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Arkansas Center for Health Improvement
ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

ISSUE BRIEF

Healthy Behavior Incentives: Private Insurance • February 2016

Arkansas has some of the highest rates of risk factors for poor health in the nation with nearly 36 percent of adults considered obese, 39 percent with hypertension, and 13 percent with diabetes.[1] As a result, Arkansas's health has ranked between 44th and 49th for the last two decades and is currently ranked 48th.[2] For 2013, projected costs of chronic disease treatment and lost productivity were $26 billion.[3] By making reasonable improvements in preventing and managing chronic disease, Arkansas can make progress in disease reduction and economic improvement. Businesses and policymakers have seen the value of investing in preventive care and encouraging individuals to make better health choices related to diet, physical activity, and tobacco use. This issue brief is part of a series that discusses the components and effectiveness of healthy behavior incentive programs with recommendations for their establishment and their impact on individuals, businesses, and Medicaid.

HEALTHY BEHAVIOR INCENTIVE PROGRAMS

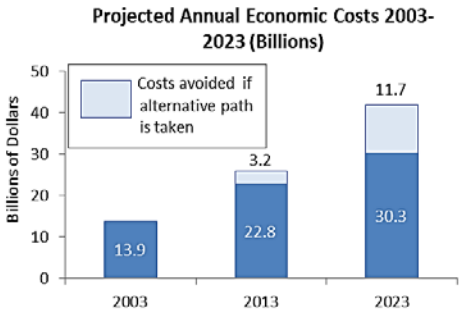
State governments and businesses have continued to face increasing healthcare costs. In addition, they have seen the financial impact of risk factors for poor health on increased employee absenteeism and decreased employee productivity at work.[4] One strategy for lowering these costs that is gaining popularity is the use of incentives to persuade program beneficiaries and employees to take greater personal responsibility for their health, use preventive care, and make healthy lifestyle choices. Behavioral changes such as eating better, exercising more, and smoking less are cost-effective strategies to contain the impact of chronic disease.[5] When offered, employees appear ready to join into the incentive programs, with 80 percent wanting incentives for wellness, 67 percent noting employers should offer a discount on health insurance for employees at a healthy weight, and 52 percent supporting rewards for adherence to chronic disease medication regimens.[6] It is important to differentiate incentive programs from comprehensive workplace wellness programs. Incentives are intended to increase engagement and encourage employees to take part in wellness programs, while the wellness programs themselves incorporate strategies to improve health, manage chronic conditions, and prevent disease.

The Cost of Chronic Disease in Arkansas

In 2007, the Milken Institute used data from the Medical Expenditure Panel Survey to develop cost projections related to seven common chronic diseases: cancers, diabetes, heart diseases, hypertension, stroke, mental disorders, and pulmonary conditions. They considered a "business-as-usual" scenario ("current path") of treatment and an optimistic scenario ("alternative path") that assumed improvements in health-related behavior and treatment (see Figure 1). With positive changes in weight control, improved nutrition, increased exercise, and reductions in smoking, Arkansas could see more than $11.7 billion in avoided health-related costs over a 20-year span, representing a 28 percent reduction in the economic impact of chronic disease.[3] Updating this report seven years later, the Milken Institute examined changes in their original projections. On the

positive side, national data indicated heart disease prevalence and expenditures per patient—aided by falling smoking rates—were lower than baseline projections. However, in all other diseases studied—cancer, diabetes, hypertension, and stroke—the number of people reporting a condition, actual treatment costs, and productivity losses exceeded estimates.[7] In addition, they found the increased prevalence of obesity contributed to the number of cases of most of these diseases. This led the Institute to recommend incentives for disease prevention and a renewed national commitment to achieving a healthy body weight.

Figure 1: Economic Costs of Chronic Disease in Arkansas[3]



Avoidable Costs in 2023 (Billions)

	Treatment Expenditures	Lost Productivity	Total
Current Path	$7.3	$34.7	$42.1
Alternative Path	$5.2	$25.1	$30.3
Costs Avoided	**$2.1 (29%)**	**$9.6 (28%)**	**$11.7 (28%)**

Use of Financial Incentives

Research in the non-Medicaid population suggests financial incentives are effective at encouraging healthy behavior.[8,9] The effectiveness of incentive programs depends on how the incentives are timed, distributed, and framed. Behavioral economics suggest that the same decision-making process that contributes to poor health-related behaviors can be used to create effective incentive programs (e.g., people are more attracted to immediate than delayed benefits and are more deterred by immediate than delayed costs).[11] Incentive programs that offer small, frequent payments for a behavior that benefits the individual, such as following a medication plan, can be more effective than less-visible incentives that reduce a monthly premium or are included in a paycheck.[12]

> Behavioral economics is the study of how people actually make choices. It draws on insights from both psychology and economics.[10]
>
> *"Behavioral economics explains why we procrastinate, buy, borrow, and grab chocolate on the spur of the moment."*
>
> *–Craig Lambert, Harvard Magazine*

Federal and State Oversight of Incentive Programs

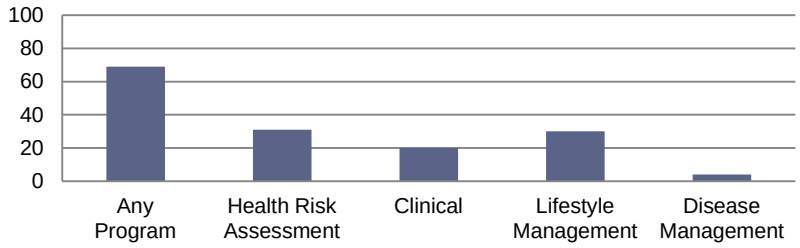
The Patient Protection and Affordable Care Act of 2010 (PPACA)[13] allows employers, starting in 2014, to use up to 30 percent of the total amount of their employees' health insurance premiums to provide outcome-based wellness incentives. If the wellness activity aims to help someone reduce or quit smoking, the incentive can be higher—up to 50 percent of the plan's cost. The regulations consider the variability of medical conditions that might make achievement of a particular health standard "medically inadvisable" or "unreasonably difficult." For people with such conditions, the regulations require that plans offer a "reasonable alternative standard." There is limited guidance as to how these terms may be interpreted.[14] However, a number of state and federal laws and regulations impose limits on the use of financial incentives in wellness programs such as group health plans and self-insured group health plans to protect beneficiaries. Regulations under the Public Health Service Act,[15] the Employee Retirement Income Security Act of 1974 (ERISA),[16] the Americans with Disabilities Act of 1990 (ADA),[17] the Health Insurance Portability and Accountability

Act of 1996 (HIPAA),[16] the Genetic Information Nondiscrimination Act of 2008 (GINA),[18] and the Internal Revenue Code[19] impact the design and administration of these programs.

Employee Incentive Programs Offered in Private Sector – What We Know

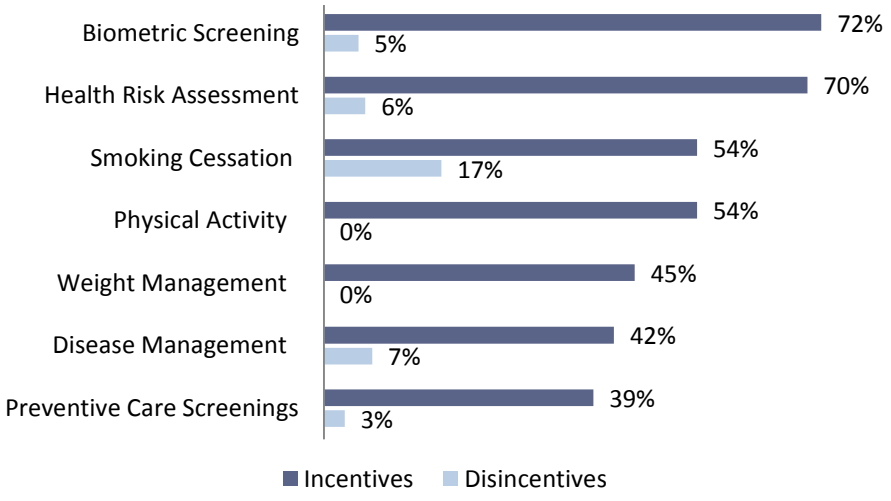
The 2012 RAND Employer Survey of businesses with at least 50 employees and workplace wellness programs found that more than two-thirds of employers utilized financial incentives to encourage program use, and 10 percent used incentives tied to health-related standards.[20] Incentives for health risk assessments (HRAs) and lifestyle management programs were most commonly offered, while those for disease management were offered less frequently (see Figure 2). Of the surveyed businesses, nearly 50 percent offered incentives directly to their employees and nearly 30 percent administered them through their group health plans, while 20 percent used a combination. Approximately 85 percent of the surveyed employers used rewards rather than penalties.[20] Financial incentives were offered in a variety of forms, including cash, gift cards, gym discounts, t-shirts, and event tickets, while disincentives were in the form of health insurance premium surcharges and copays.

Figure 2: Percent of Employers Who Offer Wellness Programs That Use Monetary Incentives for Participation[20]



The Sixth Annual Employer-Sponsored Health & Well-being Survey found that surveyed employers preferred incentives to disincentives to encourage employee participation in various aspects of wellness programs in 2015.[21] Approximately 75 percent of survey respondents used some type of incentive to boost participation in biometric screenings, HRAs, and smoking cessation programs. The prevalence of incentives to disincentives by wellness program is illustrated in Figure 3.

Figure 3: Use of Incentives and Disincentives by Type of Wellness Program[21]



Two 2014-employer surveys—one by Mercer LLC and another by Towers Watson & Co.—found that of surveyed employers, 23 percent and 18 percent, respectively, used outcomes-based incentives with their wellness programs.[22]

The Arthur J. Gallagher & Co. (AJG) 2014 Benefits Strategy & Benchmarking Survey found nearly three-fourths of employers indicated their greatest wellness challenge to be lack of employee participation. Employers who allowed their workers to choose their incentive found better program involvement. However, many employers restricted their employees' incentive options to traditional wellness opportunities such as health assessments while employees looked for options meaningful to themselves.[23]

Experience in Arkansas: Nabholz, North Little Rock, Ambetter, University of Arkansas System, and Arkansas State Employees

Arkansas-based Nabholz Construction has an outcomes-based incentive program using gift cards and bonus payments to reward employees and their spouses based on results of their annual health screenings. Of these employees, 100 percent participate and 99 percent have earned an incentive. The biometric screenings focus on the top five areas driving the company's healthcare claims: obesity, diabetes, hypertension, high cholesterol, and nicotine use. Additional incentive-driven goals include having an annual physical examination and a semiannual dental check-up as well as participation in tobacco cessation programs. The company also provides one-on-one counseling, condition monitoring, and immunizations. Started in 2010, Nabholz has seen an improvement in their employees' health with a decrease in the rates of pre-diabetes and high cholesterol of 13 percent and 18 percent, respectively. Containing costs over the last four years has allowed the company to reduce health premium costs by 4 percent for 2014-2015. Program data also show an annual savings of $1.1 million from 2010 to 2015.[24]

> Nabholz Construction has saved $1.1 million annually since implementing outcomes-based incentives. It has seen a reduction in its self-funded insurance plan premium cost as well as reductions in covered members having pre-diabetes and high cholesterol.[24]

Modeled after the Nabholz initiative, the City of North Little Rock incorporated cash incentives into its Fit 2 Live employee wellness program. In 2015, the incentives covered cholesterol, blood pressure, and blood sugar testing.[25] One-third of the city's employees participated in those screenings.[26] Subsequently, the City Council passed a resolution supporting the addition of obesity, tobacco, and nicotine reduction to their 2016 Employee Wellness, Screening and Incentive Program.[27] These additions increase the total potential incentive from $30 to $100 for the year.[28]

Ambetter of Arkansas—Centene Corporation's Health Insurance Marketplace product—offers the My Health Pays™ program, which in 2015, provided its Health Insurance Marketplace participants with up to $365 for completing an HRA, having a wellness exam, getting a flu shot, and/or visiting a gym at least eight times per month.[29] Redemption options are dependent on the participant's annual earnings relative to the current federal poverty level (FPL). Individuals at or below 138 percent of the FPL can select from items such as groceries, over-the-counter medicines, and baby care supplies, while those participants earning over 138 percent FPL can use their rewards for doctor visit copays, deductibles, coinsurance, and premium payments.

The State and Public School Life and Health Insurance Board, through the Arkansas Employee Benefits Division of the Department of Finance and Administration, established the ARBenefitsWell program in 2014 to encourage Arkansas state employees and public school employees to actively

engage in their health and reduce the cost of healthcare claims. The wellness program's incentive provided a monthly health insurance premium discount of $75 in 2015 to those employees who had an office visit with their healthcare provider during 2014.[30] This initial year saw 69,962 employees out of 72,614 take advantage of the incentive, representing approximately 98 percent of state employees and 95 percent of public school employees.[31] The criteria to achieve the discounts have been enhanced for 2016 premium discount eligibility. An employee and their spouse, if on the program, were required to complete an HRA, and the employee had to see his or her physician for a wellness visit by October 31, 2015.[32] Early estimates of employees completing the 2016 requirements indicate a drop in participation to 88 percent of state employees and 92 percent of public school employees.[33] Due to the limited time since program implementation, an evaluation of cost savings has not been conducted.

The University of Arkansas (UA) System Health Plan offered University of Arkansas for Medical Sciences (UAMS) employees the opportunity to receive a reduction in their medical insurance out-of-pocket (OOP) annual maximum cost if they completed a biometric screening, online HRA, and made two health pledges. The OOP reduction was $1,900 for the employee for health plan year 2015,[34] but was reduced to $1,400 for the employee for 2016.[35] Similarly, there was a decline in employee participation. For plan year 2015, 75 percent of employees who completed the screening-HRA process were from UAMS, while for plan year 2016, the percent dropped to 69 percent.[36] The OOP financial incentive was expanded to all UA System employees in 2016.[37]

Enacted by the Arkansas General Assembly, Act 724 of 2005 provides state employees, through the Arkansas Healthy Employee Lifestyle Program (AHELP), with up to three days of paid leave per 52 weeks if they take specific actions to improve their health. Additional incentives include exercise resistance bands, t-shirts, gym bags, pedometers, and passes for lodging at any state park. The employees can earn points in five categories: physical activity (cardiovascular, strength, and flexibility exercise); fruit and vegetable intake; tobacco cessation; completion of annual HRAs; and preventive health screenings, which are traded for the paid leave.[38,39,40] There are 31 AHELP state agencies participating in the program. These agencies have a combined total of approximately 350 worksite locations and 37,000 state employees. In 2014, 579 employees earned and redeemed leave time in increments of 1 hour, 1 day, 2 days, or 3 days. In addition, some employees chose to redeem other incentives by excluding leave or choosing leave plus additional incentives such as t-shirts, hoodies, TheraBands, and pedometers. Cardiovascular exercise and tobacco use reduction were the highest daily activities recorded followed by fruit and vegetable intake, then flexibility and strengthening. Of the annual activities, the preventive health screenings were completed more often than the HRAs.[41] A return on investment analysis has not been conducted.

The Arkansas Healthy Employee Lifestyle Program (AHELP) provides state employees with up to three days of paid leave if they complete an HRA, have preventive health screenings, exercise, eat fruits and vegetables, and reduce/stop tobacco use.

Lessons Learned from Existing Programs-Worksite Wellness and the Business Community

Incentives and penalties prompt employees to participate in wellness programs. However, the cost/benefit-oriented return on investment (ROI) evidence is varied as to whether there are improvements in health outcomes and reductions in healthcare costs.[42]

Arkansas-based Nabholz Construction has seen improvements in employee health from 2010 to 2015, and minimal increases in healthcare costs over time.[24] AHELP found that having the strong support of leadership within each state agency and designated coordinators at each worksite to promote the program actively is vital for success. A recognized barrier for employees includes a lack of guidance when trying to follow through with their HRA counseling recommendations. Inaccurate logging of behavior change has led to the consideration of biometric screenings to supplement the self-reported HRA data.[43]

Dell, Inc.'s Well at Dell health management program has seen risk reduction in physical activity, nutrition, weight, and stress with associated cost reduction and an annual ROI that has increased from $1.86:$1 in 2009 to $2.21:$1 in 2011.[44] Conversely, PepsiCo's wellness program offered financial incentives for HRA completion and lifestyle management participation, but did not see a significant impact on medical care utilization and cost from this incentive component.[45]

An emerging method to measure the value of wellness programs is the value of investment (VOI) assessment. This assessment expands the usual ROI metrics to include those used for other business decisions. The areas of measure include business profitability; revenue; and employee productivity, engagement, absenteeism, and performance.[46] The Arthur J. Gallagher & Co. survey notes about one third of employers already use one or more of these metrics to evaluate their wellness programs.[23]

Negative incentives for employee non-participation have proven problematic. Employers who have required their employees to complete an HRA and/or a biometric screening and then imposed financial penalties on those who refused have found their companies subject to lawsuits filed by the Equal Employment Opportunity Commission (EEOC).[47,48] In relation to this, the EEOC has completed a set of proposed rule revisions to harmonize provisions of the ADA with the PPACA and HIPAA regarding the use of financial rewards and penalties to encourage wellness activities and the use and confidentiality of employee medical information.[49]

Recommendations for Establishing a Healthy Behavior Incentive Program

Insights gained from academic research,[9,11,12] private businesses,[6,50] and Medicaid incentive programs[51,52] provide guidance for the establishment of healthy behavior incentive programs.

- Employees and program beneficiaries need to be aware of the existence of these programs as well as the criteria for active participation. Outreach and education using multiple channels to engage employees in these programs is crucial.[51,52]
- Simple messages should describe a program's health and financial benefits so that people at all education and health literacy levels will be able to understand them. The benefit structure should be clear about what is included in the program and how individuals qualify for it.
- Rewards for behavior change should be immediate, visible, and sufficient to motivate change.
- Targets for clinical improvement should be individually achievable relative goals to support engagement rather than absolute goals (e.g., a 5 percent[53] – 10 percent[54,55] weight loss achievement [relative goal] versus a normal weight achievement [absolute goal]).

- Partnerships among businesses, health plans, community groups, state agencies, and healthcare providers can enhance education and program participation.
- Potential administrative infrastructure complexities need to be addressed in advance, such as how to measure health behavior changes, provide incentive payments, and expedite incentive distributions.
- An evaluation component should be included to assess relative effectiveness and assist with ongoing program improvement over time.

CONCLUSION

An investment in good health is an investment in economic opportunities. Providing people with the opportunities and incentives to take control of lifestyle behaviors that impact their health helps them, their families, and their employers, as well as the state. A well-designed incentive program is likely to increase the level of participation in wellness programs and increase positive behavior changes, thus leading to healthier individuals with lower healthcare costs and less worker absenteeism. Given the burden of chronic disease in Arkansas and the opportunity to improve health and lower healthcare costs, it is worthwhile for private and public employers alike to explore the potential of adding a healthy behavior incentive program to their benefits structure.

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