2 to 3 days	326	23.71
4 to 7 days	247	17.96
8 to 14 days	134	9.75
15 to 30 days	72	5.24
More than 30 days	61	4.44
Don't know/not sure	56	4.07
Refused	6	0.44

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

For enrollees who had been in the program at least two years, 91.1% reported having a personal doctor and 59.6% said they could “always” get an appointment when needed.

Table 21. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor? (n=641)

	n	Percent
Yes	584	91.1
No	54	8.4
Don't know/not sure	3	0.5

Table 22. In the last 6 months, how often did you get an appointment for a check-up or routine care at the doctor's office or clinic as soon as you needed? Would you say never, sometimes, usually, or always? (n=641)

	n	Percent
Never	29	4.5
Sometimes	82	12.8
Usually	142	22.2
Always	382	59.6
Don't know/not sure	6	0.9

3.2: Health outcomes of WP/MPC members will be positively impacted by completing the healthy behaviors.

Data Source: HBI Completion and Outcomes Report 2018

When comparing members by completion of one or both healthy behaviors we found that that lower-income members who had an HRA or completed both activities had significantly lower rates of non-emergent ED visits. There was no association among higher-income members. We also found that the proportion of lower-income IHAWP members with a return ED visit was lower in the group that completed an HRA or both healthy behaviors in the prior year. The wellness exam alone was not statistically significant, nor were there any significant differences observed among higher-income members, regardless of their healthy behavior completion.

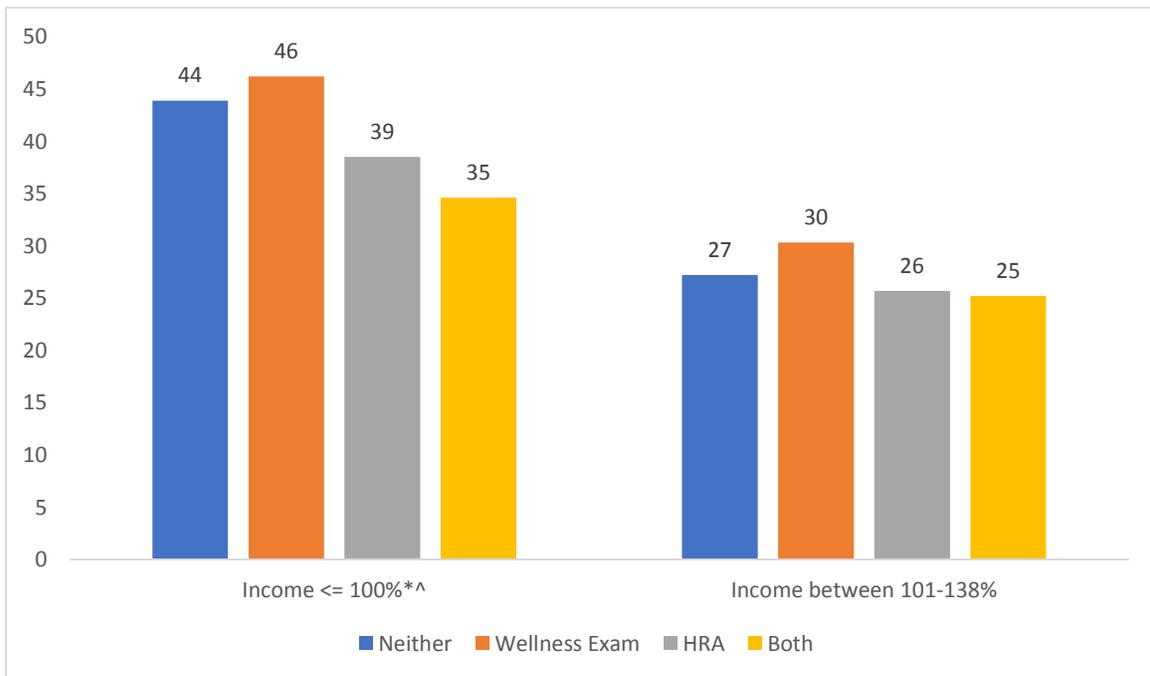
Table 23. Modeling Non-emergent ED Use as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Medicaid Expansion	0.019	-0.005	0.044
Treatment Group	-0.014	-0.048	0.019
Post Medicaid Expansion*Treatment Group	-0.028	-0.109	0.052
Age	-0.002***	-0.003	-0.001
Male	-0.027*	-0.048	-0.005
Black	0.015	-0.019	0.048
Hispanic	0.005	-0.062	0.071
Other Race	0.044	-0.002	0.090
Unknown Race	0.002	-0.024	0.029
Metropolitan	0.008	-0.015	0.032
Nonmetropolitan Rural	-0.011	-0.078	0.056
Number of Relocations	-0.000	-0.010	0.009
Number of 24 Chronic Conditions	-0.010**	-0.017	-0.004
Income between 51-100% of FPL	-0.002	-0.034	0.029
Income between 101-138% of FPL	0.025	-0.014	0.065
Constant	1.012***	0.965	1.059

N = 3,161

* p<0.05, ** p<0.01, ***p<0.001

Figure 17. Number of Non-Emergent ED Visits per 1000 Member Months, by Income and Healthy Behavior Completion



† Neither vs. wellness exam is significant at $p < 0.001$

* Neither vs. health risk assessment is significant at $p < 0.001$

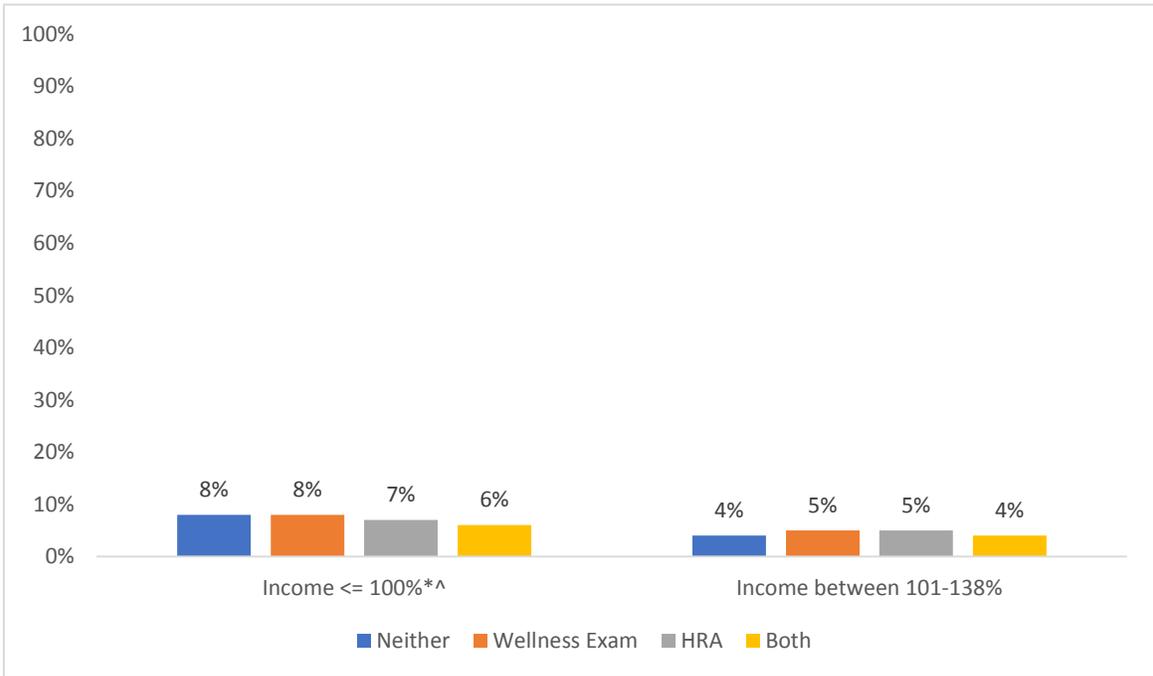
^ Neither vs. both (wellness exam and health risk assessment) is significant at $p < 0.001$

Table 24. Modeling ED Visits 30 Days After Index ED Visit as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Medicaid Expansion	-0.003	-0.037	0.032
Treatment Group	-0.018	-0.061	0.026
Post Medicaid Expansion*Treatment Group	-0.006	-0.101	0.088
Age	-0.004***	-0.005	-0.002
Male	-0.031*	-0.062	-0.001
Black	0.000	-0.052	0.053
Hispanic	-0.012	-0.1	0.077
Other Race	-0.034	-0.118	0.050
Unknown Race	-0.049**	-0.083	-0.014
Metropolitan	0.019	-0.013	0.050
Nonmetropolitan Rural	-0.013	-0.096	0.069
Number of Relocations	-0.002	-0.015	0.010
Number of 24 Chronic Conditions	0.029***	0.019	0.038
Income between 51-100% of FPL	-0.049*	-0.091	-0.007
Income between 101-138% of FPL	-0.090**	-0.148	-0.032
Constant	0.387***	0.313	0.461

N = 3,161* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

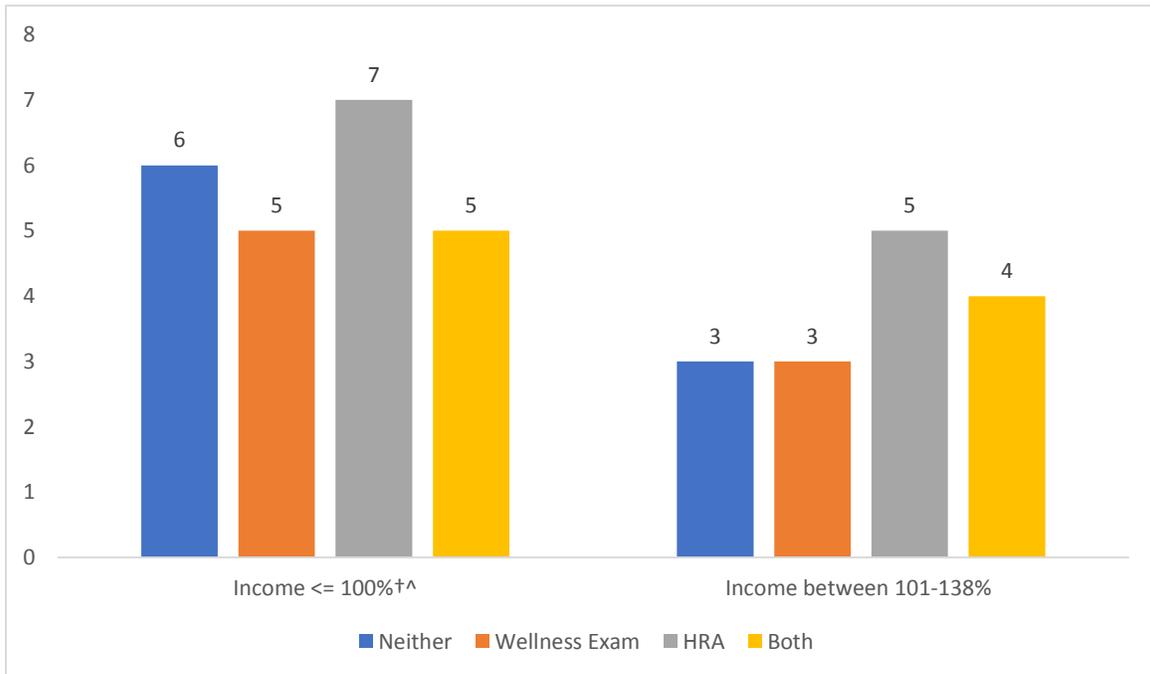
Figure 18. Percent of Members with an ED visit within first 30 days after index ED visit, by Income and Healthy Behavior Completion



* Neither vs. health risk assessment is significant at $p < 0.001$

^ Neither vs. both (wellness exam and health risk assessment) is significant at $p < 0.001$

Figure 19. Average Number of Discharges per 1000 Member Months, by Income and Healthy Behavior Completion



† Neither vs. wellness exam is significant at $p < 0.001$

* Neither vs. health risk assessment is significant at $p < 0.001$

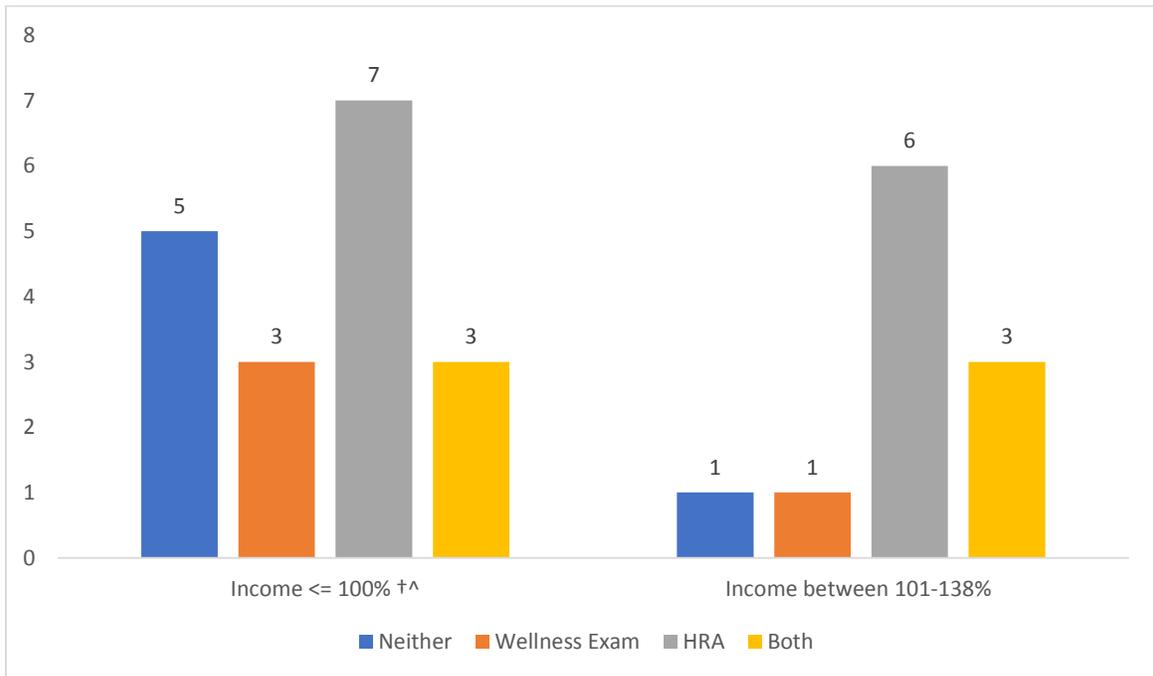
^ Neither vs. both (wellness exam and health risk assessment) is significant at $p < 0.001$

Table 25. Modeling the Likelihood of Any Hospital Readmission as a Function of Healthy Behavior Completion

	Coefficient	95% CI	
Post Medicaid Expansion	0.009	-0.048	0.067
Treatment Group	0.013	-0.061	0.088
Post Medicaid Expansion*Treatment Group	0.130	-0.065	0.326
Age	-0.003	-0.006	0.000
Male	0.081***	0.035	0.128
Black	0.061	-0.048	0.169
Hispanic	-0.025	-0.145	0.096
Other Race	-0.069**	-0.117	-0.021
Unknown Race	0.016	-0.046	0.078
Metropolitan	-0.021	-0.074	0.032
Nonmetropolitan Rural	-0.097***	-0.154	-0.040
Number of Relocations	0.000	-0.02	0.021
Number of 24 Chronic Conditions	0.016*	0.002	0.031
Income between 51-100% of FPL	0.001	-0.078	0.080
Income between 101-138% of FPL	-0.039	-0.138	0.060
Constant	0.140	-0.012	0.293

N = 536* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Figure 20. Average Annual Number of Hospital Readmissions per 1000 Members, by Income and Healthy Behavior Completion



† Neither vs. wellness exam is significant at $p < 0.001$

* Neither vs. health risk assessment is significant at $p < 0.001$

^ Neither vs. both (wellness exam and health risk assessment) is significant at $p < 0.001$

4. What are the effects of the program on health care providers?

4.2 Providers are encouraging patients to participate in the behavior incentive program

Respondents in both years indicated that the primary way they heard about the HBI program was through their MCO. The second most common ways for both years was hearing about HBI was receiving a letter from either DHS, IME, Medicaid, or Iowa Health Link.

Data Source: Enrollee Survey 2017

Table 26. How did you hear about the Healthy Behaviors Program?

	n	percent
I received a letter from my MCO (UnitedHealthCare, Amerigroup, AmeriHealth) telling me about the Healthy Behaviors Program	294	43.56
I received a letter from DHS/IME/Medicaid/Iowa Health Link telling me about the Healthy Behaviors Program	203	30.07
I received a phone call from my MCO	26	3.85
I received a call from the clinic I go to telling me about the Healthy Behaviors Program	9	1.33
My healthcare provider told me about the Healthy Behaviors Program while I was in the clinic	65	9.63
Family/Friend/Coworker	25	3.70
Letter/Brochure-unsure or other sources	36	5.33
Internet- unsure or other source	7	1.04
Received bill or disenrolled-inquired about HBP	6	0.89
Heard when completing HRA	3	0.44
Other	21	3.11
Don't know/not sure	42	6.22
Refused	0	0

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

Table 27. How did you hear about the Healthy Behaviors Program? (Select all that apply) (n=383)

	n	Percent
I received a letter from my MCO (UnitedHealthCare, AmeriGroup, AmeriHealth) telling me about the healthy behaviors program	155	40.5
I received a letter from DHS/IME/Medicaid/Iowa Health Link telling me about the healthy behaviors program	74	19.3
I received a phone call from my MCO	19	5.0
I received a call from the clinic i go to telling me about the healthy behaviors program	4	1.0
My healthcare provider told me about the healthy behaviors program while i was in the clinic	40	10.4
Family/friend/coworker	17	4.4
Letter/brochure-unsure or other sources	56	14.6
Internet	9	2.3
Received bill or disenrolled-inquired about HBO	7	1.8
Heard when completing HRA	4	1.0
From the evaluation by UI	11	2.9
TV, poster, fliers, or other advertisements	9	2.3
Other	15	3.9
Don't know/not sure	26	6.8

6. What are the implications of disenrollment?

Data Source: Healthy Behaviors Dis-enrollment Interviews Report 2017

In the interviews many members reported that losing their insurance had no impact on their health. Overwhelmingly, these individuals had not needed any kind of medical care since being disenrolled. However, several individuals also indicated that they could not access necessary health care services without their IHAWP coverage. The most common disenrollment consequences reported were financial hardship, an inability to get prescription medications, and an inability to get dental care.

Overall Experiences without Insurance

In analyzing the interviews collectively, many individuals indicated that losing their insurance had no impact on their health. Overwhelmingly, these individuals had not needed any kind of medical care since being disenrolled. However, several individuals also indicated that they could not access necessary health care services without their IHAWP coverage. The most common disenrollment consequences reported were financial hardship, an inability to get prescription medications, and an inability to get dental care.

Financial Hardship

One reoccurring theme in these interviews was financial hardship. Though more than half of interviewees (n=22) were employed full-time, a number of people reported that losing their health insurance had created a financial burden for them and that they would not be able to afford adequate healthcare without IHAWP coverage. When asked if the

disenrolled member tried to use any services, the person responded, “No. Because I, I just simply can’t afford to be billed at, billed for it.” [508] Another member provided more detail by stating,

“Once I get my, um, my check, it’s pretty well gone before I get it because of bills and stuff that I have to pay. And I’m trying to get some of my doctor bills and stuff paid. ... So I haven’t been able to get my prescriptions like I should.” [575]

Prescription Medication

A number of individuals reported that they either took fewer doses or stopped taking necessary prescription medications because of their disenrollment. Concerns about the cost of prescriptions without IHAWP coverage were common. Although the disenrollment period was short for some, a number of individuals reported needing medication on a daily basis and that going even a few weeks without health insurance could have a profound health impact. Cost of the medications was one problem outlined by a member, “...some of them are like, even 50 to 100 dollars because they’re so expensive. And sometimes I don’t have the money to get ‘em.” [575] Another respondent indicated that returning to the doctor without insurance to get a prescription refilled was a problem. The person said, “Well I’ve had a water pill, but I mean, I can’t go back to the doctor and get a prescription again because I don’t have insurance.” [621]

Dental Care

Access to dental care was another concern that came up repeatedly in interviews. Many interviewees expressed concern that they could not access dental care without the IHAWP. After weight and high blood pressure, dental issues were the most commonly cited health concerns among interview respondents. One member explained the need for dental care and the challenges the lapse in coverage created,

“...And I have bad teeth and I need my wisdom teeth out. And I’m diabetic so I have periodontia. And they won’t do anything, they won’t do any coverage for af-, ‘til you’re in it for a complete year. Now that I have that lapse now I’m, uh, I’m not covered for getting my wisdom teeth out for another year. They are sitting in my face rotting. Um. And right now with Iowa City I have a, like an 80 dollar previous bill so they won’t even make me an appointment.” [508]

The lack of coverage also directly resulted in dental need that was unmet according to one respondent, “During, um, my, um, disenrollment I actually got an abscess in a tooth, um, which is, like, huge infection and my face swelled up. (laughing) And, um, my, my dentist actually informed me with my upcoming appointment that I was disenrolled before I even got the letter. Somehow they knew. I don’t know if they check before your appointment or what it is. But, um, they told me that they could not see me. Um, and that’s considered a, a medical emergency actually. (laughing) Um, when you get those abscesses.” [552]

Despite bringing up several of the same concerns, the disenrollment experience was clearly different when comparing those that successfully got back on the IHAWP, those that successfully got other insurance, and for those who had no insurance.

Experiences

Successfully Re-Enrolled

When asked about their experiences, those that had successfully re-enrolled in the IHAWP after their initial disenrollment reported general annoyance but minimal negative consequences. The majority of these individuals reported that re-enrollment was straightforward. One respondent who was successfully re-enrolled stated,

“Um, what I did is I just went down to the Department of Human Services and asked for their advice on how to re-enroll. They had me fill out the paper packet and provide them with my financial information...so they’re actually really nice down there. Surprisingly. You know, that’s kinda hard to come by at DHS offices, but they’re really nice and they were very helpful...I am, I am enrolled again now.” [508] Other respondents re-enrolled via the telephone and online. Some interview respondents who had successfully re-enrolled in the program expressed that disenrollment had consequences, but these were minimal and were resolved quickly. For those that were able to re-enroll, the most common problem reported during the disenrollment period was lack of coverage of prescription drugs. This was explained by one respondent, “... there’s medicine I always take daily. And then when I was about to run out of, and so I hurried up and got that sent in. To re-enroll. But I didn’t actually run out until the day, almost like the day I (was like), got my insurance back. (laughing)” [641]

Another member described, “I took my pills less and everything, until I knew what was gonna happen. So I wasn’t doin’ things right. Um, ‘cuz I’m, yeah, my pills are very expensive.” [696] The individuals in this group who did report a negative health impact suffered from serious pre-existing health conditions. For example, one interviewee described suffering from lupus and mentioned that losing her insurance had not only caused her to take her medication incorrectly but also drastically increased her stress levels.

Successfully Enrolled in Other Insurance

The experiences of those that enrolled in different insurance programs were much more varied in comparison with those that were able to re-enroll in the IHAWP. The enrollment process was relatively simple for some, but frustrating and confusing for others. Individuals in this group indicated that they enrolled through work or that they utilized community resources. A respondent who recently started a new job said,

“I took on their benefits. I was able to afford their benefits. Even though I, I’m sure I still qualify. But. I wanted to have better coverage. And. I didn’t wanna be looked down upon either.” [671]

Using a resource in the community one respondent reported,

“They tried to sign me up to, (with) a program that would kinda cover me for a while, bein’ I’m 61, and I’ll be 62 in January. I also went to, through United Way with women, which would help with the medicine. And would save me a PAP smear, mammogram, stuff like that. So I was able to, kind of, do something, cover, get my medicine covered, and some other small female things.” [519]

Some individuals in this group reported considerable barriers to enrolling in a new insurance program. Common challenges included financial hardship and difficulty finding a plan with adequate coverage.

Most individuals who successfully enrolled in a different insurance program did not report that disenrollment had affected their ability to get healthcare. However, a few individuals reported difficulties paying for specialty care or

prescription medications with their new insurance. One respondent needed to have a CT scan, but the new insurance policy would not cover it [516]. Co-pays on prescriptions was a hardship described by one disenrolled member, “I have a copay that I have to pay on them. But some of them are like, even 50 to 100 dollars because they’re so expensive. And sometimes I don’t have the money to get ‘em.” [575]

Did Not Get Insurance

Those that were unable to re-enroll in the IHAWP or unable to enroll in another insurance plan reported more challenges, confusion, and frustration related to the disenrollment process compared to other interviewees who had successfully gained insurance. For example,

“Interviewer: Ok. Have you contacted DHS yet? Subject: Yes, I left a message on my caseworker. Voice mail, at least twice.

Interviewer: And have they gotten back to you? Subject: No.” [503]

Other members reported not knowing what to do or what their options were. Interviewees who had been unable to get any type of insurance coverage more frequently reported that disenrollment had influenced their health or their ability to seek medical care compared to those who had been able to get insurance. One respondent described how the lack of coverage prevented the respondent from seeking care for a sprain and missing dental and eye appointments [505] Others did not continue taking medications.

Data Source: Disenrollment Survey Report 2018

From the survey of disenrolled members, 49% of respondents had no health insurance 3 months after disenrollment. Half of the respondents reported that they did not seek health care when they needed it, while 40% delayed preventive care, 38% delayed dental care, and 35% delayed having prescriptions filled.

Almost a third of survey respondents reported that their health had gotten worse since disenrollment, and 80% of disenrolled respondents reported that they spent at least some time without health insurance. While they had no insurance over half reported a delay in seeking care when it was needed, 40% reported delaying preventive care, and 38% reported delaying dental care.

Table 28. Current health insurance status* (n=237)

Status	n	percent
I am reenrolled in IHWAP	34	14.3
I am trying to reenroll in IHWAP	24	10.1
I am looking for health insurance	18	7.6
I have purchased health insurance privately	8	3.4
I am waiting to get health insurance from my employer	10	4.2
I have health insurance from my employer	21	8.9
I am on Medicaid/Title 19	15	6.3
I am on Medicare	8	3.4
I have no health insurance	108	45.6
*Respondents were able to select multiple responses		

Table 29. While you had no health insurance coverage, did you do any of the following? (Check all that apply)

	Frequency	percent
I delayed getting prescriptions filled	77	35.5
I tried to stretch my medicine so it would last longer	59	27.1
I stopped taking prescribed medications	69	31.2
I did not seek health care when I needed it	119	52.7
I delayed getting check-ups or other preventive care	91	40.8
I delayed getting dental care	85	38.6
I paid more money for health care, dental care or prescriptions than I would have if I had insurance	47	21.9

6.1 Disenrolled members do not understand the disenrollment process.

Data Source: Healthy Behaviors Dis-enrollment Interviews Report 2017

From the disenrolled members who participated in the qualitative interviews confusion and misunderstandings were documented. The survey of disenrolled members indicated that about 50% believe they were disenrolled because they did not pay their premiums. This would be in agreement with the disenrollment reason provided by DHS. About 16% believed they were disenrolled because they made too much money and almost 12% did not know why they were disenrolled. A quarter of the respondents did not know they were going to be disenrolled before it happened.

The first set of interview questions addressed the IHAWP disenrollment process. First, respondents were asked if they remembered receiving a letter informing them they were disenrolled. If interview respondents did not remember the letter, they were asked, “Did you know that you had been disenrolled?” and “How did you find out?” All but two individuals were aware of their disenrollment from the IHAWP. Of the two that were unaware of their disenrollment, one did not believe that she had ever lost her insurance coverage, while the other had acquired another type of health insurance. Most interviewees remembered receiving the disenrollment letter from the IHAWP and reported learning of their disenrollment upon receiving the letter. However, a number of respondents described learning that they had been disenrolled at the doctor’s office, emergency room or dental office. As one disenrolled member indicated, “Well what happened was, I found out through the emergency room actually. I went to the emergency room because I was sick, I had a tonsil infection. And she said it came up on her computer that, uh, I’m no longer with my health care insurance.” [503]

Interviewees were asked to answer the question, “Can you tell me why you think you were disenrolled?” The majority of interviewees (n=24) knew that they had been disenrolled from the IHAWP because of missed premium payments. However, three respondents stated that they had been disenrolled because they were making too much money, three subjects said that they had been disenrolled because they had failed to fill out the necessary paperwork on time, and seven did not know why they had been disenrolled. One member explained that due to living arrangements mail was not consistent, “So basically, I went a couple months without payin’ the contribution, and it

went too long, and because of that it, I got disenrolled. And I, um, and I, (inaudible) on, and it went on so I, I think it went, uh, 90 days, days without paying it and I didn't know." [615] When interview respondents were asked, "Did you know in advance that you were going to be disenrolled?" three interviewees explained that they had known in advance, and one interviewee expressed a vague awareness that she might be disenrolled. For the remaining 33 interviewees, disenrollment came as a surprise. For example, one member said, "I had no idea that if you didn't pay that within a certain amount of time that they would, uh, kick you off." [667]

Many interview respondents expressed frustration or confusion about the disenrollment process. Interviewees did not feel as if they received enough notice before their disenrollment and perceived a general lack of available information. One interviewee suggested, "I would like, you know, phone calls instead of, like, letters all the time. Because, you know, mail gets shoved to the side. At least phone calls, if they left a message saying, hey, touch base with us, you know, we sent out a letter. You know, that way it kinda doubles up." [641] Largely, interview respondents felt that they did not have the resources or tools to find reliable information about the disenrollment. Respondents reported wanting more notice, "I think that there needs to be some notice. Besides just, hey! You're being done in March, and there's no notice." [654] The following quote illustrates a common issue. "That was the thing that was really frustrating to me, because I didn't have a premium payment, and then, all the sudden, here I am getting letters. And it was like, I was back three months already. When I got this letter sayin', oh by the way we're, we're making you pay a premium now. Which, I got no, you know, heads up sayin', oh, you know, by the way in the next month this is what we're considerin' doin'...all the sudden I get this letter in the mail and it shows, you know, a premium for three months back. I'm like, whoa! Wait a minute." [671] Another member indicated, "I haven't heard one thing from them. The only thing that I've heard is that, the two things that I've heard is the letter saying you're disenrolled. And then what, that in order to do this you have to reapply. And then when I reapplied, saying nope! Sorry, you're not covered." [654]

Members also reported trouble with accessing help to understand the process, I call customer service DHS, then they send me to a different person, then. They send me to a different person (laughing). They just need one person. Like, is in charge of my case. Instead of going around the merry-go-round. That's just crazy. And nobody has the answers." [633] Interview respondents reported confusion related to their disenrollment. Three individuals believed they had fulfilled the requirements of the HBI program, three individuals indicated that they did not owe money because they had selected the financial hardship option, and one individual believed that she had not missed any payments. One of the members who believed they had completed the HBI requirements said, "I did my yearly health and wellness risk assessment with [the doctor], um, as soon as I got put, put on it. And that would've been in June of last year. So I, I guess if that would've been the case then I shouldn't have been, even been able to be disconnected (disenrolled) until June of this year." [516] One member related their story and the frustration they felt about being told they were behind in payments, "I called DHS and they told me that, uh, after three months behind, they kick you off. And I said, I was never three months behind. And I had got a letter sayin' that I was three months behind, and I called 'em and said, no, that's not the issue. And then I called DHS back and they said that, um, they only go offa what those other people tell them, and they told them I'm three months behind. They have no way of seein' it, they said. It was all a bunch of crock" [696]

Data Source: HBI Disenrollment Survey Report 2018

At the time respondents received the survey they were generally aware that they were disenrolled (84%), but only about 25% knew that they would be disenrolled before it happened. About 50% believed that they were disenrolled because they did not pay their premiums, 15% believed it was because they made too much money, and about 12% reported that they did not know why they were disenrolled.

Table 30. Disenrollment Experience – Awareness, Timing of Notification & Actions Taken

Characteristic	n	percent
Aware of Disenrollment (n=229)		
Yes	192	83.8
No	37	16.2
Knew before it was going to happen (n=203)		
Yes	50	24.6
No	152	74.9
Actions taken before disenrollment, if disenrollment was known in advance* (n=237)		
I filled prescription before I was disenrolled	13	5.5
I went to see a health care provider before I was disenrolled	3	1.3
I did not do anything to prepare for being disenrolled	65	27.4
Other	15	6.3

*Respondents were able to select multiple responses

Table 31. Mode of Discovery of Disenrollment & Perceived Reason for Disenrollment

Characteristic	n	percent
Discovery of disenrollment (n=203)		
I received a letter telling me I was disenrolled	156	76.8
I was told when I went to get health care	19	9.4
I was told when I went to get dental care	4	2.0
I was told when I went to get a prescription filled	17	8.4
Other	7	3.4
Perceived reason for disenrollment* (n=237)		
I did not pay premiums/contributions	116	48.9
I made too much money	35	14.8
I did not pay co-pays	16	6.8
I did not return proper paperwork	18	7.6
I do not know	28	11.8
Other	37	15.6

*Respondents were able to select multiple responses

6.2 Disenrolled members do not understand premiums.

Data Source: HBI Disenrollment Survey Report 2018

Only 48% of the respondents reported knowing that they owed a premium while enrolled in IHAWP. Over 90% said there were months they did not pay premiums. When asked why they did not pay 46% indicated that they did not have the money and 38% said they did not know they needed to pay. Only 40% reported knowing that they could claim "financial hardship" if they could not pay.

Just over half (52%) of respondents reported that they were unaware that they owed a monthly premium and 91% indicated that there were months when they did not pay. Top cited reasons for lack of payment included not having the money (44%), not knowing that they needed to pay (35%), forgetting to pay (18%), and not understanding the invoices

or bills that they received (10%). Only 41% of respondents were aware of the financial hardship option for those unable to pay. At the time of the survey, 69% of respondents had not paid their premiums, and of those respondents, 60% were concerned about their debt being sent to collections.

Table 32. Premium Payment – Awareness, Ability to Pay, Reason for Lack of Payment, Awareness of Financial Hardship, Debt Status & Concern About Debt

Characteristic	n	Percent
Awareness of premium owed while on IWP (n=230)		
Yes	110	47.8
No	120	52.2
“Were there months when you did not pay your premiums?” (n=230)		
Yes	209	90.9
No	21	9.1
Reason for not paying monthly premiums* (n=237)		
I did not have the money	105	44.3
I did not know I needed to pay	84	35.4
I forgot to pay	42	17.7
I did not receive invoices or bills telling me to pay	28	11.8
I did not understand the invoices or bills I received	20	8.4
I did not know how to pay or who to pay	13	5.5
Other	34	14.3
Awareness of the “financial hardship” option if unable to pay (n=233)		
Yes	95	40.8
No	138	59.2
Respondent reported that they have paid their premiums to the State of Iowa (n=228)		
Yes	35	15.4
No	158	69.3
I do not owe a debt to the state	35	15.4
Concern over debt being sent to collections (n=165)		
Yes	99	60.0
No	66	40.0
*Respondents were able to select multiple responses		

6.3 Disenrolled members do not understand the HBP.

Data Source: Healthy Behaviors Dis-enrollment Interviews Report 2017

Only seven interviewees reported being aware of the HBI program before they were disenrolled. Only two individuals correctly described both components of the HBI program, the other five were only vaguely familiar with it. More people were familiar with the wellness exam than with the health risk assessment. One respondent described how both behaviors were completed,

“Interviewer: Ok. Um. Are you, or did you get any information about getting a wellness checkup? Subject: I think I did. And I think I did it over, um, I think I did the health assessment online as well. I know I did. Interviewer: Ok. So did you

get the wellness exam as well? Subject: I'm sure I did. I went to [the doctor]. I go to the doctor so much, honey, I don't know." [696]

Respondents reported some knowledge of pieces of the program, for example,

"Interviewer: Ok. Who. How did you know about it? Subject: I got a letter, said if you don't go get your wellness check, you have to pay ridiculous amount of, of somethin', (some) (inaudible)...Yeah, something negative and bad will happen to your coverage, so go get one. I said ok! Well, I did and they said you're perfectly healthy. I said I know!" [597]

Another indicated that the wellness exam did not seem needed,

"I did a health assessment on the computer... I didn't get a checkup. 'Cuz that's, like, ...I didn't wanna go to the doctors 'cuz it gives me anxiety because, like, sick people go to the doctor, and if I'm healthy I don't have to expose myself to sickness. That's why I don't go. (laughing) Unless I'm sick." [639]

A number of individuals learned about the HBI program during the re-enrollment process. Out of the 16 interviewees that successfully re-enrolled, six reported learning about the HBI program after they had been initially disenrolled. A typical situation was described by one respondent, "Interviewer: Ok. So you mentioned that you paid, uh, contributions. Um, were you aware that there's a program through your health plan that will waive your contribution if you get an annual checkup or wellness exam and complete a health risk assessment? Subject: At the point, no. But I do now." [557] Another reported, "Um, I, beforehand I had not (inaudible) anything about it. Um. So I had not gotten any information on that part. Um, after I was appealing it, they explained the whole process that I wouldn't even have to pay the contribution if I did the. Um, those two things." [615]

Twenty-six interview respondents explicitly expressed that they would have liked to participate in the HBI program had they been aware of it. For example, one respondent said, "No, I never heard about it [HBI]. I would've liked that!" [610] Only two individuals indicated that they might not want to participate in the HBI program. One expressed general apathy towards the program, and the other explained that going to the doctor gave her too much anxiety.

Data Source: HBI Disenrollment Survey Report 2018

Survey respondents indicated that they had little knowledge of the Healthy Behaviors Program with only 27% reporting that they had heard about it.

Table 33. Awareness of Healthy Behavior Program

Characteristic	n	percent
Heard about the Healthy Behaviors Program (n=231)		
Yes	63	27.3
No	168	75.7

6.4 Disenrolled members find it difficult to meet their health needs.

Data Source: HBI Disenrollment Survey Report 2018

Without health insurance, disenrolled members reported that they did not seek health care they needed (53%), delayed preventive care (41%), delayed dental care (39%), stopped taking prescription medication (31%), and stretched medication so it would last longer (27%).

Table 34. Gaps in Health Care Coverage & Actions Taken During That Time

Characteristic	n	percent
Respondent experienced any period of time without health insurance (n=234)		
Yes	192	82.1
No	42	17.9
Actions taken while having no health insurance coverage* (n=237)		
I delayed getting prescriptions filled	77	35.5
I tried to stretch my medicine so it would last longer	59	27.1
I stopped taking prescribed medications	69	31.2
I did not seek health care when I needed it	119	52.7
I delayed getting check-ups or other preventative care	91	40.8
I delayed getting dental care	85	38.6
I paid more money for health care, dental care or prescriptions than I would have if I had insurance	47	21.9
*Respondents were able to select multiple responses		

6.5 Disenrolled members are unable to re-enroll due to administrative issues.

Data Source: HBI Disenrollment Interviews Report 2017

From those that were interviewed, almost all described the re-enrollment process as negative.

Re-Enrollment Process

Interview respondents were asked “What has happened since you were disenrolled?” Almost all interviewees described the disenrollment process as a negative experience. Of the 32 interviewees who took immediate action, 27 attempted to re-enroll in the IHAWP and five attempted to enroll in an alternate plan. The remaining two interviewees took no action. Of the two individuals that indicated they had not yet tried to re-enroll in a health insurance plan, one had plans to re-enroll in the IHAWP, and one was not aware that re-enrollment was an option, as indicated here, “Um, I’ve just been goin’ without insurance. Hopin’ I don’t get injured.... Interviewer: Have you tried to get re-enrolled?

Subject: No. I wasn’t aware that I could.” [656]

Many individuals were able to re-enroll online, on the phone, or in person without any difficulty and reported that losing their insurance for a short period had no major impact on them. However, some individuals were denied coverage when they tried to re-enroll, and some individuals described that the disenrollment had affected their health or their ability to receive medical care. On several occasions, respondents attempted to appeal their status but ended up reapplying

instead. Nobody reported successfully appealing their disenrollment. One member explained why appealing was not workable,

“I explained to them what, exactly what happened and. Although they seemed to agree with me that, um, it wasn’t fair with the mail, um, not being consistent and not clear, laid out that, that I definitely had a case but the, uh, final decision was apparently just to disenroll me and help me re-en-, re-enroll.” [615] Another member agreed, “Oh let’s see. (laughing) ...Uh, it was actually a better strategy to withdraw that appeal than it was to appeal. Which. I suppose under some sort of Newtonian law that makes sense, but.” [505]

Of the 32 individuals that reported taking action to obtain health insurance, 16 successfully reenrolled in the IHAWP, seven successfully enrolled in another insurance plan, and nine did not have any form of health insurance at the time of the interview. These three groups of interviewees had distinctive experiences. However, there were a few overarching themes across all three groups.

Did Not Get Insurance

Those that were unable to re-enroll in the IHAWP or unable to enroll in another insurance plan reported more challenges, confusion, and frustration related to the disenrollment process compared to other interviewees who had successfully gained insurance. For example,

“Interviewer: Ok. Have you contacted DHS yet? Subject: Yes, I left a message on my caseworker’s voicemail, at least twice.

Interviewer: And have they gotten back to you? Subject: No.” [503]

Other members reported not knowing what to do or what their options were.

Data Source: HBI Disenrollment Survey Report 2018

According to disenrolled members who responded to the survey, 24% were able to re-enroll in IHAWP. Of those that re-enrolled in any insurance program, over 50% found it very easy or easy.

Table 35. Able to Reenroll & Level of Ease Associated with Reenrollment in IWP

Characteristic	n	Percent
Able to reenroll in IWP (n=225)		
Yes	55	24.4
No	170	75.6
Ease of reenrollment (n=66)		
Very easy	13	19.1
Easy	30	44.1
Difficult	18	26.5
Very difficult	7	10.3

7. What are members' knowledge and perceptions of the HBP?

7.1 Members (WP/MPC) will value incentives offered to complete the healthy behaviors.

Data Source: Enrollee Survey 2017

Respondents overwhelmingly chose to complete a wellness/dental exam and the HRA (90.53%) rather than pay \$10 dollars per month (9.47%) (Figure 21). Respondents who completed each individual behavior reported significantly higher scores for the importance of completing a wellness exam ($t=10.60$, $p<0.001$), a dental exam ($t=14.65$, $p<0.001$), and a health risk assessment ($t=7.19$, $p<0.001$) compared to those who did not complete the behavior (Figure 22).

Figure 21. Respondents' preference for completing a wellness/dental exam and HRA or to paying \$10 per month premium

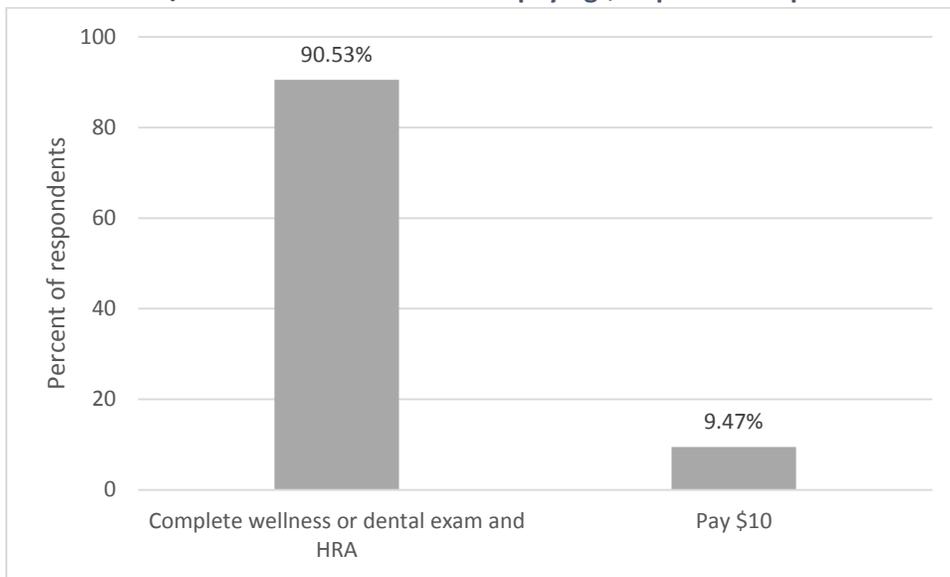
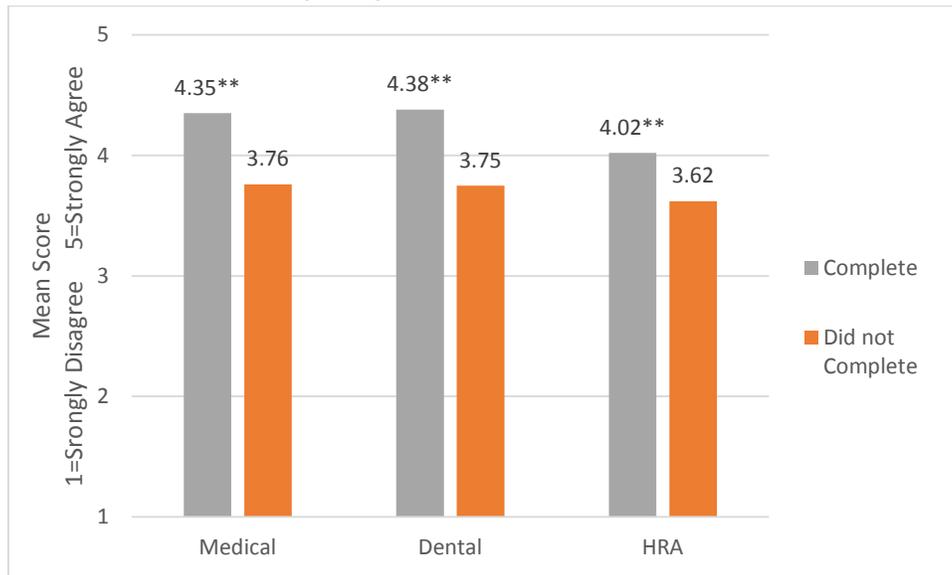


Figure 22. Respondents' perception of the importance of completing each behavior by completion of behavior status

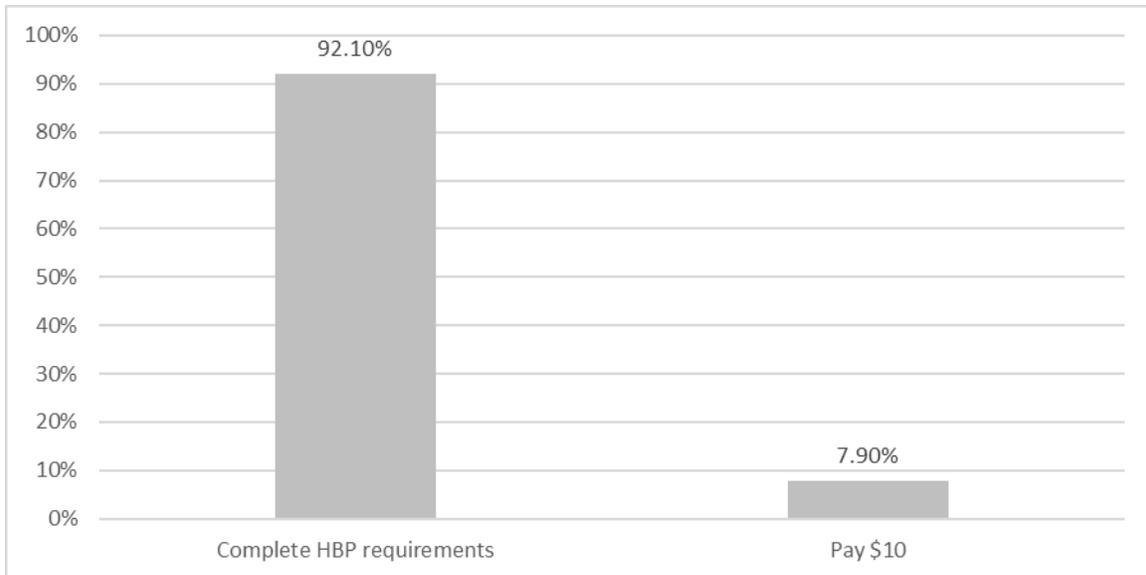


* indicates significant difference at $p < 0.05$
** indicates significant difference at $p < 0.001$

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

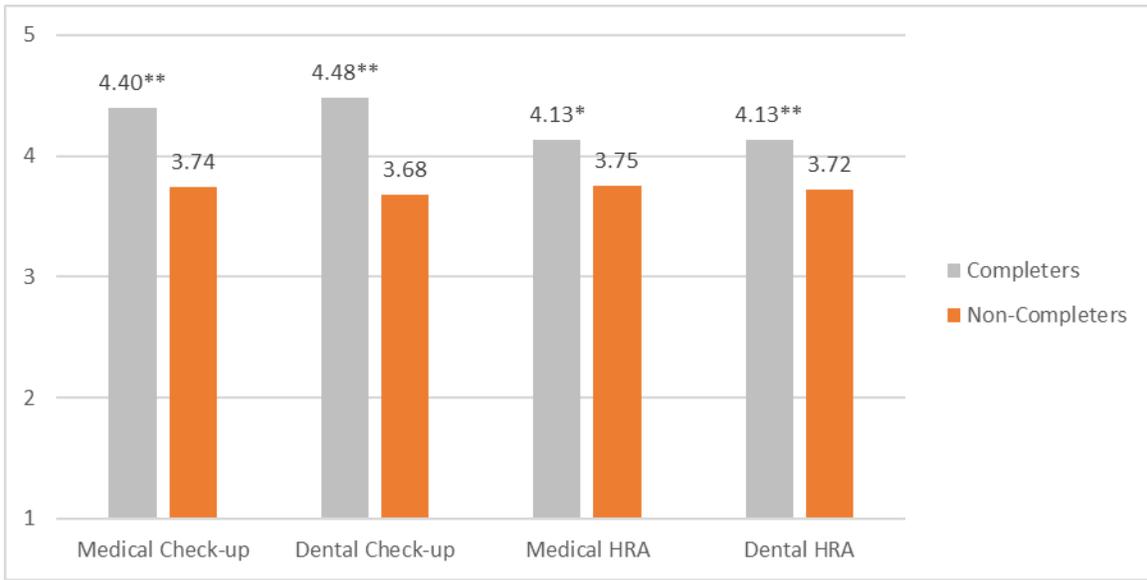
Respondents overwhelmingly chose to complete a wellness/dental exam and the HRA (92%) rather than pay \$10 per month (8%). Respondents who completed each behavior reported significantly higher scores for the importance of completing the behavior than those who did not complete the behavior.

Figure 23. Respondents' preference for completing a wellness/dental exam and HRA or to paying \$10 per month premium



Respondents who completed each individual behavior reported significantly higher scores for the importance of completing a wellness exam ($t=6.47$, $p<0.001$), a dental exam ($t=11.28$, $p<0.001$), a medical health risk assessment ($t=4.29$, $p<0.001$), and an oral health risk assessment ($t=5.17$, $p<0.001$) compared to those who did not complete the behavior (Figure 24).

Figure 24. Respondents' perception of the importance of completing each behavior by completion of behavior status



* indicates significant difference at $p < 0.05$
** indicates significant difference at $p < 0.001$

7.2 Members (WP/MPC) will be most willing to complete behaviors that have lower costs/barriers compared to those with higher benefits and relevance.

Data Source: Enrollee Survey 2017

Respondents to the member survey reported completing a wellness exam (83.49%), a dental exam (60.15%), and an HRA (64.84%), with 62.11% reporting having completed a wellness/dental exam and an HRA. The barriers to completing these behaviors are difficult to quantify as some barriers are more challenging to overcome than others. The most common barrier for not completing a wellness exam was not believing one was needed (27.18%). For dental exams, having dentures or having no or few teeth was the most frequently cited barrier (18.67%). The most frequently cited barrier for completing the HRA was not being aware it was required (42.77%)

Table 36 provides a summary of the barriers to obtaining a wellness exam reported by respondents who reported not completing an exam.

Table 36. Barriers to obtaining a wellness exam*

	n	percent
I don't believe I need a medical check-up	56	27.18
I can't get time off from work	29	14.08
It wasn't a priority, no reason, I just haven't, or I forgot	26	12.62
I was busy	25	12.14
I haven't yet but intend to or it is scheduled	14	6.80
I only go if i need to	13	6.31
It is hard to get an appointment for a medical check-up from my doctor	11	5.34
I am not sure where to go to get a medical check-up	10	4.85
I don't currently have a doctor	7	3.40
Getting transportation to my doctor's office is hard	7	3.40
I don't like getting a medical check-up	5	2.43
I can't get child care	5	2.43
I don't like my current doctor	4	1.94
Issues or confusion with insurance	3	1.46
Not time for an appointment	3	1.46
I didn't know I was supposed to	3	1.46

*Respondents were able to select multiple responses

Table 37 provides a summary of the barriers to obtaining a dental exam reported by respondents who said they did not have a dental exam.

Table 37. Barriers to obtaining a dental exam*

	n	percent
I have dentures, no teeth, or few teeth	84	18.67
I don't believe I need a dental check-up	61	13.56
I am not sure where to go to get a dental check-up	53	11.78
I don't currently have a dentist	49	10.89
I was busy	48	10.67
It's not a priority, no reason, I just haven't, I forgot, or I did not schedule one	48	10.67
I don't like getting a dental check-up	46	10.22
I can't get time off from work	44	9.76
Local provider does not take insurance/no local provider	38	8.44
It is hard to get an appointment for a dental check-up from my dentist	28	6.22
Getting transportation to my dentist's office is hard	22	4.89
I do not believe I have dental insurance/ I did not know until recently	20	4.44
I didn't get a card/other insurance issues	15	3.33
I don't like my current dentist	13	2.89
Financial reasons	10	2.22
I haven't yet but intend to/is scheduled	8	1.78
I can't get child care	5	1.11
I didn't know I was supposed to	4	0.89

*Respondents were able to select multiple responses

Table 38 provides a summary of the barriers to completing a HRA reported by respondents, who reported not completing an HRA.

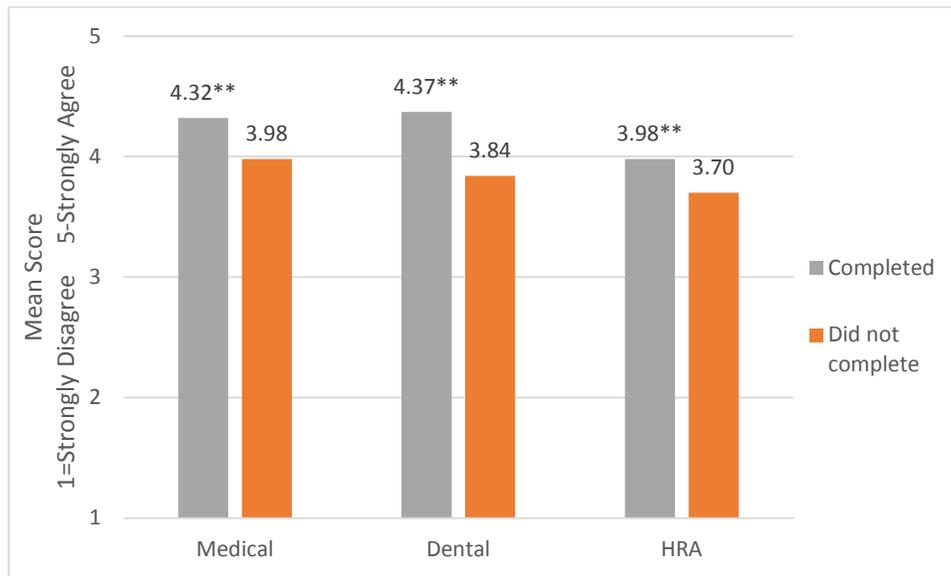
Table 38. Barriers to completing an HRA*

	n	percent
I wasn't aware I was supposed to complete the health risk assessment	142	42.77
I forgot	31	9.34
I did not think it was important	28	8.43
I was busy	25	7.53
It was not a priority, no reasons, or I just haven't	21	6.33
The health risk assessment was too long to complete	11	3.31
I lost the letter	10	3.01
I feel healthy/it is not necessary	10	3.01
I was not provided enough information	7	2.11
I don't like providing information	5	1.51
I do not have internet access	4	1.20
The health risk assessment was about information my health care provider already has	4	1.20
I do not know how to use the internet	3	0.90
I haven't yet but intend to	3	0.90
I didn't know how to use my pin to log in	2	0.60
I'd rather pay	2	0.60
I didn't know how to turn it into the clinic	1	0.30
I don't think I need one	1	0.30

*Respondents were able to select multiple responses

Members who completed each health behavior reported higher benefits compared to those who did not for completing a wellness exam (t=6.67, p<0.001), completing a dental exam (t=13.11, p<0.001), completing a HRA (t=5.10, p<0.001) (Figure 25). Respondents who completed a behavior reported higher benefits compared to those did not complete the behavior. This relationship was true across all three behaviors.

Figure 25. Respondents’ perception of how beneficial wellness exams, dental exams, and HRA are for those who completed the behavior and those who did not complete the behavior



* indicates significant difference at p < 0.05
 ** indicates significant difference at p < 0.001

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

In the most recent survey (2018), members reported completing a wellness exam (85.6%), a dental exam (73.5%), a medical HRA (71.5%), an oral HRA (35.1%), with 67.9% reporting that they completed both a wellness or dental exam and an HRA. The barriers to completing these behaviors are difficulty to quantify as some barriers are more challenging to overcome than others. The most common barrier for not completing a wellness exam was being too busy (35.7%). For a dental exam the most common barrier was having no teeth or dentures (26.8%). The most common barrier to completing a medical HRA was not being aware one was needed (35.1%) and the most common barrier to completing an oral HRA was also not being aware that it was needed (37.5%)

Table 39. Awareness of HBI and Completion of Behaviors

	2018		2017	
	n	percent	n	percent
Awareness of HBI	383	59.8	336	52.4
Complete wellness exam	549	85.6	559	87.2
Complete dental exam	407	63.5	401	62.6
Complete medical HRA	458	71.5	441	68.8
Complete oral HRA	225	35.1	N/A	N/A
Complete wellness or dental exam and HRA	435	67.9	426	66.5

Table 40 provides a summary of the barriers to obtaining a wellness exam reported by respondents who reported not completing an exam.

Table 40. Barriers to obtaining a wellness exam* (n=84)

	n	Percent
I am too busy	30	35.7
I don't believe i need a medical check-up	20	23.8
Intend to soon or appointment scheduled	12	14.3
I can't get time off from work	5	6
Getting transportation to my doctor's office is hard	4	4.8
I am not sure where to go to get a medical check-up	3	3.6
I don't currently have a doctor	3	3.6
It is hard to get an appointment for a medical checkup from my doctor	2	2.4
I don't like my current doctor	1	1.2
I don't like getting a medical check-up	1	1.2
Other	24	28.6
*Respondents were able to select multiple responses		

Table 41 provides a summary of the barriers to obtaining a dental exam reported by respondents who reported not completing a dental exam.

Table 41. Barriers to obtaining a dental exam* (n=231)

	n	percent
No teeth or have dentures	62	26.8
Local providers do not take coverage or no local providers	45	19.5
I am too busy	41	17.7
Don't like going to the dentist	23	10.0
I don't believe i need a dental check-up	19	8.2
I don't currently have a dentist	17	7.4
Getting transportation to my dentist's office is hard	13	5.6
I don't like getting a dental check-up	11	4.8
I am not sure where to go to get a dental check-up	10	4.3
It is hard to get an appointment for a dental check-up from my dentist	10	4.3
Intend to soon or appointment scheduled	10	4.3
I don't like my current dentist	7	3.0
Financial situations	7	3.0
I did not know i had dental insurance	6	2.6
I can't get time off from work	5	2.2
I can't get child care	3	1.3
Other	22	9.5
Don't know/not sure	2	0.9
*Respondents were able to select multiple responses		

Table 42 provides a summary of the barriers to completing a medical HRA reported by respondents who reported not completing a medical HRA.

Table 42. Barriers to completing a medical HRA* (n=111)

	n	percent
I wasn't aware I was supposed to complete the HRA	39	35.1
I am too busy	19	17.1
Don't think I need one	10	9.0
I forgot	10	9.0
I did not think it was important	6	5.4
I do not have internet access	2	1.8
I lost the letter	1	0.9
I didn't know how to use my pin to log in	1	0.9
The HRA was too long to complete	1	0.9
Other	42	37.8
Don't know/not sure	4	3.6
*Respondents were able to select multiple responses		

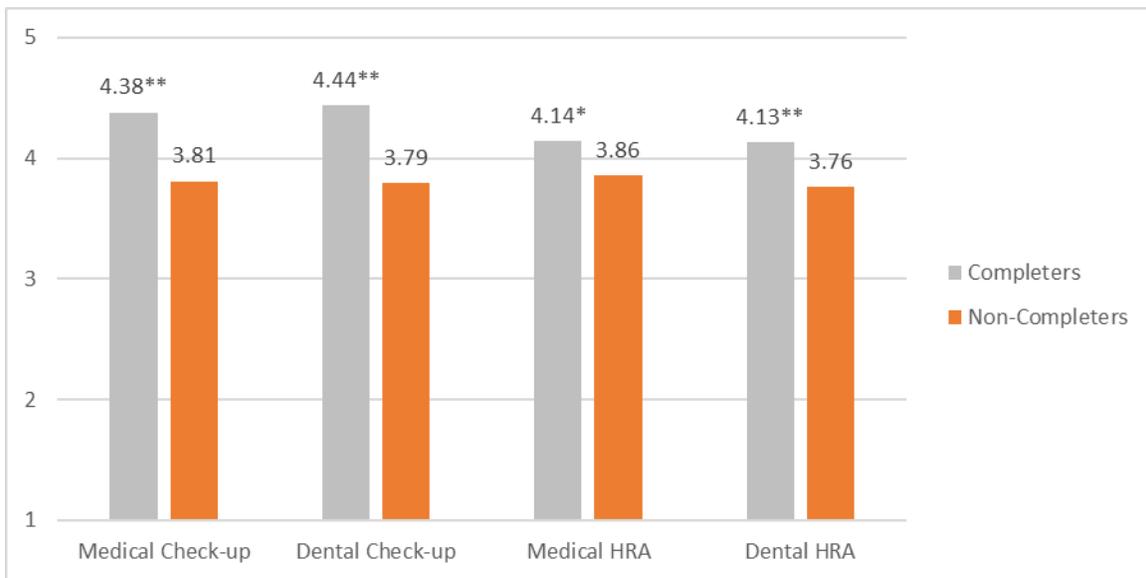
Table 43 provides a summary of the barriers to completing an oral HRA reported by respondents who reported not completing an oral HRA.

Table 43. Barriers to completing an oral HRA* (n=304)

	n	percent
I wasn't aware I was supposed to complete the oral health self-assessment	114	37.5
I haven't been to a dentist	43	14.1
I am too busy	30	9.9
Dentures/ no teeth	28	9.2
Don't think I need one	20	6.6
I don't have a dentist	19	6.3
Never received one	16	5.3
I forgot	15	4.9
I do not have dental coverage	13	4.3
I didn't know how to turn it	10	3.3
I did not think it was important	9	3.0
Dentists don't take insurance	8	2.6
I don't like dentists	6	2.0
I do not have internet access	2	0.7
I do not know how to use the internet	1	0.3
Other	39	12.8
Don't know/not sure	5	1.6
*Respondents were able to select multiple responses		

Respondents who completed each individual behavior reported significantly higher scores for the benefit of completing a wellness exam ($t=7.51, p<0.001$), a dental exam ($t=10.04, p<0.001$), a medical HRA ($t=3.28, p=0.001$), and an oral HRA ($t=4.99, p<0.001$) compared to those who did not complete the behavior (Figure 26). This relationship was true across all four behaviors.

Figure 26. Respondents' perception of how beneficial wellness exams, dental exams, medical HRA, and oral HRA are for those who completed the behavior and those who did not complete the behavior



* indicates significant difference at $p < 0.05$

** indicates significant difference at $p < 0.001$

7.3 Members (WP/MPC) with a greater sense of locus of control will be more willing to participate.

Data Source: Enrollee Survey 2017

There was no significant difference ($t=1.20, p=0.230$) in average scores for locus of control between members who completed the healthy behaviors ($M=8.11, SD=1.96$) and those who did not ($M=7.98, SD=2.13$).

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

There was no significant difference ($t=1.24, p=0.215$) in average scores for locus of control between respondents who completed the healthy behaviors ($M=8.18, SD=1.80$) and those who did not ($M=7.99, SD=1.90$).

7.4 Members (WP/MPC) understand the logistics (for example- payment, payment options, requirements of the program, ...) of the HBP.

Data Source: Enrollee Survey 2017

Only 678 respondents (49.31%) stated that they were aware of the monthly premium that they may have to pay if they did not complete the healthy behaviors. When asked why they did not pay their premium payments, respondents

reported that they did not receive invoices or bills (40.00%), almost 20% reported they did not have the money to pay and just over 25% did not believe they owed premiums.

Table 44. Reasons why respondents did not pay monthly premiums*

	n	percent
I did not know I needed to pay	92	9.34
I did not have the money	194	19.70
I forgot to pay	48	4.87
I did not know how to pay or who to pay	5	0.51
I did not receive invoices or bills telling me to pay	394	40.00
I did not understand the invoices or bills i received	11	1.12
I don't have premiums	263	26.70
I had a hardship waiver	5	0.51
I had issues with the methods to pay	12	1.22
Other	23	2.34
Don't know/not sure	10	1.02
Refused	0	0.00

*Respondents were able to select multiple responses

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

Only 386 respondents (60%) stated that they were aware of the monthly premium that they may have to pay if they did not complete the healthy behaviors. When asked why they did not pay their premium payments, those respondents who had not reported that they did not have the money to pay (48%), had a hardship waiver (16%) or did not receive invoices or bills (15%).

Table 45. Reasons why respondents did not pay monthly premiums* (n=304)

	n	percent
I did not have the money	92	48.4
I had a hardship waiver	30	15.8
I did not receive invoices or bills telling me to pay	29	15.3
I don't have premiums	21	11.1
I did not know I needed to pay	17	8.9
I forgot to pay	12	6.3
I had issues with the methods to pay	11	5.8
I did not know how to pay or who to pay	4	2.1
I did not understand the invoices or bills I received	3	1.6
Other	18	9.5
Don't know/not sure	2	1.1

*Respondents were able to select multiple responses

7.5 Members (WP/MPC) understand the purpose of the HPB and how it is supposed to influence their behavior.

Data Source: Health Behaviors Incentive Program Evaluation, 2016

Interview data from members indicates there was some level of understanding that the wellness exam and HRA could help identify health problems early.

To assess measure 52, interviewees were probed Why do you think your health plan is encouraging people to get check-ups/annual exams? What about health risk assessments? Interviewees enrolled in both Marketplace Choice plans and the Iowa Wellness plan identified preventive care, identifying current and future healthcare issues, general health promotion, encouraging annual checkups, and lowering healthcare costs in the long term as reasons health plans are encouraging individuals to participate the HBI program. Preventative care and lowering healthcare costs were the most common responses among all interviewees.

Quotes from Marketplace Choice members:

- I think it's important to get annual exams. I mean, there's underlying health issues that a lot of people don't realize they have. That need to be addressed. And. So. I think that's very important to have an annual exam. I think it makes 'em think more in depth about their health. And, you know, why they should or shouldn't have health insurance. And, 'cuz they ask, it asks good questions about you and makes ya think about it. [3001]

Quotes from Iowa Wellness Plan members:

- Well, maybe they, it's to head off any problems, you know. Catching things early. And, you know, for your own betterment and. [1079]
- Well I imagine it's because of the increase in illnesses like diabetes and cancer. Now, I don't know if we're seeing it more often or if before people just didn't notice. So I'm guessing that now they want people to be able to detect all of that sooner and to be able to get treatment sooner, to be able to fight it off. [2002]
- Well I think if we stay on top of things, then that keeps health costs down. [3101]
- Just to make sure they're healthy, and that they're not covering things that could be prevented. [4103]
- One, because preventative care, you know, is one, life-saving. It's money-saving. And, you know, people need to be aware and, you know, take (very) care for themselves. [3010]
- To avoid any major problems like, for example the mammogram that prevents your or they do an early (detection) of cancer, so. [3066]

To assess measure 53, Interviewees were asked What do you think the benefits are to getting regular check-ups? and What do you think are the benefits from completing this assessment? Interviewees enrolled in Marketplace Choice stated that participating in the program made them consider health and lifestyle decisions that they may not have previously. Interviewees enrolled in the Wellness Plan also mentioned that participation lead them to consider health and lifestyle decision with some specifically mentioning diet and exercise as examples of area that could be improved. A common sentiment among the responses was that participation raised awareness and stimulated action towards

healthier decision and lifestyle. Many interviewees from both the Marketplace Choice and Iowa Wellness Plan did not comment on any change in their behavior or how enrollment in the program influenced did or could influence their behavior.

Quotes from Marketplace Choice members:

- Just to be healthy and stay healthy...You know, and if they, and then if there's, something is wrong, you know, they're gonna let me know I'm sure and I could rectify the situation. [1016]
- Well, that way I know what's going on with my health. And I can get help from my doctor, you know, if something is wrong...I wanna stay healthy. I don't like being sick, it's just not like me to be sick. I haven't been sick in seven or eight years. [1016]
- Where there's stuff that sometimes you don't think of as a daily basic of your health and stuff so sometimes I think it would be good to learn. Or, to understand other stuff, so. I think it's a benefit and plus if they're willing to pay the premium for the year, that's even better too! [4002]

Quotes from Iowa Wellness Plan members:

- You could use whatever you said was like a way to improve your opinion on your own health and actually take action on that. And actually improve your health (laughing) instead of just thinking about it.[3053]
- Well, some of the benefits is that you really have to get on top of your health. Like if you have a problem with your heart or high blood pressure, it could be your weight, you know. If you have any diabetes and then your, they look for it, you know, the blood glucose. And stuff like that. It's pretty important. [1106]
- Basically, you know, you go in and you talk to your doctors. They tell you what you should and shouldn't be doin', what you should and shouldn't be eatin'...You know, things like that.
- It has. I don't know, it made me stop and think about my lifestyles. (laughing). [1007]

7.6 Members (WP/MPC) do not report difficulties paying premiums related to payment form accepted by IME

Data Source: Enrollee Survey 2017

About one third of respondents, 462, had received an invoice for a monthly premium. Of those respondents, 298 (64.50%) stated that they were able to pay their premium. The majority of respondents, 71.61%, reported months where they did not pay their premiums. See Table 45 for reasons why respondents stated they did not pay the monthly premium. About 50% of respondents reported that they knew they could claim a financial hardship if they were not able to pay the bill and would not have to pay the premium. Survey respondents overwhelmingly did not owe a debt to the states (44.00%) or had paid their premiums (41.75%), but 119 (8.65%) of the respondents stated that they have not yet paid the State of Iowa for the unpaid premiums (Table 46). Of those who had not paid the State of Iowa, 46 (38.02%) stated they are concerned about the debt being sent to collectors (Table 47).

Table 46. Have you paid the State of Iowa for your premiums of \$5 or \$10 a month?

	n	percent
Yes	574	41.75
No	119	8.65
I do not owe a debt to the state	605	44.00
Don't know/not sure	75	5.45
Refused	2	0.15

Table 47. Are you concerned about your debt being sent to collections?

	n	percent
Yes	46	38.02
No	72	59.50
Don't know/not sure	1	0.83
Refused	2	1.65

Data Source: Enrollee follow up survey 2018 of those surveyed in 2017

About two fifths of respondents, 251, had received an invoice for a monthly premium. Of those respondents, 171 (68%) stated that they were able to pay their premium. Approximately a third of respondents, 30%, reported months where they did not pay their premiums. See Table 45 for reasons why respondents stated they did not pay the monthly premium. About 60% of respondents reported that they knew they could claim a financial hardship if they were not able to pay the bill and would not have to pay the premium.