Mindful Medicaid

Using behavioral economics to move the needle on maternal and child health

HAVE YOU EVER sworn off fast food, only to sneak a fry from your kid's plate when she looks the other way? Or realized you still haven't enrolled in that 401k plan even though you promised yourself you would? Sure you have. We all have.

As common as these problems are, they're pretty odd when you think about it. We tend to see ourselves as rational human beings who make decisions consistent with our own self-interests, but these are just two examples of how we make choices each day that are at odds with what we actually want for ourselves.

It turns out that economists can't always predict how even the most rational people will respond to policies or incentives. So how can policymakers design programs to drive desired behaviors?

That might be a job for *behavioral economists*. Behavioral economics goes beyond simple incentive structures and examines the complex psychological, social, and cognitive factors that impact human decision-making. Through an understanding of these factors, behavioral economists develop theories about human behavior, run real-world experiments to validate their hypotheses, and offer solutions.

The use of behavioral economics by government is fairly recent. In 2010, Britain became the first country to create a government unit dedicated to the study and application of behavioral economics. The Behavioural Insights Team (BIT), also known as the Nudge Unit, designs interventions that prompt people to pay their taxes on time or show up for scheduled medical appointments.[1]

Indeed, the field of behavioral economics is ripe with applications for health care, and the Medicaid program in particular. Medicaid accounts for a substantial portion of state budgets and covers vulnerable populations at critical points in their lives. And though Medicaid coverage and services are available at nominal or no cost, getting eligible people to enroll in the program and use cost-effective preventive services can be a challenge.[2] Behavioral economics can offer a low-cost way to decrease program costs while driving better health outcomes—a true "win-win" strategy.

Focus the microscope: Drawing from behavioral science to promote maternal and child health

Collectively, Medicaid programs across the country cover roughly half of all childbirths and 40 percent of children.[3] This makes the program uniquely positioned to promote maternal and child health in the United States. In our article *Mindful Medicaid*, we discuss how pregnant women enrolled in Medicaid are more likely than women with private insurance to delay prenatal care until late in their pregnancy or to skip prenatal care altogether, and how low-income children are less likely than higher-income children to receive complete vaccinations.[4]

To address these disparities, we explore how behavioral economics could be harnessed to move the needle on maternal and child health in Medicaid by focusing on three areas:

1. **Messaging.** Communications that leverage positive peer pressure (or *social proof*, as behavioral economists like to call it) can be effective at getting pregnant women to quit smoking. The Louisiana Department of Health has already caught on to this concept. It has teamed up with the 2Morrow Inc. smoking cessation app, SmartQuit, which regularly sends soon-to-be parents success stories about people who, under similar pressures, were able to quit smoking to achieve their goals. The initial results have suggested that the behavioral-based strategies of SmartQuit are more effective than alternative smoking cessation apps.[5]

2. **Choice architecture.** Behavioral science reveals that people are more likely to stick with a *default*—the result you get if you do not make a choice—than they are to actively make a new, alternative choice. So why not make the default the best option? There is evidence that automatically booking people for vaccination appointments increases vaccination rates. States could auto-book children and expectant moms for vaccine appointments in order to increase vaccination take-up rates.

3. **Program tools.** It might sound simple, but sending out text reminders and having people make formal commitments (to themselves and to others) could go a long way in improving maternal and child health. Findings from behavioral economics show that detailed, personal commitments (or *implementation intentions*) have increased the rate at which unemployment beneficiaries in the United Kingdom have returned to work.

   Another study indicates that making commitments to others (or *social commitments*) were the most effective approach at getting people in Kenya—even those with the most limited financial resources—to save money.[6] Commitment devices and reminders are effective program tools and can be used to nudge expectant mothers to attend prenatal appointments and stay healthy during their pregnancy. They can also encourage parents to bring their babies in for well-baby visits.

Getting started: Bringing these insights back to your state

For program directors and managed care organizations looking to apply these insights to their Medicaid population, we suggest an experimental approach before going to scale (figure 1). No two Medicaid programs are the same, so before designing an intervention, policy makers should consider taking the following steps:

- **Develop a hypothesis** about where your program may be falling short. If you believe it's the message, consider a more socially driven communication.
- **Establish evaluation measures.** Whatever initiative you settle upon, test it. Collect quality data, and rigorously evaluate its effectiveness.
- **Revise accordingly.** Did the test produce positive outcomes? If not, and the problem was with the behavioral nudge itself, think about drawing on other behavioral tools to address this problem.

While behavioral economics is still an emerging field, a rich body of evidence is beginning to develop to inform how people can be nudged to make better choices for themselves. For Medicaid programs that effectively leverage these behavioral principles, the potential payoff is better health outcomes at lower cost.

FIGURE 1

Connecting behavioral concepts to Medicaid opportunities

Area of focus	Behavioral concept	Medicaid opportunities
Messaging	• *Social proof* to motivate behavior and inspire confidence	• Help expectant mothers quit smoking
Choice architecture	• *Smart defaults* to make the path of least resistance the best choice	• Encourage Medicaid enrollment and increase vaccination rates
Program tools	• *Commitment devices* to articulate plans and engender positive reinforcement • *Reminders* embedded in technology to minimize forgetfulness	• May increase likelihood of receiving prenatal care and staying healthy during pregnancy • May increase vaccination rates, prenatal visits, and well-baby visits

Source: Deloitte analysis.

Endnotes

1. Gov.UK, "Behavioral Insights Team," accessed November 20, 2019.
2. Bill J. Wright et al., "Low-cost behavioral nudges increase Medicaid take-up among eligible residents of Oregon," *Health Affairs* 36, no.5 (2017): pp. 838-45, DOI: 10.1377/hlthaff.2016.1325.
3. Vernon K. Smith et al., "Implementing coverage and payment initiatives: Results from a 50-state Medicaid Budget Survey for state fiscal years 2016 and 2017," Kaiser Commission on Medicaid and the Uninsured, October 13, 2016; Kaiser Family Foundation estimates based on the Census Bureau's March 2014, March 2015, and March 2016 Current Population Survey; Kaiser Family Foundation, "State Health Facts: Health insurance coverage of children 0–18," accessed November 2019.
4. Melissa Majerol and Timothy Murphy, *Mindful Medicaid: Nudging expectant mothers and children toward preventive care*, Deloitte University Press, March 9, 2017.
5. Satish Misra, "Evidence based smoking cessation app SmartQuit adopted by State Health Agency," Medpage Today, July 8, 2016.
6. Pascaline Dupas and Jonathan Robinson, "Why don't the poor save more? Evidence from health savings experiments," *American Economic Review* 103, no. 4 (2013): pp. 1138–71.
7. Ibid.

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