Current trends in the use of incentives for employee wellness ........................... 3
Effectiveness of incentives for health assessment participation .......................... 3
Effectiveness of incentives for participation in wellness programs ...................... 4
Effectiveness of incentives for achievement of health risk improvement .......... 5
A review of rules and regulations in the use of financial incentives .................... 6
Additional resources ............................................................................................ 8
Conclusion ............................................................................................................ 9
References ............................................................................................................ 10

CONNECT WITH US

staywell.com
1.800.373.3577
engage@staywell.com

© 2014 The StayWell Company, LLC
Financial incentives in population health management

This update on the use of financial incentives in health promotion programs provides StayWell clients with information on the most current research, new developments, and resources for decision-making.

Here we offer summaries of current industry trends around use of incentives, as well as a summary of the advantages, disadvantages, and effectiveness of using incentives to promote participation in health assessments (HAs), participation in wellness programs, and achievement of health outcomes.

In addition, we provide a brief review of federal rules and regulations pertaining to the use of financial incentives.

Current trends in the use of incentives for employee wellness

Results from several national surveys indicate a continuing increase in the use of financial incentives to encourage participation in wellness programs. A survey by the National Business Group on Health (NBGH) found that 74 percent of employers reported that they currently offered incentives, compared to 57 percent in 2009. Nearly all of the employers who responded in both 2013 and 2014 will continue to offer incentives. Moreover, the dollar amount offered continues to increase from an average of $430 per employee in 2010 to $594 per employee in 2014 which is a 38 percent increase. Spending on wellness incentives for employees’ spouses/domestic partners is likely to increase this year as well, with employers planning to spend an average of $530 on incentives per member, compared with $465 per member in 2013. Additionally, 57 percent of employers said they plan to expand their wellness incentive strategies over the next three to five years, while 36 percent said they intend to maintain their current level of incentive spending.

Interest in outcomes-based incentives continues to grow as well with 42 percent of employers who offer incentives tying those incentives to health outcomes. Employers that are using outcomes-based designs tend to expect more from their employees; however, they also generally invest more with an average of $764 per employee versus $594.

There is still a preference toward rewards rather than penalties or disincentives with one exception being tobacco where employers seem more comfortable with administering a penalty. Incentives related to premiums/benefits are still the most common; however, health account contributions are becoming more popular. A survey of large employers by NBGH found that 61 percent of respondents believe consumer driven health plans to be one of the three most effective methods for controlling costs and thus see contributions into these accounts as common vehicles for wellness incentives.

According to a 2013 survey by Towers Watson, companies are recognizing that engagement is not all about financial incentives. A supportive workplace culture is important to engage employees in their own well-being. In fact, seven of ten respondents indicate a top wellness priority as developing cultures where employees are responsible for their health. The practice of using financial incentive and penalties will continue to be a method to hold individuals more accountable.

Effectiveness of incentives for health assessment participation

Research by StayWell and others has demonstrated that financial incentives are effective in increasing rates of simple behaviors like completing an HA or other one-time events that do not require sustained motivation (e.g., a biometric screening event). A 2008 study by StayWell demonstrated a positive relationship between the size of an incentive and HA participation rates. In addition, Nyce and colleagues showed that HA or biometric screening participation rates increased by about 11 percentage points for each $100 increase
in financial incentives. The 2013 RAND report on workplace wellness programs similarly suggested that every $10 increase in HA incentive value is associated with a participation rate of 1.6 percentage points higher.

Further StayWell research demonstrated that, while financial incentives for HA completion are effective, a supportive culture and strong communication greatly increase their effectiveness. A similar study demonstrated that to achieve a 50 percent HA participation rate, employers with low levels of organizational commitment or weak communication would need an incentive value of approximately $120 compared to only $40 to achieve this rate of participation with strong commitment and communication.

In addition, some studies have shown that use of behavioral economics principles may increase the cost-effectiveness of incentives for HA completion. However, evidence on using financial incentives as rewards for behavior change is equivocal. Motivation theory indicates, and some studies demonstrate, that financial incentives may decrease the intrinsic motivation that is required for sustained behavior change.

Essentially, financial incentives can buy compliance, but this may come at the expense of true engagement. For this reason, incentives alone are not likely to be a practical approach to health behavior change because the cost of buying daily compliance with externally imposed health standards may be prohibitive.

StayWell recommends that incentives always be applied within the context of the communication, climate, and culture of an organization. For a detailed review of the literature on the use of incentives, along with case studies and recommendations, download StayWell’s incentives white paper.

Summary of advantages: Offering incentives for completion of simple behaviors such as HA completion is effective, particularly when accompanied by a strong culture and communication.

Summary of disadvantages: Offering incentives for an HA will not inspire long-term behavior change.

Effectiveness of incentives for participation in wellness programs

Research by StayWell and others offers considerable insight into the pros and cons of “participation-based” incentives, and we have quantified their effects in a best-practice approach to program design.

On the “pro” side, it is clear that incentives can drive significantly greater participation in wellness programs, particularly when they are supported by effective communication and a strong culture of health. It is less clear exactly what type of incentive will work best to increase participation within any given population. A study from StayWell shows that similar incentives can have very different effects depending on the age, gender, and risk make up of a group of employees.

A major con of participation-based incentives becomes figuring out whether any increased participation in wellness programs yields improvements in population health or primarily represents compliance with incentive rules. A study of 87 employer groups showed that incentives paired with a wide variety of communication strategies produced the greatest participation levels. Larger incentives led to higher participation, but communication strategies such as frequently repeated or reminder emails and health fairs “played a significant role” in both program participation and completion.

StayWell researchers have examined the association between incentives, engagement in behavior change programs and outcomes. Researchers assessed results from 24 companies using incentives for completion of a health coaching program and found that offering an incentive was associated with higher completion rates, but slightly lower risk reduction among participants. Because incentives did not improve outcomes, incentives in this study were not a cost-effective investment for those companies.

Long-term change and risk reduction require helping participants achieve and maintain a high level of motivation to change unhealthy behaviors. Research has shown that, to be successful, changing a problem behavior needs to be one of the most important priorities in an individual’s life for an extended period of time. Studies also demonstrate how environmental triggers that make healthy choices the easier choices
are a vital component for sustainable success. It is common for individuals to take six months to a year to establish new habits, and this daily attention to a healthier lifestyle usually needs to be reinforced by an environment full of healthy cues to action.

Summary of advantages: Offering incentives for participation in wellness programs such as participation in health coaching can be effective, particularly when the value of the incentive is not so large that motivation to participate becomes largely extrinsic rather than intrinsic.

Summary of disadvantages: Offering incentives for participation in wellness programs will not necessarily lead to sustained behavior change. In fact, research demonstrates reliance on incentives alone may diminish the intrinsic motivation needed for sustained behavior change.

Effectiveness of incentives for achievement of health risk improvement

Many employers view the current and more common use of participation-based incentives as too easily exploited and insufficient to break intractable health habits, while many public health and medical professional societies have argued that incentives should be confined to participation only and have focused on the cons of outcomes-based incentives.

Research suggests that incentives can have short-term impact, but whether behavior change resulting from use of incentives can be sustained long term is less clear. Among the conclusions in the 2013 RAND report was that incentives were associated with small improvements in weight, smoking, and exercise, but that these improvements were not clinically meaningful. Several randomized trials of different incentive structures have demonstrated that properly designed incentives are effective in the short term (6-9 months) at improving outcomes such as smoking cessation and weight loss (compared to the success of a group without incentives) but longer-term results were inconclusive and required further investigation. Other outcomes may or may not be similarly influenced by incentives. Additional research is needed to determine which health behaviors are or are not influenced by incentives, as well as the direction and duration of any influence. It will be especially important for future research to understand what happens if and when an incentive is taken away.

Another worksite-based trial of weight loss incentives suggested that incorporating some principles of behavioral economics helped improve outcomes for people who stayed in the program, but keeping people in the program was a challenge. In fact, the people who lost less weight were more likely to drop out of the study, suggesting that the outcomes-based incentive was least helpful to those who needed the most help.

StayWell supports addressing this issue with a “progress-based” incentive model that we believe can increase employee accountability and engagement while preserving fairness and equity in the use of incentives. Our article, “Finding common ground in the use of financial incentives,” is available free online. We describe the pros and cons of each approach and recommend a “progress-based” incentive strategy that is a participant-centered, risk-adjusted and safe approach to achieving population health goals.

In a progress-based model, the goal is to offer participants who fail to satisfy the health standard an opportunity to earn incentives regardless of how far they are from the recommended health standard as they begin their journey. Options in this model can be the attainment of a reasonable health goal, such as losing 10 percent of body weight, the use of an appeal if the participant is actively working with his or her physician, and participation in other wellness programs to earn the incentive and make strides toward healthy changes.

Summary of advantages: Offering incentives for health outcomes—such as achievement of a healthy body mass index—may result in short-term behavior change, and may be perceived as a reward for objectively measured health status, but when the financial incentive is removed, behavior change and maintenance of the healthy outcome may relapse to pre-incentive levels.

Summary of disadvantages: Offering incentives for health outcomes has not been demonstrated to result in long-term behavior change, and provision of financial incentives may not be sustainable for companies over the long term. Moreover, this strategy may alienate the highest risk individuals who would likely benefit most from health improvement activities. Use of a progress-based model can help overcome these issues.
Annual Update: Financial incentives in population health management

by providing an achievable alternative for individuals across the health continuum and may be viewed more positively by individuals for whom the ideal goal is not deemed achievable. Companies that invest in outcomes-based incentives should invest in building an organizational culture of health and strategies to increase and sustain intrinsic motivation.

A review of rules and regulations in the use of financial incentives

Under the Patient Protection and Affordable Care Act (ACA), Congress has encouraged and supported employers interested in offering significant financial incentives to individuals based on health status factors. The Department of Health and Human Services, Department of Labor (DOL), and the Internal Revenue Service released final regulations, effective January 1, 2014 as required in the ACA, that amend and clarify rules for non-discriminatory use of incentives in wellness programs for both grandfathered and non-grandfathered group health plans. Changes and clarifications to the final regulations are summarized here.

In prior financial incentives updates StayWell provided guidance to our clients concerning the original regulations and our interpretation of the rules concerning the use of “reasonable alternative standards.” We published a point of view concerning where the rules needed clarifications and also provided our input during the public comment period following the DOL draft revisions. The final regulations should satisfy many of those who were concerned the ACA wellness provisions, particularly the so-called “outcomes-based” incentives, could serve as subterfuge for insurance underwriting. Indeed, StayWell’s leadership is encouraged that the final regulation language concerning reasonable alternatives aligns closely with the “progress-based” approach to incentives that we have published and that we have been recommending at health promotion conferences.

Retroactive Incentives Provision

Employers considering an outcomes-based incentive should be aware of one provision that has been deemed by some to add administrative complexity. That is, those who do not achieve a recommended health standard in a “health contingent” incentives plan must be eligible for the same, and entire, reward as others if and when they satisfy a reasonable alternative standard. This has been commonly understood to mean that the plan must provide a retroactive reward once the alternative standard has been achieved. From a behavioral science perspective, aligning the extrinsic reinforcement proximal to when change occurs is more effective than a delayed reward. However, some companies, particularly those with large populations and/or multi-faceted incentive models, may not feel equipped to administer rewards intermittently and retroactively.

Of specific interest to employers is the timing of incentives administration. ACA language states that employees will vary in their approach to behavior change and that they “may take some time to request, establish, and satisfy a reasonable alternative standard, the same, full reward must be provided to that individual as is provided to individuals who meet the initial standard for that plan year.”

Because employers will also vary in their preferred method for administering the full reward, the rules state that “plans and issuers have flexibility to determine how to provide the portion of the reward corresponding to the period before an alternative was satisfied (e.g., payment for the retroactive period or pro rata over the remainder of the year) as long as the method is reasonable and the individual receives the full amount of the reward.”

Furthermore, the rules anticipate that employers may opt to offer an incentive in a defined benefits year but delay administration of rewards until the subsequent year(s). While delaying payment is discouraged, employers who elect to implement such a strategy should proceed with reasonable action. The ACA language specifically states that “the plan or issuer may provide a retroactive payment of the reward for that year within a reasonable time after the end of the year, but may not provide pro rata payments over the following year (a year after the year to which the reward corresponds)” when the circumstance is such that an individual may not satisfy the reasonable alternative standard until the end of the year.

Paying for the Alternative Standard

Other administrative issues of note per the use
of incentives under the final ACA rules are that the incentives sponsor must make the alternative standard (such as a smoking cessation class or nutrition counseling sessions) available at no charge and at reasonable times for the participants. What’s more, participants remain eligible for these rewards even after repeated failures at goals such as quitting smoking or attaining a recommended lipid level. The employer must also continue to make reasonable alternatives available each year for those who fail to meet the reasonable alternatives in prior years. While these rules make incentive administration more complex, using the phased approach that StayWell recommends along with a thoughtful and comprehensive communications plan has been shown to be effective in supporting a robust incentives strategy.

Including family members in incentives design

Some StayWell clients are not only inviting spouses to participate in increasingly more components of their employee wellness programs, a small percentage of them have also made spouses eligible for financial incentives. As such, questions concerning how best to apportion rewards are being raised. To our knowledge, there are no studies that offer evidenced based guidance on how spouse incentives, or incentives for other dependents, will affect program participation or behavior change outcomes. The ACA offers some guidance concerning the level of family incentives by noting that the 30 percent ceiling applies to both family and individual coverage: “If, in addition to employees, any class of dependents (such as spouses, or spouses and dependent children) may participate in the health contingent wellness program, the reward cannot exceed the applicable percentage of the total cost of the coverage in which the employee and any dependents are enrolled (such as family coverage or employee-plus-one coverage).”

Even though the incentives cap applies to families, no guidance is provided concerning whether the cap should be apportioned evenly or weighted toward employees or dependents. Specific language notes that “these final regulations do not set forth detailed rules governing apportionment of the reward under a health-contingent wellness program. Instead, plans and issuers have flexibility to determine apportionment of the reward among family members, as long as the method is reasonable.”

ACA Incentives Provisions and the EEOC

HIPAA and ACA also require that employers providing health management programs adhere to a voluntariness standard. StayWell routinely reviews these standards with our clients that use incentives. However, the Equal Employment Opportunity Commission (EEOC) has yet to provide guidance concerning whether the HIPAA tests for voluntariness will also satisfy the Americans with Disabilities Act (ADA) non-discrimination rules. EEOC Commissioners have fielded balanced presentations and opinions from experts concerning the pros and cons of incentives as they relate to the ADA. Still, the Commissioners offered no guidance concerning how the EEOC might rule.

Proponents of the ACA wellness provisions, representing employers and the Employee Retirement Income Security Act (ERISA), argued that EEOC should adopt ERISA’s self-compliance checklist that already assures health status non-discrimination. Opponents of the wellness provisions argued that incentives based on attainment of a health standard could be viewed as a form of discrimination that limits health care access to vulnerable employees. Though EEOC Commissioners acknowledged that “confusion persists” among employers concerned about the ACA and ADA incompatibility, they also noted that they were waiting for “points of consensus” from the opposing groups represented at the hearing “on which we can issue strong and clear guidance.”

A “Reasonably Designed” Wellness Program as a Safeguard

As with many components of the ACA, the final rules concerning the use of incentives will not likely quell continued debates so, in the interest of offering guidance to practitioners, a consensus statement of several leading health organizations was recently published. This joint consensus statement resulted from a process that included reviewing the literature, regulations, case studies, and other resources, while developing consensus among representatives from each of the organizations represented as co-authors. This guidance not only gives health promotion program planners objective perspective, but the Health
Enhancement Research Organization also offers a series of hands-on pointers for establishing safe and effective incentive strategies.

As employers and their legal counsel await clarification concerning the ACA final rules and EEOC guidance on the voluntariness issue, StayWell intends to continue to offer science based guidance concerning the best role for incentives in improving population health. Given the focus incentives have garnered, we have urged policy makers and researchers not to confuse an incentive program with a wellness program. We believe the most important safeguard concerning the prevention of “discriminatory wellness” is presently extant in the ACA wellness provisions: health contingent incentives can only be used in the context of a “reasonably designed” wellness program. Consistent with recommendations in the Joint Consensus Statement referenced above, StayWell continues to sponsor a research agenda focused on defining and testing best practices in health promotion. Our findings to date affirm the principle that a worksite culture confers meaning onto the programs, and incentives, an organization offers. In a culture that values health, wellness interventions and accompanying incentives will likely be experienced as supportive. In a culture that makes healthy choices difficult, interventions and incentives will more likely be experienced as coercive and discriminatory.

Additional resources

StayWell has provided clients a detailed summary of the final ACA wellness provisions and regulations. The ACA’s final rules placed new requirements on employers with respect to incentive offerings. A brief summary of the new requirements follows:

1. Health-contingent wellness programs are programs that require individuals to satisfy a health factor standard to earn an incentive.

   Activity-only incentives require individuals to perform an activity related to a health factor to obtain a reward but do not require the individual to satisfy specific health outcomes.

   Outcome-based wellness programs require achieving specific health outcome(s) to obtain a reward.

2. Five requirements apply to health-contingent wellness programs but not to participatory wellness programs.

   a) Eligible individuals must be given the opportunity to qualify for the incentive at least once per year.

   b) The incentive for a health-contingent wellness program cannot exceed 30 percent of the cost of coverage or, for programs designed to prevent or reduce tobacco use, 50 percent of the cost of coverage.

   c) Health-contingent wellness programs must be reasonably designed to promote health or prevent disease whether activity-only or outcome-based. That is, the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals, and is not overly burdensome.

   d) The full incentive under a health-contingent wellness program must be available to all similarly situated individuals. Both the individuals who satisfy the initial health factor standard and those who satisfy a reasonable alternative standard later in a program year qualify for the same full incentive amount.

   e) Plans are required to disclose the availability of a reasonable alternative standard (or applicable waiver) in all plan materials describing the terms of a health-contingent wellness program — both activity-only and outcome-based. This disclosure must include contact information for obtaining the alternative and a statement that recommendations of the individual’s personal physician will be accommodated. For outcome-based wellness programs, this notice must also be included in any disclosure that the individual did not satisfy the initial health factor standard.
Conclusion

Though the use of financial incentives has garnered tremendous attention, research and debate, effectiveness of incentives always will depend on how they are used within the context of the many other strategies needed to increase participation and improve program outcomes.

Be sure to nurture a culture of health within your workplace and position your program so everyone, from leadership to front-line employees, realizes the value of the effort. It is vital every year to establish specific program goals and measure against them, conduct one-on-one employee outreach, target your communication and assess your program on a regular basis. As you design your incentive strategies, continue to offer a menu of intervention options to reach and reward employees at all stages of change.
References


27. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans; Final Rule. In: Department of the Treasury, Department of Labor, Department of Health and Human Services, eds 2013:33158-33192.

Disclaimer: This article is provided for general informational and educational purposes only and does not constitute legal advice. This information is intended, but not promised or guaranteed to be current, complete, or up-to-date.

© 2014 The StayWell Company, LLC