FINANCIAL INCENTIVES TO ENCOURAGE HEALTHY BEHAVIORS

A joint issue brief from the American Cancer Society Cancer Action Network, the American Diabetes Association, and the American Heart Association

Issue

Healthy behaviors and lifestyles have great potential to help individuals avoid illness and prevent or exacerbate serious and expensive chronic conditions including heart disease, cancer, stroke and diabetes. Decades of clinical research have produced evidence-based interventions that can improve healthy behaviors related to smoking, diet, exercise, and weight control, resulting in better management of high blood pressure and cholesterol, diabetes and reduced risk factors for some cancers. Translation of this scientific knowledge into policy and practice remains challenging but critical, as chronic disease continues to place a significant burden on the nation.

Policy makers are exploring incentives that may encourage behaviors that promote health, reduce disease, and reduce corresponding health care costs. Among the options under consideration is an expanded use of financial incentives to encourage healthy behaviors, which can include providing discounts on health insurance premiums or deductibles.

Policy Statement

The American Heart Association, American Cancer, Society, and American Diabetes Association support comprehensive wellness programs in the workplace. However, all three groups believe that financial incentives used to motivate behavior should not be tied to premiums, deductibles or other coinsurance paid by employers. The evidence that insurance based incentives change behavior is lacking, and the risk that these plans could be used to discriminate against persons who are less healthy than their counterparts is not insignificant. Health care reform should not replace the practice of charging higher premiums for individuals who smoke, are overweight, or suffer from high blood pressure, with plans that charge lower premiums for people who don't smoke, are not overweight, or who have normal blood pressure. Many individuals with chronic conditions will find it difficult to meet the standards set by wellness plans and could end up paying higher premiums in the individual and small group markets – just as they do now. Furthermore, the individual's right to privacy about their personal health status in the workplace can be compromised by these programs.

The current regulatory environment gives employers some latitude to offer wellness incentives through premium adjustments as long as the incentive programs meet certain criteria. To date, there is no evidence in peer reviewed journals that suggests these programs have altered behavior and there is at least one set of plans on the market that is using this new flexibility to attract healthier populations. Attempts to use financial incentives to encourage wellness should be

closely regulated to make certain that they are not discriminatory. These programs should also include evaluations to assess the impact on disparate populations and include an analysis of desired outcomes and unintended consequences. These findings can be used to support future program designs and public policy decision-making.

The most significant barrier that employees note for not engaging in healthy lifestyle behaviors are lack of time to exercise before, during, and after work; and lack of convenience and location of programs, screenings and exercise facilities.[1] Based on evidence to date, reducing these barriers by offering health promotion services such as smoking cessation programs, fitness centers, weight loss programs and exercise classes on-site, and offering healthy vending and food choices throughout the workplace environment will be more effective in improving employee health – and reducing employer health care costs – than applying financial incentives through their employer sponsored insurance plan. Financial incentives offered directly to the employee and paired with these measures, may also be effective. Some employers offer incentives for people who quit smoking or lose weight, often in the form of nominal cash awards or gift certificates. Numerous options are available to employers that are not tied to the employee's costs for health insurance. Based on the evidence to date regarding the impact of financial incentives on behavior, we believe the potential to discriminate against persons with chronic conditions – like heart disease, cancer, and diabetes – far outweigh any potential benefits to improving wellness.

Background

The incidence of chronic disease and the resulting financial costs have led some major health care purchasers to experiment with premium reductions to encourage healthy behaviors. These programs have been allowed through regulatory action by the Departments of Labor, Treasury and Health and Human Services (HHS).[2]

The Health Insurance Portability and Accountability Act's (HIPAA) nondiscrimination provisions generally prohibit a group health plan from charging similarly situated individuals different premiums based on a health factor. However, Congress added language stating that HIPAA "does not prevent a group health plan from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention."[1] Subsequent regulation delineated between "participation only" programs that have no requirements of results and those programs that require an employee to achieve a certain standard.[3] "Participation only" programs do not have to meet additional requirements, however programs that are "standard-based" have to meet five additional benchmarks:[1]

- The reward for the wellness program must not exceed 20 percent of the cost of employee only coverage under the plan;
- The program must be reasonably designed to promote health or prevent disease;
- The program must give individuals the opportunity to qualify for the reward under the program at least once per year;
- The reward must be available to all individuals, and a reasonable alternative standard for obtaining the reward has to be available to any individual for whom it is unreasonably

difficult to satisfy the standard due to a medical condition, or for whom it is medically inadvisable to attempt to satisfy the standard; and
- The plan must disclose in materials describing the program the availability of a reasonable alternative standard.

The final rules for the multi-agency regulatory action include several examples of employer based wellness programs that use financial incentives. However, the development of plans such as "Benecomp Wellness products", which provide lower deductibles for individuals who have few or no risk factors for chronic disease, suggest that enforcement may be lax.

In addition to meeting the HIPPA conditions described in the regulatory action above, incentive based wellness programs must also comply with the federal Americans with Disabilities Act (ADA) and any state laws that address lifestyle discrimination such as the Colorado Anti-Discrimination Act and its Lifestyle Statute. The ADA regulations are administered by the U.S. Equal Employment Opportunity Commission (EEOC) that covers all civil rights and disability legislation affecting employment.[2] The EEOC has expressed concern about incentives and other components of worksite wellness programs, including: completion of an annual mandatory Health Risk Assessment (HRA), the use of monetary incentives connected to program participation or wellness activities, mandatory medical exams or testing, employers making inquiries about obesity, heart disease, diabetes, or other "disabilities," "triggers" for refusal to participate in disease management or behavior change programs, and employer inquiries concerning prescription drug use.[2] At this point, the EEOC has not issued formal opinions on these issues. So employers who choose to develop programming that would violate these initial rulings are taking the risk that EEOC will not aggressively prosecute or impose fines.

One example of a program taking this kind of risk is in Rhode Island where the state worked with insurance carriers to offer small businesses the Healthpact Rhode Island insurance product, where premiums are tied to healthy lifestyles. Currently offered through BlueCross BlueShield and United Healthcare, Healthpact Rhode Island products have premiums that are about 15 to 20 percent lower than comparable plans, but these products are only available if all employees agree to abide by five preventive healthy behaviors, including: (1) completing a health risk assessment; (2) selecting a primary care physician; (3) pledging to remain at a healthy weight or to participate in weight management programs if morbidly obese; (4) pledging to remain smoke free or to participate in smoking-cessation programs; and (5) pledging to participate in disease management programs, if applicable. It's unclear if this program has resulted in firms declining to hire individuals who don't already fit those categories; or if employees seek coverage through a spouse or refuse coverage because of the criteria set by their small business.

This experimentation is also occurring in the large group insurance market where some employers have adopted "reward programs" that offer lower health insurance premiums to employees who do not smoke or to those who participate in smoking cessation programs and confirm through testing that they are abstinent.[4] Of course, lower premiums for individuals who do not smoke operate as penalties for those who do.

Policy Considerations

Several policy issues should be considered when evaluating health insurance premium adjustments to promote healthy behaviors.

1) Differentiating benefits (e.g. cost-sharing based on modifying premiums, reducing deductibles, or offering credits) based on health status and risk profiles in employer-sponsored health insurance have real potential for unintended consequences;
   - Premium surcharges or other cost-sharing measures can make coverage less affordable. People who can't afford coverage may have reduced access to therapies and interventions that can help curb unhealthy behaviors (e.g. prescription cessation medication, medically supervised weight loss programs, medications to control cholesterol and blood pressure, etc.)
   - Premium surcharges or other cost-sharing measures are a blunt instrument. When policies cover a family or employer group, the surcharge penalizes everybody
   - Tying financial incentives to lifestyle choices can lead to a slippery slope. Lifestyle adjustments can be used as a proxy for discrimination based on health status that would otherwise be disallowed. In the future, what other lifestyle choices might be penalized?

2) A number of the wellness program require an individual and in some cases family members to complete a health risk assessment or be interviewed by a 'health coach" employed by the health insurer or a third party health wellness company. The information requested in these transactions is frequently personal health information that is only known to the employee or family member. Many employees understandably prefer to keep this type of information private out of concern that they may be treated differently in the work place, including potentially being deprived of promotions or other opportunities for advancement if their health issues are known by their employer. Most large and a number of small and medium sized employers self-insure their health benefits under the ERISA Exemption. As a result, these employer owns all the health data collect by their insurer or third party administrator on their behalf. The AHA, ACS, and ADA are concerned that there are insufficient safeguards to ensure and protect an individual' right to privacy within these mechanisms to establish financial incentives to encourage healthy behaviors in an employment settings.

3) Studies of the use of financial incentives to foster long-term behavior change are inconclusive. Some studies have shown success in the use of financial incentives to foster long-term behavior change, like quitting smoking or losing weight, especially if the financial incentives are large enough.[5,6,7] Other studies have not found incentives to be effective,. However, these studies are often limited by small numbers of participants, lack of longitudinal data, and/or small awards.[8] In addition, non of the studies cited involved incentives that were delivered through premium adjustments in employee sponsored health care programs.

4) Traditionally, incentives have been directed toward providers of health care services through Pay-for-Performance programs. There is a growing consensus that incentives should be provided directly to the individual who is engaging in the behavior change.[5,9] Further research is required to determine the true efficacy of incentive rewards within workplace wellness programs and whether they promote robust, long-term behavior change, whether

incentives should be linked to behavior outcome, and whether positive or negative incentives are most effective.

5) Health insurance premium adjustments offer a means for abuse (segmenting of risk) unless regulated appropriately;

   - "Healthy lifestyle" premium ratings can lead to segmentation of the insurance pool, which makes health insurance most costly for those who are less healthy. Risk spreading evens out the cost of health insurance, using revenue collected from premiums paid by people when they are healthy to pay the claims of people when they are sick. In so doing, risk spreading makes the cost of coverage more predictable for everyone and makes medical bills more affordable for people when they are sick. However, there are powerful financial incentives for insurers to segregate risks rather than spread them, when permitted by state law, so they can refuse to sell coverage to those with high expected costs, charge them higher premiums, or permanently exclude coverage for their pre-existing health conditions. These behaviors are observed in most private non-group health insurance markets today.[10]
   - Health insurance is intended as a means of providing access to health care when a person's health is threatened. The cause of the health problem is not intended to be a determinant of the level of benefits. By introducing the cause of the health problem as a factor in coverage, more administrative complexity and disputes are likely to result. For example, what are the criteria for adjustment, who enforces such rules, and how are disputes resolved?.
   - "Healthy lifestyle" premium ratings could adversely impact the population which would benefit most from prevention services and could increase health disparities (particularly with regard to obesity where prevalence is higher among minority women.)

6) Using health insurance premiums as incentives is really only possible with large employers, meaning that this benefit is not universally available to all employees. It is difficult for small employers to offer health insurance premium adjustments because their health insurance premiums are typically "community rated." This means their premiums are set by the medical utilization experience of their community. Large employers are "experience rated," which means premiums are based on the company's own medical utilization. Therefore, small employers who are successful in reducing medical care costs by improving the health of their employees will still pay the same medical premiums to their insurance company, eliminating an important financial incentive to develop a health promotion program in these small companies.[11]I

[1] Kruger J, Yore MM, Bauer DR, Kohl HW. Selected barriers and incentives for worksite health promotion services and policies. Am J Health Promot. 2007;21(5):439-447.
[2] 1 26 CFR Part 54; 29 CFR Part 2590; 45 CFR Part 146.
[3] Chapman LS. Regulatory and tax issues for worksite wellness programs. Am J Health Promot. 2007;21(5):suppl 1-11.
[4] Volpp KG. Paying people to lose weight and stop smoking. LDI Issue Brief. 2009;14(3):1-4.
[5] Volpp KG, Troxel AB, Pauly MV, Glick HA, Puig A, Asch DA, Galvin R, Zhu J, Wan F, DeGuzman J, Corbett E, Weiner J, Audrain-McGovern J. A randomized, controlled trial of financial incentives for smoking cessation. N Engl J Med. 2009;360(7):699-709.
[6] Volpp KG, Pauly MV, Loewenstein G, Bangsberg D. P4P4P: an agenda for research on pay-for-performance for patients. Health Aff (Millwood). 2009;28(1):206-214.
[7] Finkelstein EA, Linnan LA, Tate DF, Birken BE. A pilot study testing the effect of different levels of financial incentives on weight loss among overweight employees. J Occup Environ Med. 2007;49(9):981-989.
[8] Hey K, Perera R. Competitions and incentives for smoking cessation. Cochrane Database Syst Rev. 2005(2):CD004307.
[9] Loewenstein G, Brennan T, Volpp KG. Asymmetric paternalism to improve health behaviors. JAMA. 2007;298(20):2415-2417.
[10] Blumberg LJ. Pollitz K. Health insurance exchanges: organizing health insurance marketplaces to promote health reform goals. April 2009. Available online at http://www.urban.org/UploadedPDF/411875_health_insurance_marketplaces.pdf.
[11] O'Donnell MP. The rationale for federal policy to stimulate workplace health promotion programs. N C Med J. 2006;67(6):455-457.