

Commentary

Commentaries on “Workplace Health Promotion Will Become Irrelevant in National Policy if We Do Not Learn to Speak With One Voice”

Michael P. O'Donnell, PhD, MBA, MPH

I have written several Editor's Notes on the issue of federal law (1) that prohibits asking questions about family health history in health risk assessments (HRAs) when financial incentives are provided to complete the HRAs,¹ and (2) that allows employers to charge differential health plan premiums to workers based on achieving health goals or participating in health promotion programs to achieve those goals.²⁻⁴ Central to several of those articles has been the fact that the American Heart Association (AHA) and American Cancer Society (ACS) organized a coalition to advocate positions on these issues that I believe will hurt workplace health promotion and will ultimately hurt the health of the American people. My most recent article focused on the importance of the workplace health promotion community working with the AHA/ACS coalition so we can begin to speak with one unified voice on these issues. If we do not speak with one voice, we risk being ignored in national policy discussions. The key points in my articles are summarized below; the references supporting my points are in my original articles and are omitted for brevity.

We received dozens of letters in response to these articles. Most were short letters that expressed support for the positions I advocated and concerns about the position AHA and ACS are taking. Letters have come from individual health promotion professionals, as well as professional and trade associations that represent employers, benefits managers, and health promotion providers. We are publishing two letters that express different perspectives. Both focused on my most recent article, titled “Workplace Health Promotion Will Become Irrelevant in National Policy if We Do Not Learn to Speak With One Voice.”³ The first is a direct response from leaders at the AHA, the ACS, and the American Diabetes Association. The second is from executives of a health promotion provider, who seek common ground and offer a middle position.

In bringing this issue to light, I am challenging people and organizations that I respect and admire. I do this in hopes of stimulating more dialogue that can help us learn to speak with one voice.

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My comments below are for incentives offered by employers who provide health insurance for their employees and pay the lions share of the premium.

Family History Questions in HRAs With Financial Incentives

Current Regulations on Asking Questions About Family History in HRAs and AHA/ACS Position. Current law in regulation form prohibits employers from providing a financial incentive to complete an HRA if the HRA has questions about family history. These regulations emerged from Public Law 110-233, the Genetic Information Nondiscrimination Act of 2008,⁵ which prohibits group health plans and insurers from denying coverage or charging higher premiums based solely on genetic predisposition to a disease and prohibits employers from using genetic information when making hiring, firing, job placement, or promotion decisions. The law does not mention HRAs or financial incentives. The only mention of health promotion programs is to confirm that they are permitted to collect information on genetics and family history. The AHA/ACS coalition led the effort to write the regulations restricting use of incentive with HRAs.

Importance of Financial Incentives in HRA Participation. Providing financial incentives for workers to complete HRAs pushes participation rates from the 20% to 40% range to the 70% to 90% range.

Importance of Family Health History Questions in HRAs. Family health history is one of the most powerful predictors of future health risks. Without knowledge of family history, employers are less able to tailor health promotion programs to serve workers' specific needs and less able to know how to focus additional resources on engaging and helping workers who need the most help.

Link Between Family Health History, Genetics, and Diseases. The link between family health history and genetics is tenuous. Family health history is a strong predictor of an individual's health risk primarily because of family behavioral norms related to eating, physical activity, smoking, abuse of other substance, expressing anger and love, forming relationships, and achievement. Family history is a stronger predictor of chronic disease than genetics for

most chronic and acute diseases, and the genetic predisposition to most diseases can be moderated by lifestyle practices.

Health Plan Premium Differentials Based on Achieving Health Goals or Participation in Health Promotion Programs

Current Statute on Health Plan Premiums and AHA/ACS Position. Current law in statute form⁶ (Section 2705 of the Patient Protection and Affordable Care Act) allows employers to charge lower health plan premiums or provide other financial incentives to workers who achieve health goals or participate in health promotion programs to achieve those goals. AHA and ACS are leading a coalition to create regulations that would limit employers' ability to provide financial incentives for achieving health goals and would impose significant administrative burdens on employers that implement these incentive programs.

Importance of Financial Incentives for Participation. From a health perspective, providing financial incentives to stimulate participation (i.e., tying health plan premiums to participating in health promotion programs) is more important than providing incentives to achieve health goals because participation incentives will motivate people to enroll in programs that will in turn help them improve health habits and achieve health goals. If implemented correctly, these incentives can push participation rates close to 100%.

Importance of Financial Incentives for Achieving Health Goals. From a health improvement perspective, providing financial incentives (i.e., tying health plan premiums to achieving health goals) for changing behavior to achieve new health goals is probably not very important. They are very effective in motivating people to maintain existing behaviors once the goal is achieved, and in motivating people to participate in programs, independent of specific incentives tied to participating.

Equity for Workers. Tying health plan premiums to achieving health goals also provides a more equitable way to share health plan costs among workers by reducing the amount workers with good health practices are required to subsidize the premiums of workers with poor health practices who are not willing to make an effort to improve their health practices.

Funding Incentives and Cost Effectiveness of Incentives. Tying health plan premiums to achieving health goals provides an actuarially sound mechanism to finance the entire cost of the incentives and a comprehensive health promotion program in a way that is cost neutral or cost beneficial to the employer and to workers who either achieve health goals or participate in programs. The cost of the incentives necessary to motivate

people to participate in programs may be greater than the savings that result from their participation, making the incentives a poor investment in the absence of this financing mechanism.

Relative Amount of Incentives. To maintain actuarial soundness, incentives for achieving health goals should be larger than incentives to participate and should probably be in the range of the 20% of total health plan premiums allowed now, and possibly as high as the 30% that will be allowed in 2014. Increasing them to the 50% that may be allowed in 2014 is probably not necessary from a behavior change perspective, but may be appropriate from a worker equity perspective.

Reporting Requirements and Worker Projections. Reporting and other administrative requirements for employers should be minimal to encourage employers to implement these incentive programs. At the same time, basic protections need to be in place to protect worker privacy, accommodate workers with challenging health conditions, and ensure that effective health promotion programs are in place.

Importance of Speaking With One Voice

The AHA and ACS are huge organizations with extensive networks of volunteers and a large professional staff. They are very influential in public health circles and in Congress. The workplace health promotion community is too small to overcome their influence and must work with them to speak with one voice on these issues. If we do not do this, we risk cancelling each other's messages and making workplace health promotion irrelevant in national health policy.

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Speaking With One Voice on Worksite Wellness: The American Cancer Society, the American Diabetes Association, and the American Heart Association

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Two of our three organizations were the subject of a recent Editor's Note published in the *American Journal of Health Promotion*.¹ That editorial, we believe, misrepresented both our position on the use of incentives in worksite wellness programs and the legal environment surrounding these issues. We appreciate this opportunity to respond.

The American Cancer Society, the American Diabetes Association, and the American Heart Association are long-time supporters of worksite wellness. Our organizations work with a multitude of employers to implement effective health promotion programs, and we collectively employ about 10,000 people to whom we offer a variety of evidence-based wellness programs that often incorporate incentives. Our organizations support the use of incentives tied to program participation as an element of a comprehensive worksite wellness program, including financial incentives for participation in a health risk assessment (HRA).

We would like to clarify an important point regarding HRAs about which there may be some lingering confusion: employers can provide workers with financial incentives for participation in HRAs and may also include *optional* family history questions as long as the reward is not contingent upon completion of that section.² Although our organizations support this approach, worksite wellness programs still can be designed and operated effectively without family history information. The critical issue involving disclosure of family history is balancing program effectiveness with the need to protect employees from workplace discrimination and infringement on medical privacy rights.

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It is inaccurate to claim or suggest that our organizations are advocating for regulatory restrictions that would apply to health promotion programs that use premium discount incentives linked to participation. Instead, our recommendations for increased consumer protections focus only on incentive programs based on an individual satisfying a standard that is related to a health status factor, such as body mass index, blood pressure, or blood glucose. Without sufficient safeguards, we are concerned that outcomes-based incentives can be equivalent to *medical underwriting*—the practice of using health status factors to determine a person's health insurance costs.

Medical underwriting has been illegal in the group health plan market since 1996 under federal law. However, regulations dating from 2006 allow an exemption for worksite wellness incentives. These regulations were codified and expanded in the Affordable Care Act (ACA). Under these provisions, companies are allowed to charge employees more or less for their health insurance based on whether they achieve a specified health outcome or meet a health status standard provided it is done under the auspices of a worksite wellness program. The premium variation is currently capped at 20%. When the new law goes into effect, the cap will go to 30% of the health plan's total cost (the employer plus employee contribution), with the potential to reach as high as 50%.

Proponents of these provisions describe them as providing "rewards" and "discounts." However, the law also allows for the use of penalties or surcharges, like higher premiums, deductibles, and copays. Moreover, these incentives and disincentives can be significant: \$4000 or more per year at 30% of the cost of the average family health plan. When these provisions were considered during the health reform debate, we joined more than 100 patient and consumer advocacy groups to express concern that premium differentials of this magnitude could create financial barriers to coverage and reduce access to health care.³

The premise behind the inclusion of these provisions in the ACA is that financial rewards and/or penalties based on health status will improve health behaviors in the workforce. Although perhaps intuitively appealing to some, this rationale is not currently supported by empirical research.

Dr. O'Donnell has acknowledged that "there is very little evidence that financial incentives directly improve health behaviors."^{4(pv)} Seaverson et al. noted that providing significant financial incentives to employees "decreases the likelihood they will make the intrinsic causal attributions necessary to sustain long-term behavior changes."^{5(p343)} Additional research is needed to clarify the impact of outcomes-based incentives on access to health care and employee health.

When the Departments of Labor, Treasury, and Health and Human Services recently stated that they were "considering what accompanying consumer protections may be needed to prevent the [worksite wellness] program from being used as a subterfuge for discrimination based on health status,"⁶ our three organizations joined 30 others in offering suggestions specific to the use of outcomes-based incentives.

We believe a worksite wellness program should be required to meet a reasonable set of standards when an employer seeks an exemption from federal law in order for the program to vary premiums or other health plan costs based on an employee's health status rather than participation. This is not presently the case. A program need only be "reasonably designed," which was intended to be "an easy standard to satisfy," and "there does not need to be a scientific record that the method promotes wellness."^{7(p75018)} Such an inadequate standard creates the potential for significant premium variations with no assurance of offering any effective programs to help employees achieve the desired health status.

We applaud the many employers that are presently offering comprehensive worksite wellness programs, healthy work environments, and other resources to help employees achieve their health goals. There is risk, however, that some employers will hold employees and their families accountable for unreasonable health metrics without the benefit of any meaningful support or assistance.⁸ A worksite program that simply charges a worker more for poor health status is, in our collective opinion, discriminating based on health status even if the stated rationale for doing so is motivating workers to improve their health.

We are concerned that racial and ethnic minorities or workers who are less educated, older, or low income, will be disproportionately impacted by penalties tied to health outcomes because they often suffer higher rates of traditional risk factors.⁹ Decades of health behavior research has confirmed that numerous "biological, environmental, and socioeconomic factors greatly affect health, regardless of how a person behaves."^{8(p848)} We recommend that those with a legitimate hardship factor that makes it difficult to meet a health status standard should be eligible either for an alternative standard or a waiver of the standard.

Some have portrayed our efforts to address these concerns as detrimental to worksite wellness programs.¹ Quite the opposite, we wish to promote an expansion of well-designed worksite wellness interventions that may utilize positive incentives tied to participation. At the same time, it is important to discourage programs that are driven by disincentives and penalties based on health status standards that may not be reasonable or appropriate for some workers.^{8,9}

Our goal is consistent with the American College of Occupational and Environmental Medicine's position that

"incentives should be used to encourage participation in these programs and should not be tied to health status, biometric results or meeting outcomes from health improvement programs."^{10(p4)} We also agree with the American College of Physicians that "positive incentives, such as meaningful rewards, may successfully promote beneficial and sustained behavior change unlike negative incentives that are punitive and coercive."^{11(p4)}

The predicted trend in the use of worksite incentives is a shift away from positive rewards for participation toward an emphasis on penalties for those who fail to improve their health.^{12,13} In this model, employers add the costs of the incentive and any wellness program costs to their health plan premiums so that all employees are subject to a higher overall premium contribution.¹⁴ Then, employers can provide substantial premium discounts that are cost neutral because "premiums are raised for employees who do not qualify to cover the reduction for employees who do qualify."^{4(pv)} Dr. O'Donnell predicts "that financing health promotion programs using this mechanism will become the norm among major employers in the next few years."^{4(piv)}

This cost-shifting paradigm can easily lead to a zero-sum game in which some employees necessarily must fail to meet the health standard in order to finance the discounts.¹³ Then it will be the worker who is obese but has been unable to lose weight who pays, or the employee who has a genetic predisposition to high cholesterol, or the person who has failed to quit smoking after numerous attempts. Irrespective of whether one believes such people should be financially penalized for their conditions, they do need affordable health insurance. There is ample evidence that patients are far less able to manage chronic conditions such as hypertension or hyperglycemia when their health plans require excessive cost sharing.¹⁵

We must take dramatic steps to reduce the prevalence of chronic diseases and the risk factors associated with them. The worksite environment is an ideal setting to help people adopt healthy lifestyles and reduce or eliminate risk factors that are the precursors to chronic disease.

We look forward to continuing to work with members of the health promotion community to advance our shared goal of promoting evidence-based workplace wellness programs that afford all workers the opportunity to improve their health. Although the challenges are formidable, the potential outcomes could markedly improve our nation's health, and simultaneously reduce our skyrocketing health care costs.

But, worksite wellness programs do not need to penalize employees for their health status to succeed.¹⁰ In the absence of clear evidence regarding the effectiveness of this practice, varying opinions have been expressed across the health promotion community. Several prominent experts in the field noted in a recent issue of the *New England Journal of Medicine* that "the effectiveness of outcome-based wellness incentives is uncertain, and their use raises concerns about distributional equity..." that "could undermine some of the ACA's intended benefits."^{16(pp389-390)} Other experts highlight this approach as a way to help employees connect their daily activities to medical costs while reducing the subsidy that healthy employees pay in their health plan premiums for sick employees.¹⁷

Our hope is that employers, health advocates, and the health promotion community will continue to engage in a thoughtful dialogue as we collectively strive to promote workplace wellness programs that ensure strong consumer protections in the use of outcomes-based incentives while providing employers with the flexibility to design innovative and effective programs.

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Commentary

Finding Common Ground in the Use of Financial Incentives for Employee Health Management: A Call for a Progress-Based Approach

Paul E. Terry, PhD; David R. Anderson, PhD

The growing controversy over wellness incentives authorized by the Patient Protection and Affordable Care Act (PPACA) is disconcerting. Just when worksite wellness is being embraced as an effective strategy to curb the growth of chronic health conditions and related costs, recent position statements regarding Section 2705 of PPACA suggest opposing views among important wellness champions.¹⁻³ After summarizing the arguments supporting and opposing key

elements of Section 2705, this commentary proposes a perspective we believe represents common ground for advancing equitable, effective use of incentives.

Opposing Views on Financial Incentives

To encourage incentives for healthy behavior while prohibiting discrimination based on employee health status, Section 2705 allows employers to provide rewards (e.g., premium reductions) to individuals who meet a health standard, such as healthy weight, if they also offer a “reasonable alternative standard” or waiver for employees with medical conditions precluding them from achieving the health standard.⁴ Such outcomes-based incentives are being implemented or planned by many employers.⁵

The editor in chief of this journal, Michael O'Donnell, PhD, wrote that this PPACA provision “may be the most

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important development of the decade.” He led an effort that delivered 11,000 letters to Congress supporting the provision and posited that it could yield nearly 100% participation in worksite wellness programs and “fully fund health promotion programs at no net cost to employers.”⁶

Others view outcomes-based incentives tied to health plan costs as unfair and discriminatory, instead advocating “participation-based” incentives. American Heart Association (AHA) position statements support incentives for participation paid directly to employees but oppose incentives tied to a “health factor or a behavior metric without significant consumer protections”³ and express “significant concern with incentives tied to health insurance premiums or deductibles.”⁷ Similarly, an American College of Occupational and Environmental Medicine (ACOEM) position statement asserts that “incentives should be used to encourage participation in these [wellness] programs and should not be tied to health status, biometric results or meeting outcomes from health improvement programs.”² ACOEM emphasizes, however, that eliminating employers’ freedom to use participation-based incentives would “effectively end these programs and the positive results they have produced for employees.”²

There is more than one bottom line for these constituents given the high stakes, legitimate differences, and acknowledged mutual respect. AHA notes that “many employees, especially the most vulnerable, do not have access to healthy affordable foods or safe spaces to be physically active in their communities.”³ This concern is widely shared. O’Donnell believes it is “unfair to force employees who do everything possible to practice healthy lifestyles to subsidize health plan premiums for those who are unwilling to at least try to improve their health.”⁶ Many agree. ACOEM argues incentives are not enough unless the employer “helps to create the true culture of health that is needed for workplace wellness programs to take hold and thrive.”² Few disagree.

Battle Lines or Starting Lines for the Best Uses of Incentives?

Outcomes-based and participation-based incentives each have merits and shortcomings. Detractors contend outcomes-based incentives shift costs to unhealthy individuals least able to afford them. AHA worries the law will be used as a “subterfuge for discrimination” and “back door...to medical underwriting for individuals with preexisting health conditions or disabilities.”³ O’Donnell’s recent editorial decried the AHA position that “draws the line at requiring attainment of a health factor...without consumer protections,”⁷ fearing their proposed approach to consumer protection will destroy worksite wellness because “virtually every worker would qualify for the premium discount without achieving a health goal or participating in a program.”¹ Though ACOEM advocates participation-based incentives, they share O’Donnell’s concerns about undue administrative burden and note that employers should be able to provide financial rewards “with assurance that such incentives will not be considered a violation of the Americans with Disabilities Act.”² That thoughtful stakeholders disagree is not surprising given the complex issues and limited research informing these policies.

Finding Common Ground

Thankfully for policy makers debating the fairest and most effective uses of incentives, research is providing important

new insights. Among the most instructive is work by Volpp and colleagues, which offers evidence that incentives can have near-term benefits while suggesting caution about their salience and cost-effectiveness.^{8–10} Recent books also inform the debate by synthesizing research on human motivation and behavioral economics, e.g., *Drive, Nudge*, and *Predictably Irrational*.^{11–13} This body of evidence underscores that research on extrinsic motivators, including financial incentives, must account for effects on intrinsic motivation in calculating their net impact on behavior.

Others urge caution in using incentives. Among other concerns, they warn that incentives can teeter on an ethical slippery slope and be insensitive to genetic factors,¹⁴ spawn mercenaries and sap intrinsic motivation,¹⁵ and cast doctors in watchdog roles that impair the therapeutic relationship.^{16,17} Alfie Kohn’s book *Punished by Rewards* offers a thought-provoking, albeit one-sided, litany of failures and unintended consequences of incentives.¹⁸

We share O’Donnell’s concern that, if outcomes-based incentives are constrained by administrative loopholes intended as consumer protections, workers who could benefit most from wellness programs may instead “opt out.” Though the PPACA “reasonable alternative standard” provision could alleviate this concern, we’ve seen examples of employers encouraging affected employees to simply get a waiver from their doctor. A review of employee disability practices offers a likely result—doctors see themselves as the patient’s advocate, not the payer’s. We also appreciate the perspective of AHA and ACOEM that outcomes-based incentives are perilously close to a cost-shifting scheme. Though our research shows incentives can drive wellness participation,¹⁹ our findings also resonate with ACOEM’s position that incentives without investment in healthy culture are unlikely to produce desired results.²⁰ The one position all stakeholders embrace is that we need more research into whether financial incentives can produce sustainable health outcomes for worksite populations.

If we consider the evidence on whether outcomes-based or participation-based incentives produce better population health outcomes, we can summarize our conclusion in four words: we don’t yet know. While acknowledging that the empirical question has not yet been answered and there are important ethical issues, we believe there is ample common ground in this Goldilocks debate over whether participation-based incentives are too soft and outcomes-based incentives are too hard.

A Call for Progress-Based Incentives

As Aristotle proposed ages ago, we believe the wisdom is in the middle. Because the evidence on incentives remains equivocal, employers testing new incentive strategies risk making well-intended changes that lead to troubling unintended consequences. Nevertheless, innovators always push boundaries and seldom have the luxury of conclusive evidence before advancing new ideas. Borrowing tenets from the Institute of Medicine, we advocate incentive designs compatible with five principles—that they be safe, effective, participant centered, timely and equitable.²¹ We believe the framers of the wellness incentive section of PPACA had such principles in mind in drafting the “reasonable alternative

standard” provision. Like O’Donnell, we believe an approach encouraging waivers misses the critical opportunity to engage almost all employees in improving their health regardless of whether they can meet a health standard.

Occupying the middle ground between outcomes-based and participation-based approaches, we believe current best practice deploys highly trained health coaches (with relevant physician involvement) to help those who do not meet the health standard set an individual health goal, such as losing 10% of body weight, as a reasonable alternative standard. In addition to encouraging adherence to a health standard, this *progress-based* approach may engage the many who deem the health standard unattainable, and those for whom it is not medically appropriate, in behavior changes that meaningfully improve their health. Perspectives will vary on what constitutes “progress” as the reasonable alternative standard for these individuals. Many employers will view participation in wellness activities as acceptable progress. Others will define progress as meeting a tangible health goal, although they may also provide a portion of the incentive for participation.

Although a few employers are already eliminating rewards not tied to health outcomes, several factors align against exclusive reliance on biometric outcomes in pursuing population health improvements. Some individuals fall so far from the health standard it is neither realistic nor healthy for them to try to attain it in time to earn the incentive. Additionally, because health status is not solely the product of lifestyle but also of genetic, environmental, and physiological factors, what works for one person may not work for another who makes the same lifestyle changes.

These fundamental pitfalls of an outcomes-based model are additional reasons we recommend a progress-based reasonable alternative standard rather than simply penalizing or waiving the many unable to meet the health standard. This offers all participants an opportunity to earn incentives regardless of where they are on the health continuum. Consistent with Institute of Medicine guidelines, we believe a progress-based approach is safer and more equitable and effective across the population, because it considers the starting point of each individual and sets a risk-adjusted target rather than presuming one size fits all.

Most important, a progress-based approach accommodating both outcomes and steps along the way allows employers to test innovative incentive strategies while respecting the diversity of employee circumstances. We believe this is the middle ground where all stakeholders win.

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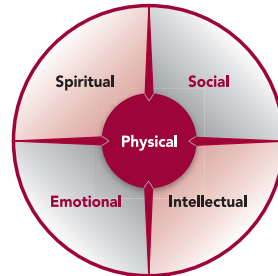
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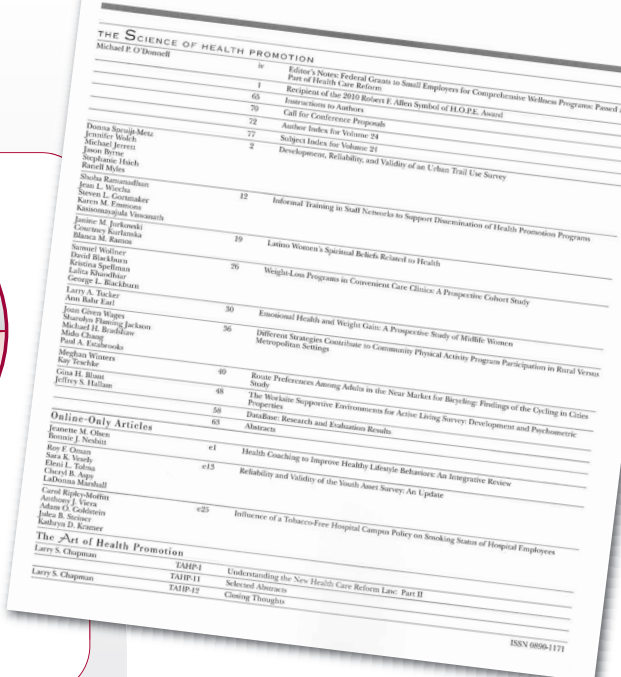
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