

Medicare Advantage Insurers Often Use Rewards, Incentives to Encourage Enrollees to Complete Health Risk Assessments

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But KFF research reports new findings that raise concerns.

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Beginning in 2014, the Centers for Medicare & Medicaid Services (CMS) has permitted Medicare Advantage insurers to offer [Rewards and Incentives Programs](#) to their enrollees to encourage participation in activities that focus on improving health, preventing illness or injury, or promoting the efficient use of health resources.

Two common ways these programs work include offering gift cards, as long as they are not redeemable for cash, or “points” or “tokens” that can then be used to acquire tangible items, such as gift cards or fitness accessories.

Completing a health risk assessment (HRA) is one of the activities for which insurers may provide a reward or incentive. HRAs are used to collect information about enrollees’ characteristics and health status. They may be conducted in the home, at a physician’s office, or via telehealth, and HRAs are also required as a component of an [Annual Wellness Visit](#). As part of their role in ensuring coordination of care, Medicare Advantage plans must make a “best-effort” attempt to conduct an initial health risk assessment of all new enrollees within 90 days of enrollment, as well as annually.

While HRAs may be used to develop a personalized care plan and help with care management, they are also a source of diagnoses codes used to calculate a person’s risk score, and the Medicare Payment Advisory Commission (MedPAC) [has estimated](#) that Medicare Advantage plans received \$15 billion in 2023 as a result of diagnoses captured during HRAs.

Are Medicare Advantage enrollees getting the care they need?

Further, MedPAC and the [Office of the Inspector General \(OIG\)](#) have both found that some diagnoses are only supported by HRAs, meaning enrollees received no related care. [These findings raise concerns](#) that either these diagnoses are inaccurate, or enrollees are not receiving follow-up services for conditions documented in these assessments, while at the same time, boosting payments to plans.

Insurers are required to enter into a contract with CMS to offer Medicare Advantage plans, and each contract may offer multiple Medicare Advantage plans. Many Medicare Advantage requirements and data, such as those pertaining to network adequacy and star ratings measures, are evaluated and reported at the contract rather than the plan level.

Using data submitted by Medicare Advantage insurers to CMS, this analysis examines the share of Medicare Advantage enrollees in contracts (which usually include multiple plans) that offered rewards or incentives for completing HRAs in 2023, as well as differences across Medicare Advantage insurers.

Because these data are at the contract level, KFF does not have data about whether individual plans offered rewards or incentives, though a review of the largest reward and incentive programs suggest these programs are broadly available.

The majority of Medicare Advantage enrollees were in contracts that offered HRA rewards or incentives in 2023.

More than six in ten (62%) or 18.2 million Medicare Advantage enrollees, were in contracts that offered a reward or incentive specifically for completing an HRA to at least some of its enrollees in 2023. These contracts may also include a reward or incentive for an Annual Wellness Visit, which is mandated to include an HRA, or other activities, but specifically include a reward for completing an HRA.

One in five enrollees (20%), or nearly 6 million people, were in contracts that offered rewards and incentives for completing an Annual Wellness Visit, but do not specify rewards for HRAs more broadly.

About one in ten (9% or 2.5 million) were in contracts that offered rewards and incentives for other activities with no mention of HRAs or Annual Wellness Visits.

The remaining 9% of enrollees, or 2.7 million people, were in contracts that did not offer any Rewards and Incentives Programs.

Here's what data constraints actually show.

Due to data constraints, we are unable to determine which individual plans offered rewards within a contract and how many enrollees actually received a reward for completing an HRA. However, for those enrollees that do complete an HRA and receive a reward, there is the potential for insurers to receive a high return on investment for providing that reward. For example, [in a recent report](#), OIG found that for each HRA completed in the home, Medicare Advantage insurers generated \$1,869 on average in estimated risk-adjusted payments.

For those HRAs conducted in a facility – typically as part of Annual Wellness Visit – insurers generated \$365 on average in estimated risk-adjusted payments.

Rewards and Incentives Programs vary by contract.

These programs are often unique to each insurer and may also vary by contract. For example, UnitedHealthcare uses its [HouseCalls](#) program to perform HRAs in the home. It also offers [rewards](#) for completing other eligible-health related activities, such as receiving a flu shot or engaging in certain fitness activities such as biking, jogging, and swimming.

Humana uses its [Go365](#) program to encourage enrollees to participate in health and fitness activities, such as Annual Wellness Visits, preventive screenings, or being active 12 days a month. Once members have earned at least \$10 in rewards, [they can redeem them for gift cards in the Go365 Mall](#) at retailers such as Barnes and Noble, Macy's, PetSmart, and Chipotle, among others.

The current reporting requirements make it impossible to determine how many unique enrollees receive rewards, the amount insurers spend on these rewards, and the specific activities enrollees complete to earn a reward.

Medicare Advantage insurers are required to submit data on rewards and incentives at the contract level rather than that at the plan level to CMS, and CMS does not specify any quality assurance procedures to identify outliers or potentially erroneous entries, as it does for some other data sets, such as [prior authorization determinations](#).

Most data fields are free text, which results in a lack of uniformity in reporting. Frequently, information on multiple rewards is entered on the same line (for example, Annual Wellness Exam, cancer screenings, and HRAs), making it difficult to determine how many individual rewards were distributed, as well as the dollar amount allocated to each reward.

Due to this complexity, it is not possible to calculate the total amount spent by insurers on the Rewards and Incentives Programs generally, nor for specific activities such as HRAs.

This information would be useful to better understand how insurers use their budgets to increase the completion of HRAs and what the potential return on that investment is in the form of higher payments from CMS due to increased coding, as well as the potential to improve the quality of enrollees' care and identify conditions early and prevent them from becoming more costly in the future.
