

Editor's Notes

Integrating Financial Incentives for Workplace Health Promotion Programs Into Health Plan Premiums Is the Best Idea Since Sliced Bread

Current Health Insurance Portability and Accountability Act (HIPAA) regulations allow employers to offer a 20% differential in health plan premiums charged to employees who either meet a health goal—like not smoking, achieving a recommended body mass index (BMI) level, high density lipoprotein cholesterol (HDL) level, blood pressure, or similar measure—or participate in a health promotion program.¹ For example, if the total cost of the health premium for an individual was \$5000, and the employer paid 70% of the total premium, all employees would have annual premiums of \$1500 (30% of \$5000 is \$1500). With differential premiums, employees who met the health goal or participated in the program would have premiums of \$1000 per year (20% of \$5000), whereas employees who did neither would have premiums of \$2000 per year (40% of \$5000). A handful of employers have implemented premium differential programs like this with the goal of controlling their medical costs and motivating employees to improve their health. However, most employers are reluctant to implement these premium differential programs because their authority to do this is established through HIPAA regulations, not through legislative statute. Employers are concerned that the regulations could change at any time with short notice.

A group of employers, led by Safeway,² have been working to pass legislation to codify the regulations in statute, and to increase the amount of the premium differential. They have had some success. The Patient Protection and Affordable Care Act, passed by the U.S. Senate on December 24, 2009, includes provisions that do three things: (1) codify existing regulations that allow employers to offer the premium differential, (2) increase the amount of the differential from 20% to 30%, and (3) allow the Secretaries of Labor and Health and Human Services to increase the amount to 50% if they feel it is appropriate.³(pp.83–95) Disease advocacy groups, led by the American Cancer Society (ACS) and the American Heart Association (AHA), have been fighting these new provisions. They were successful in defeating similar provisions that had been proposed for the Affordable Health Care for America Act (House Act), which was passed by the House of Representatives on November 7, 2009.

Experts on behavior change in the health promotion community have been silent on this issue and must speak up. I have three goals for this commentary: (1) explain why integrating financial incentives for workplace health promotion programs into health plan premiums is a good idea, (2) briefly review the efforts

of the disease groups to oppose these and related efforts, and (3) encourage more dialogue between the health promotion community and disease groups to help the disease groups understand the detrimental impact of their efforts on workplace health promotion.

Efforts by Disease Advocacy Groups to Undermine Using Financial Incentives in Workplace Health Promotion

I am writing this commentary on December 26, 2009, a few days after the Senate passed the Patient Protection and Affordable Care Act. By the time this commentary is published in March of 2010, a health care reform bill will have either been passed and signed by the President or defeated. Round 1 on this incentive issue will be over, but I fear that round 2 on use of financial incentives in health promotion programs will just be starting, because disease advocacy groups have been successful in influencing policy in at least three other ways, including the following: (1) adding a clause to a small business wellness grant program in the House Act that prohibits grants from being awarded to employers who tie health promotion incentives into health plan premiums or deductibles,⁴(p.75,lines 8–11) (2) adding a clause that excludes research on integrating incentives into health plan premiums to a \$155 million research program in the House Act that was created to study subsidies and rewards to encourage wellness and healthy behavior,⁵(p.1318,lines 21–23) (3) influencing the rules guiding the Genetic Information Nondiscrimination Act (GINA) so that financial incentives cannot be offered for health risk assessments (HRAs) that include questions on family history.⁶ I am concerned that the positions taken by the disease advocacy groups on these issues will severely limit the ability of health promotion programs to help people improve their health and quality of life. Collectively, these efforts will do more to damage the workplace health promotion field than anything I can recall from the past decade.

Concerns of Disease Advocacy Groups

I do want to acknowledge what I understand to be the core concerns of the disease advocacy groups. They want to make sure that no patient is denied affordable health insurance coverage because of an existing or future condition, such as cancer, heart disease, diabetes, stroke, HIV/AIDS, etc. I share this concern. Health insurance was created to make it possible for people to afford medical care when they are sick. The cost of this expensive care should be spread among large population groups to make it affordable, and people should not be penalized for having existing medical conditions. Fortunately, financial incentives for health promotion programs can be

Am J Health Promot 2010;24(4):iv-vi

DOI: 10.4278/ajhp.24.4.iv

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integrated into health plan premiums without jeopardizing coverage or affordability for people who are sick.

Preventing Disease Provides Higher Quality of Life and Saves Money

Providing optimal medical treatment for patients who need it is critically important, but preventing disease through health promotion provides a better quality of life for individuals and a more affordable strategy for employers and nations. The literature linking health behavior with health conditions and medical costs is vast and compelling. The Partnership to Fight Chronic Disease expresses it succinctly: three lifestyle behaviors (tobacco use, inactivity, and poor nutrition) cause 75% of chronic disease and 75% of medical costs, including 99% of Medicare and 83% of Medicaid spending.⁷ Furthermore, a growing literature demonstrates that well-designed workplace health promotion programs reduce medical costs, sometimes producing savings three times as great as their costs.⁸ It is also important to recognize that providing medical insurance is becoming increasingly difficult for employers. More than 97% of large firms offer health insurance, and this has been steady over the past 10 years. However, the percentage of small firms offering health insurance has dropped from a high of 68% in 2000 to a low of 62% in 2008. Furthermore, only 78% of employees in those firms are eligible to enroll in health insurance programs.⁹

Financial Incentives Drive Participation and Participation Drives Population Health

The literature supporting the impact of financial incentives on program participation is also quite compelling. We have known for years that financial incentives are very effective in motivating people to join programs,¹⁰ but are not very effective in persuading people to actually change behavior.¹¹ We have also learned that motivation to maintain long-term behavior changes will be stronger when they are based on intrinsic motivation.¹² The optimal application of financial incentives is therefore to use them to engage people in programs that can help them gain skills to change health behaviors and connect with intrinsic motivators to help them maintain long-term behavior changes. Recent studies have shown that participation rates for HRAs increase as financial incentives increase,¹³ and that participation rates are highest when incentives are integrated into the health plan.¹⁴ The combination of incentives being integrated into a health plan and amounts of \$200 is producing participation rates in the 90%+ range. In contrast, programs that have good marketing efforts and visible top management support, but do not use financial incentives, are producing participation rates in the 20% to 40% range. Programs that engage 20% to 40% of an organization can produce life-changing outcomes for that small percentage of people, whereas programs that engage 90% can improve the health of the entire organization. Incentives clearly drive participation, but they are prohibitively expensive for most programs, especially if incentives of \$200 are provided for multiple program components. Budgets for the best workplace health promotion programs are in the \$200–\$250 per year per eligible employee range, whereas typical program budgets are in the \$60 to \$80 range. The only feasible way to add sufficiently large financial incentives is to tie the incentives into the health plan premium. In fact, it makes sense to tie the entire health promotion program budget into the health plan premium. This approach allows employers to provide a comprehensive health promotion program and incentives at no net cost increase to the employer. There is also likely to be no net cost to employees, because well-designed programs usually save more than they cost. The other advantage of integrating the incentive into the health plan premium is that it allows the employee to receive the financial incentive in the form of a health plan premium discount, which is not taxable to the employee.

Connecting Health Behavior with Medical Costs in the Minds of Employees

Another advantage of linking financial incentives to health plan premiums is that it reminds employees that their health behavior choices impact their health conditions and their medical costs. One of the reasons medical costs are so high in the United States is that very few people are responsible for their own medical costs. If they receive care through their employers, they typically pay only 20%–40% of the premium cost. As a result, people are not aware of the full cost of medical care until they get very sick and have to pay the deductibles and co-pays that are not covered by their insurance. Even then, they do not pay the full cost. Employers or health plans typically pay 80% or more of costs when people are sick. Medicare pays most of the costs for older people, and Medicaid pays most of the costs for people with low incomes. Not being aware of or responsible for the full cost reduces people's motivation to control these costs.¹⁵ Furthermore, most people do not make a connection between their daily activities and medical costs. Tying a portion of the health plan premium to achieving a health goal or participating in a health promotion program will help employees better understand that their health behaviors impact their health and medical costs.

Equity

Disease advocacy groups and politicians who oppose tying health plan premiums to achieving a health goal or participating in a health promotion program are concerned that this places an inequitable burden on patients with chronic conditions. Senator Rockefeller summarized these feelings in his comments opposing these provisions after they were approved by a 19 to 4 vote in the Senate Finance Committee bill on October 14, 2009. He said the following: "This provision means that some employees will have to pay more than their fellow employees for the same benefits. It also means that people who do not participate in such wellness programs will be subsidizing the premiums of those who do participate."¹⁶ The reality is that employees who practice healthy lifestyles have the lowest medical care costs and they subsidize the premium payments and benefits of everyone else. For example, the Centers for Disease Control and Prevention (CDC) estimated that medical care costs for smokers were \$1623 higher than for nonsmokers in 1998 dollars.¹⁷ Those costs might be twice as great in 2009 dollars. Similarly, Finkelstein calculated that medical costs increase as obesity increases, with rates for women higher by \$495, \$1071, and \$1549 respectively for women with BMIs of 25.0 to 29.9, 30.0 to 34.9, and 35.0 to 39.9.¹⁸ Furthermore, the HERO (Health Enhancement Research Organization) study¹⁹ found that employees who had heart disease risk factors (stress, tobacco use, overweight, inactivity, high blood pressure, high cholesterol, poor nutrition, and excess alcohol use) had costs 3.28 higher than employees who did not. In 2009 dollars, this would translate to average annual medical costs of \$3000 for employees with none of these risk factors and \$9840 for employees with these risk factors, a difference of \$6560. Employees who actually contract cancer, heart disease, or diabetes or have a stroke can have medical costs of \$50,000, \$100,000, or more, but they still have the same medical premiums as their fellow employees who have no risk factors and no disease. The employees with no risk factors and the employer are the ones subsidizing the higher medical costs of those who have risk factors or actual disease.

Another argument of the disease advocacy groups is that the differential in premiums creates a heavier burden on people with low incomes. This is true from the perspective that a higher premium represents a higher portion of the disposable income of a person with a lower income. Also, people with lower income or education have higher rates of some unhealthy habits than people

with higher income or more education. For example, in 2002, the tobacco use rate was 32.9% for people with incomes below the poverty line compared to 22.2% for those above, and 42.3% for people with a GED degree compared to 7.2% for people with a graduate degree.²⁰ These same facts can support the argument that the lower-income employee will benefit from the financial incentive more than the high-income employee because they have a greater need to save money and will be more motivated to change behavior in order to save this money. For example, research on tobacco excise taxes shows that increasing taxes reduces consumption among low-income smokers more than among high-income smokers.²¹ The combination of being able to pay a lower health plan premium and saving the \$2000 to \$4000 a year it takes to support a pack-a-day smoking habit creates a very powerful incentive for the low-income employee to work very hard to quit smoking. Quitting smoking also prevents dying 13 to 14 years prematurely, and significantly reduces the likelihood of contracting chronic diseases and conditions, including cancer, heart disease, aneurysms, bronchitis, emphysema, stroke, peripheral vascular disease, reproductive failures, gum disease, cataracts, bone thinning, fractures, peptic ulcers, macular degeneration, erectile dysfunction, and many more conditions.²²

Disease advocacy groups also make the very valid claim that people with severe illnesses are often too sick to participate in wellness programs and should not be penalized. The current regulations and the pending legislation both include protections for these employees by specifying that employees who have physical and medical conditions that make it difficult for them to participate in programs can receive the same premium discount if they can document their condition.

Conclusion

In summary, I believe employers should be allowed to integrate financial incentives for health promotion programs into health plan premiums for the following reasons: (1) this approach will help employees become more aware of the cost of medical care and the connection between health behaviors and medical costs; (2) financial incentives drive program participation, and program participation is the key to enhancing the health of the whole organization; (3) protections are in place for employees whose medical condition prevents them from participating in programs; (4) healthy employees already subsidize health plan premiums for sick employees; and (5) integrating financial incentives for health promotion programs into health plan premiums is the only feasible way to cover the cost of the health promotion program and the incentives.

The positions taken by disease advocacy groups have already hurt the effectiveness of workplace health promotion programs, and have driven a wedge between the health promotion community and these groups. ACS and AHA are great organizations that have worked to advance health promotion for decades. They are natural allies with the workplace health promotion community. Hopefully, the gap in positions will be short lived and will be resolved through more dialogue and closer adherence to the evidence on what works best to improve health.

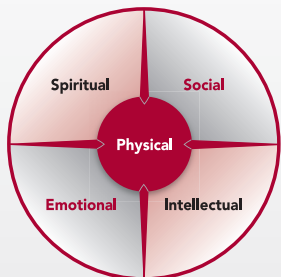
Michael O'Donnell

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(O’Donnell, *American Journal of Health Promotion*, 2009, 24,1,iv)

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