pansion as a fallback. Second, exchange enrollees may object to being forced to sign up and pay premiums to a "Medicaid" plan, especially since such plans have received mixed performance reviews.[3] But with 73 million enrollees, Medicaid is becoming increasingly mainstream, and health plans in the Medicaid market have figured out how to develop sufficient provider capacity (albeit with relatively narrow networks). Third, health plans will object to the idea that participation in one market (Medicaid) can be conditioned on participation in another, but few plans are likely to withdraw as a result, given that Medicaid is often their primary source of revenue.

The opposition to a proposal of this sort is sure to be fierce, especially in a Republican administration more inclined to eliminate the ACA than to fix it and more interested in block-granting Medicaid than in expanding it. But candidate Trump argued that he would ensure decent coverage for all, and administratively expanding the role of Medicaid managed care may be the easiest way to do so. Moreover, Medicaid managed care plans have the needed administrative infrastructure, provider networks, and experience with the target population to make it work.

I believe President Trump should adopt Medicaid as the fallback option for the exchanges, perhaps emphasizing to Republicans that the coverage would be provided by private firms. Such a plan would make our insurance markets more efficient, more competitive, and more likely to deliver good health care to millions of Americans.

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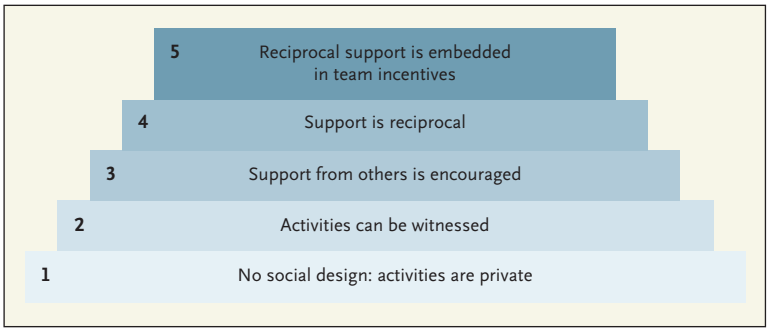
Engineering Social Incentives for Health

David A. Asch, M.D., M.B.A., and Roy Rosin, M.B.A.

Who is more likely to be around when patients are deciding what to eat or whether to watch TV or take a walk — a doctor or a spouse? A nurse-navigator or a friend? Convention has organized the process of health care into interactions between a clinician and a patient. But even patients with chronic illness may spend only a few hours a year with a physician, as compared with the thousands of waking hours when so much of what determines their health occurs out of clinicians' reach. Some strategies for engaging patients during the course of their daily lives, such as remote monitoring, still rely on busy clinicians, whose time is expensive. Other approaches rely on community health workers whose services cost less and who often reside in the same neighborhoods as the patients they serve. Largely untapped are ways of organizing existing, cost-free social interactions with friends and relatives who are already embedded in patients' lives.

Existing social relationships have the additional advantage of being highly influential. You might be more likely to go to a gym if your friend also goes — and even more likely if you go together. A couple who lost a combined 500 lb (227 kg) needed to find new friends to dine with because socializing with their old friends revolved around unhealthy eating. People are strongly influenced by what others do and by what others think of them, which means that our behavior can change or affect others' behavior when it's made visible. The notion that health-related behavior deserves extra privacy may explain why social-engagement strategies are uncommon. But because of the high cost and potential lost opportunities involved in keeping organized health care between clinicians and patients, we believe it's important to engineer social engagements that promote health and to test their acceptability and effectiveness.

We envision a ladder of such



Escalating Rungs of Social Support.

strategies (see diagram). On the bottom rung, patients have no explicit social engagement. Your bottle of antihypertensive medication is in your bathroom. You hope to make taking your medicine part of your routine, along with brushing your teeth. No one sees you take your medication — not because it's a secret but because typically no one sees you brush your teeth either. Many of our health-related activities fall into this category of being private by default, not by necessity. Sometimes these activities are hidden even from ourselves: without a pedometer we have little sense of how many steps we take, just as without a scale we may have little sense of our progress on a diet.

On the second rung, patients' activities, outcomes, or goals are visible to others. You move your pill bottles from the bathroom to the kitchen, where you're more likely to be witnessed taking (or not taking) your medication, much as some restaurants have moved the sink out of the bathroom to a visible place in order to promote hand washing. Or a wireless electronic pill bottle tracks and broadcasts your medication adherence in a way your spouse or friend can observe. Missing a dose is now public, which makes you more conscious of your behavior and permits interventions that support adherence. In an ongoing trial, we're testing whether witnessed adherence as a supplement to individual encouragement improves medication adherence after a heart attack.[1]

Interventions on this rung also support behavior propagation, because people naturally model themselves after others — but they can do so only if others' behavior is visible. Growing a mustache for "Movember" turns a normally private action — providing charitable support for men's health issues — into a public statement that can be copied. Since the beginning of the movement, more than 5 million participants have collectively raised more than half a billion dollars. Similarly, in a recent clinical trial, physicians who received e-mails comparing their antibiotic-prescribing habits with those of their high-performing colleagues reduced their inappropriate prescribing, whereas a more traditional strategy for promoting behavior change — suggesting alternatives to antibiotics — had no effect.[2]

On the third rung, external support is explicitly established. You ask your partner to keep cookies out of the house or to sign up to receive text messages encouraging compliance with your perioperative activities to improve surgical outcomes. An intervention involving peer mentors — as simple as a weekly phone call between a patient struggling to control his or her blood sugar and a mentor who has already succeeded in doing so — led to a 1.08-percentage-point decline, on average, in glycated hemoglobin levels over 6 months, an effect superior to what's been accomplished with financial incentives and billion-dollar blockbuster drugs.[3]

Interventions on the fourth rung leverage reciprocity. You establish a weight-loss pact or gym regimen with a friend. You each feel committed to your own and the other person's goals, determined to not let your friend down. In a randomized trial, patients with diabetes who were asked to talk on the phone weekly with age-matched peers — a technique known as reciprocal mentorship — had a 6-month decline in glycated hemoglobin levels that was 0.58-percentage-point greater than the change observed in patients receiving more typical nurse-led case management.[4]

On the fifth rung, reputational or economic incentives are layered on top of social commitments. Leaderboards and competitions explicitly place individual achievement in a social context, but team-based designs increase social accountability as team members collaborate to compete and depend on each other to succeed as a group. In a recent 13-week randomized trial, employees who received financial incentives for reaching individual and team goals were twice as likely to achieve a physical-activity goal as those who received feedback on only their own progress.[5] In pilot programs, we have found even

stronger effects when team members know each other beforehand, feel accountable to each other, and can interact to influence their teammates' behavior.

This model reveals opportunities to advance health by taking advantage of naturally occurring social forces. We don't normally think of competition or collaboration among patients as part of managing chronic diseases such as hypertension, heart failure, or diabetes, but why not? After all, teams of physicians often compete, sometimes explicitly, to improve performance ratings. Social interactions and competitions can also harness elements of surprise and fun. Yet health care organizations rarely consider the power of social ties to help patients and hardly ever think about fun ways to engage them.

We know that patients care about privacy. A formidable regulatory enterprise aims to keep health-related information private because privacy can be critically important. But often it isn't. Although only a fraction of patients with serious illnesses blog about their journey, many share their experiences with friends and family. In that sense, social engagement in health care isn't new, and leveraging social designs needn't be seen as out of bounds.

An audio interview with Dr. Asch is available at NEJM.org

What is new is a better understanding of how health care organizations can use social engagement strategically to further advance health. If hospitals, insurers, disease-specific advocacy organizations, or other institutions sponsored adherence contests or created platforms for peer-support networks, voluntary opt-in designs could leave alone people who don't want to be involved while good security practices could satisfy those who do. Such approaches have the additional advantage of using what are essentially free extenders of care.

Health care organizations, newly focused on population outcomes, can develop and test social interventions for advancing health. Given the increasing evidence that behavior is contagious, there's good reason to believe that such models could work. You are more likely to smoke if people close to you smoke — and more likely to quit if they quit. Yet most health care interventions are designed for the individual. For some time, doctors have recognized that some patients' social connections have a beneficial effect on their health. Now, doctors and hospitals can develop new approaches to prescribe social engagement for everyone else.

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Supporting Family Caregivers of Older Americans

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Every day, millions of older Americans (those 65 years of age or older) manage basic health and functioning needs with the help of family caregivers. These family caregivers (defined as relatives, partners, friends, or neighbors who provide help because of a personal relationship rather than financial compensation) may arrange and attend medical appointments, participate in routine and high-stakes treatment decisions, coordinate care and services, help with daily tasks such as dressing and bathing, manage medicines, obtain and oversee the use of medical equipment, handle bills and banking, and ensure that older adults' needs for food and shelter are met. The availability and adequacy of support provided by family caregivers has important consequences for older