Position Statement on Financial Incentives within Worksite Wellness Programs

The AHA Position

As health care costs continue to skyrocket, employers are considering innovative strategies to reduce their costs. Many employers are offering comprehensive worksite wellness programs that have tremendous return on investment and improve employee health and productivity. The American Heart Association is a long-time supporter of these programs and wholeheartedly endorses their implementation, creating a culture of health in an environment where a majority of adults spend a large part of their day. These benefits were recently detailed in an AHA policy statement (Worksite wellness programs for cardiovascular disease prevention. Circulation. 2009. Found at: http://circ.ahajournals.org/content/120/17/1725.full?sid=3357d63f-f0a2-4aeb-862c-59e4a6523e1f)

In fact, the AHA is committed to doing more than just "talk the talk." The AHA “walks the walk,” with a robust program for its approximately 2,800 employees which includes the Start! At Work fitness program, the Simple Choices initiative, fitness reimbursements, healthier vending options, and many other worksite wellness programs, supporting the organization’s efforts to achieve its 2020 impact Goal and improve the lives of its employees.

Another approach some employers are using to reduce costs is to charge selected employees more for their health insurance premiums or deductibles if they are overweight, smoke, or do not achieve other healthy behaviors. The 2010 Patient Protection and Affordable Care Act codifies existing statute that allows employers to charge employees a differential insurance premium based on meeting certain health status factors or behavior metrics. This goes beyond just requiring employees to participate in worksite wellness programs. The maximum differential that an employer or health plan could charge for not meeting the behavior or health status goals was increased from 20 to 30 percent and allows the Secretaries of Health and Human Services and Treasury to increase this to 50 percent if they deem appropriate.

Table 1 shows the additional amount employees would have to pay for their insurance coverage under the new law. This means that employers can charge a 30% higher deductible to their obese employees or to their employees who are using tobacco and concurrently normal-weight employees or those who are physically fit can pay a lower deductible. A recent survey\(^ 1\) showed that because of rising health care costs and the new allowance under the federal law, 62% of employers plan on switching from incentives for participation to incentives for improvements in health metrics, shifting costs from healthy employees to their less healthy counterparts. The premise behind the new law is that the financial incentive/disincentive will motivate employees to take personal responsibility for their own health and improve their behaviors and health status over the short-and long term. However, this underlying premise is not well supported by evidence-based research. Moreover, the unintended ramifications of this policy are unclear. The AHA supports additional research to monitor the outcomes of an incentive-based approach tied to health care premiums for behavior outcomes on the quality of worksite wellness programming, employee health, and access to health care. Some of this analysis will be done by the Rand Corporation under the Affordable Care Act provisions.
The AHA opposes holding employees accountable for achieving health behavior outcomes or health metrics without significant consumer protections to prevent these programs from being used as a subterfuge for discrimination based on health status. Health is impacted by factors that are sometimes beyond lifestyle behaviors, such as genetics, family history, gender, and age. Additionally, many employees, especially the most vulnerable, do not have access to healthy, affordable foods, or safe spaces to be physically active in their communities, or they are overwhelmed with child care or elder care. Penalizing employees for their health status violates one of the major purposes of health reform - preserving and expanding access to affordable, adequate, high quality insurance coverage for all Americans. Increasing premiums or deductibles if employees can't reach certain health/behavior metrics will deny them access to the very care they need, especially for the most vulnerable employees where chronic disease incidence and unhealthy behaviors are highest.

The AHA supports comprehensive worksite wellness programs and their significant role in health promotion and cardiovascular disease prevention. The AHA even supports providing incentives for employees to participate in these programs. However, the AHA is very concerned about requiring attainment of a health factor or a behavior metric without consumer protections. As these programs are implemented under the new law, the AHA will advocate for the inclusion of effective and enforceable consumer protections so that the current regulations are not used as a backdoor to discrimination or medical underwriting for individuals with preexisting health conditions or disabilities. The ultimate goal is to make certain that Americans are not penalized financially for preexisting health conditions and that access to care becomes more, rather than less, affordable.

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<th>Total Cost of ESI Plan</th>
<th>Additional Amount Paid for Percentages</th>
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<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td>Individual</td>
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<tr>
<td>Family</td>
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<td>$2,675</td>
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Source: Average premiums for individual and family coverage in 2009 based on Kaiser/HRET annual survey of health plans
Rationale

The AHA’s concern is based on the following issues:

- The law does not provide a clear definition of “health status factor,” leaving it open to many interpretations. Where do employers draw the line with unhealthy behaviors or health outcomes?

- Evidence does not show that financial incentives have been effective in achieving sustained health improvements, particularly for weight loss. Some studies show favorable outcomes, especially if the financial incentives are sufficient. However, a systematic review that included randomized controlled trials found that incentives do not enhance long-term success—early gains reversed when rewards were no longer offered. A larger review of economic incentives relating to a larger spectrum of preventive health behaviors found that economic incentives worked 73% of the time, especially for the short-term and for simple preventive care with distinct, well-defined behavioral goals such as vaccinations. However, it was not clear what size incentive was required to maintain a sustained effect. Many of these studies were limited by small numbers of participants, cross-sectional designs, and/or very modest awards. Future research needs to evaluate the short- and long-term impact of financial incentives on behavior change, whether positive or negative incentives have the greatest impact, and whether there are unintended consequences such as employees choosing to delay care or not adhere to their medication protocol because they cannot afford to participate in their health care plans. Also, whether extrinsic motivation like incentives has longer term efficacy or more impact than intrinsic motivation and a person’s readiness to change.

- Evidence shows that individuals delay needed health care because of cost. High deductible benefit designs requiring significant cost-sharing may create real barriers to preventive care and disease management and lead to higher medical costs over the long-term.

- For those who want to opt out - privacy issues are important. Some employees may not want their employers to know about certain health conditions, worrying that they might impact future promotion or employment opportunities or they simply want to keep this information private.

- Evidence-based programs can be a win-win for employers and employees but standards for wellness programs are not mandated in the provisions. Without specific standards, the quality of worksite wellness programming could be compromised. A comprehensive program aimed at improving employees’ cardiovascular and general health should include tobacco cessation and prevention, regular physical activity, stress management/reduction, early detection and screening programs, nutrition education and promotion, weight management, disease management, cardiovascular disease education, and changes in the work environment to encourage healthy behaviors and promote occupational safety and health. The AHA believes the majority of employers has the welfare of employees as a top priority and is doing the right thing, but there are some employers who do not have the resources or are not committed to worksite wellness and could simply use this provision as medical underwriting. These employers would charge employees who cannot lose weight or quit smoking more for their health insurance and provide nothing more than the number for the local weight loss support group or smoking cessation class.
Conclusion

The AHA is very concerned that implementation of financial incentives around health behavior outcomes will have deleterious consequences on access to quality, affordable health care especially for the most vulnerable employees and also on the quality of worksite wellness programming that is delivered by some employers. The provision was passed with little evidence for efficacy, with only a premise that it would drive employees to take responsibility for their health. Thankfully, the legislation directs the Secretaries of Labor, HHS and Treasury to issue a report by 2013 based on employer data that shows the law’s impact on the effectiveness of wellness programs, the impact of programs on access to care and affordability of coverage, and the impact of premium based and cost-sharing incentives on changing health behavior, and effectiveness of different types of rewards. The AHA is very interested in the design of this study that will be conducted by the Rand Corporation to assure that the data collected will be most helpful to inform policy around financial incentives and health care premiums and deductibles. The AHA will work with employers and consumer health groups to develop consensus and evidence-based recommendations that will impact regulation and improve implementation of this law to protect employees, address access to quality, affordable health care and preserve effective worksite wellness programming.
### Summary Table on AHA’s Position Regarding Worksite Wellness and Financial Incentives in Insurance Design

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<th>AHA Position</th>
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| **Comprehensive worksite wellness programs to address cardiovascular health** | A comprehensive program aimed at improving employees’ cardiovascular and general health should include the following:  
  - Tobacco cessation and prevention  
  - Regular physical activity  
  - Stress management/reduction  
  - Early detection/screening  
  - Nutrition education and promotion  
  - Weight management  
  - Disease management  
  - Cardiovascular disease education including cardiopulmonary resuscitation (CPR) and Automated External Defibrillator (AED) training  
  - Changes in the work environment to encourage healthy behaviors and promote occupational safety and health. |
| **Effective Programming** | Should be integrated into the organizational structure of the workplace:  
  - Should incorporate health education that relies on existing valid sources and is focused on skill development that is consistent with employees’ readiness to make behavior changes  
  - Weave initiatives into existing employee assistance programs  
  - Worksite screening should be voluntary and linked with medical care for follow-up on modifiable risk factors.  
  - Employers should continue to evaluate the effectiveness of their programming to tailor both programming and policies for maximum impact.  
  - Wellness programs must address the needs of all employees at a given workplace, regardless of gender, age, ethnicity, socioeconomic status, culture, job type or physical or intellectual capacity.  
  - Should be designed to be culturally sensitive and all-inclusive and employers should also consider targeted, complimentary interventions for their more vulnerable employees specifically designed to engage those who are economically challenged, less educated, or underserved.  
  - Worksite wellness programs should help working families balance work and family commitments and incorporate policies around child care, elder/dependent care, telecommuting, and flexible work schedules. |
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| **Health Risk Appraisals** | Employers should administer health risk appraisals (HRA):  
  - Ideally on a volunteer basis  
  - All information obtained from these HRAs should be kept completely confidential and should not be sold or shared, unless with the employee’s primary care provider.  
  - Should be administered prior to initiating programming to identify health needs in the workplace and learn health risks and health status to maximize programming effectiveness.  
  - Financial incentives can be provided to employees to fill out HRAs. However HRAs should only include questions on family history unless that part of the HRA is filled out on a voluntary basis and employees receive the financial incentive for completing the HRA whether they complete this section or not. |
| **Financial Incentives for Enrolling or Participating in Worksite Wellness Programs** | Ideally should be paid directly to the employee. However, AHA can support incentives for participating/enrolling in worksite wellness programs tied to health care premiums/deductibles. |
| **Financial Incentives based on Behavior Outcomes (such as smoking or weight loss)** | Financial incentives for making a behavior change such as quitting smoking or losing weight should be paid directly to the employee. Incentives should NOT be tied to health care premiums or deductibles.  
  - These behavior outcome programs tied to health care plans can potentially be penalties or direct surcharges for failure to meet the standard, they can lead to cost shifting from healthier to sicker employees and most importantly, can limit access to health care for those who need it most.  
  - States should not apply for exemptions from the Healthy Insurance Portability and Accountability Act (HIPAA) regulations to exceed the 20% cap on behavior outcome programs.  
  - If quitting smoking, losing weight or some other behavior outcome program is initiated by an employer, the employer should provide employees with on-site or ready, easy access to programming, facilities, and resources needed to address the health behavior(s). |
References:

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.