The role of incentives in improving engagement and outcomes in population health management: An evidence-based perspective

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Executive summary

As a leading evidence-based provider of population health management with unmatched experience across a diverse range of clients, StayWell Health Management takes a practical but disciplined approach to consulting with employers about their health-related strategies and programs. Rapidly evolving trends in the use of financial incentives in worksite wellness make this an exciting time to consider policy changes in health plan design that advance employee health and productivity. However, because the evidence regarding the impact of incentives still is preliminary and somewhat equivocal, employers testing new incentive strategies run the risk of making well-intended changes that lead to troubling unintended consequences.

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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. It is clear incentives can drive significantly greater participation, particularly when they are supported by effective communications and a strong culture of health. What is less clear is whether this increased participation yields incremental employee engagement and improvements in population health or primarily represents compliance with incentive rules. Focusing on this key issue, StayWell research is beginning to reveal when incentives deliver more health, and at what cost, and when they primarily stimulate activity and incremental costs with little marginal value.

The 2010 health care reform legislation authorized the use of wellness incentives by group health plan sponsors and specified when premium reductions, rebates or other rewards may be given to an enrollee contingent on "satisfying a standard that is related to a health status factor." Encouraged by this legislation, many of our clients and other employers are moving toward what often are referred to as "outcomes based" incentives, where financial rewards are tied to whether employees are within healthy ranges on biometric measures such as blood pressure, lipids or body mass index. Notably, the legislation requires incentive implementers to offer either a "reasonable alternative standard" or a waiver to individuals for whom meeting the outcomes-based standard would be either unreasonably difficult due to a medical condition or medically inadvisable.

We have examined all of the evidence available, including large StayWell data sets, to assess whether and how an outcomes-based incentive strategy yields better overall engagement and health improvement for an employee population. Findings to date can best be summarized in four words: We don't yet know. Nevertheless, innovators always have pushed boundaries and seldom have the luxury of conclusive evidence before moving ahead with new ideas. Accordingly, we will continue to aggressively pursue research on outcomes-based and other incentive strategies. In the meantime, this white paper aims to provide leaders with the latest research and commentary on the use of financial incentives in employee health improvement strategies.

Our recommendations focus on making incentive designs compatible with five core principles — that they be safe, effective, participant-centered, timely and equitable. It is clear that framers of the wellness incentive section of the health reform bill had such principles in mind when they included the "reasonable alternative standard" provision.

Some employers are choosing not to integrate the "reasonable alternative standard" into their incentive strategy and simply require individuals who do not meet the health standard to seek a waiver from a physician. We believe this approach misses an important opportunity to engage almost all employees in improving their health regardless of whether they can meet the outcomes-based health standard. A better approach deploys highly trained health coaches (with relevant physician involvement) to help those who do not meet the health standard set an individually tailored health goal as a reasonable alternative standard. In addition to encouraging adherence to the health standard, this **progress-based approach** has the potential to engage the many who deem the health standard unattainable, as well as others for whom it is not medically appropriate, in behavior changes that meaningfully improve their health and performance.

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We understand that executive leaders and human resource policy makers are faced with a daunting balancing act of increasing employee responsibility for their health while still providing popular and competitive benefits. This is one reason the current landscape for outcomes-based incentives varies considerably — from employers philosophically opposed to any financial incentives to those who aspire to tie sizable incentives solely to employee health outcomes. Although a few employers are already eliminating rewards not tied to health outcomes, several factors line up against the exclusive use of biometric outcomes as the most effective strategy for producing population-wide health improvements. Some individuals fall so far short of the health standard it is neither realistic nor even healthy for them to try to attain it in the time required to earn the reward. Additionally, since 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 exactly the same lifestyle changes.

These fundamental pitfalls of a purely outcomes-based incentive model are additional reasons we recommend offering **progress-based** rewards to satisfy the "reasonable alternative standard" of the health care reform act rather than simply penalizing or waiving those unable to meet the health standard. In a **progress-based** model, health coaches support setting and attaining a realistic health goal, such as losing 10 percent of body weight. This offers all participants an opportunity to earn incentives regardless of where they are on the health continuum. Consistent with Institute of Medicine guidelines (Institute of Medicine & Committee on Quality of Health Care in America, 2001), a **progress-based** approach is safer because it considers the starting point of each individual and sets a "risk adjusted" target rather than presuming that one size fits all in the attainment of health goals. We also believe a **progress-based** approach incorporates participant-centered programming, equity and effectiveness as described in this white paper.

The most appropriate and cost-effective use of incentives remains high on the StayWell research and development agenda. We will continue to evaluate the role of behavioral economics, the impact of varying incentive designs, and the effectiveness of incentives across gender, age, income, and other socio-demographic variations in our client base. At StayWell, we believe true innovation should be effective as well as new, and in that spirit of innovation we will continue to share the best available evidence for informing policy makers in this exciting new era of employee health management.

Introduction

America's legacy of independence suggests we are culturally taught from an early age to believe we can achieve anything if we put our mind to it. But we also are a society steeped in the value of holding one another accountable for our actions. When Congress passed a health care reform law that included provisions for offering financial incentives in the form of a health plan premium discount, rebate, or other reward for satisfying a standard related to a health status factor ("PPACA," 2010), national policy makers clearly signaled an interest in staking out new territory in balancing individual freedom and social responsibility in the area of personal health choices. By increasing the maximum amount of this incentive from 20 percent of the cost of health care coverage currently allowed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to 30 percent in 2014, and up to 50 percent at a later date if demonstrations prove effective, lawmakers signaled that providing incentives to citizens for engaging in healthy behavior is an essential ingredient in improving the health of the nation, and set the stage for dramatic changes in the practice of population health management.

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StayWell is working with an increasing number of employers interested in basing part or all of their incentives on employee satisfaction of a health standard (e.g., achieving body mass index, blood pressure, and cholesterol targets), as provided for by the health care reform law. Commonly referred to as an "outcomes-based" incentive, we do not know if this kind of strategy will prove to be more effective in reducing risks and costs than participation-based incentive strategies, although it clearly is more cost-effective because incentives only are provided to those who meet desired health goals. Additionally, it is not clear whether any incentive strategy is as effective in the long run as cultural or environmental change.

This paper describes current financial incentive issues in workplace health management and identifies research evidence to inform decision makers concerning health management incentive strategies.

Incentives and employee engagement in health

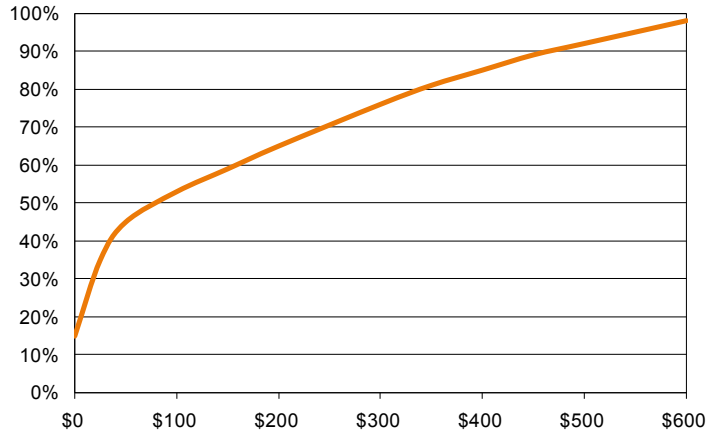
Very few studies have attempted to determine the most effective use of financial incentives for improving the health of employee populations. Findings to date suggest that increasing participation in simple activities is relatively straightforward, but the role of incentives in changing complex health behaviors in sustainable ways is less clear. Some studies have raised concerns about the use of incentives in health management, and the evidence to date indicates they are at best a double-edged sword. Evidence of effectiveness is especially important for employers. However, early adopters must rely on limited evidence concerning the risks and benefits of new incentive approaches.

The three pillars of engagement

StayWell researchers have demonstrated a positive and curvilinear relationship between the size of an incentive and health assessment (HA) participation rates (Anderson, Grossmeier, Seaverson, & Snyder, 2008). Further analysis demonstrated

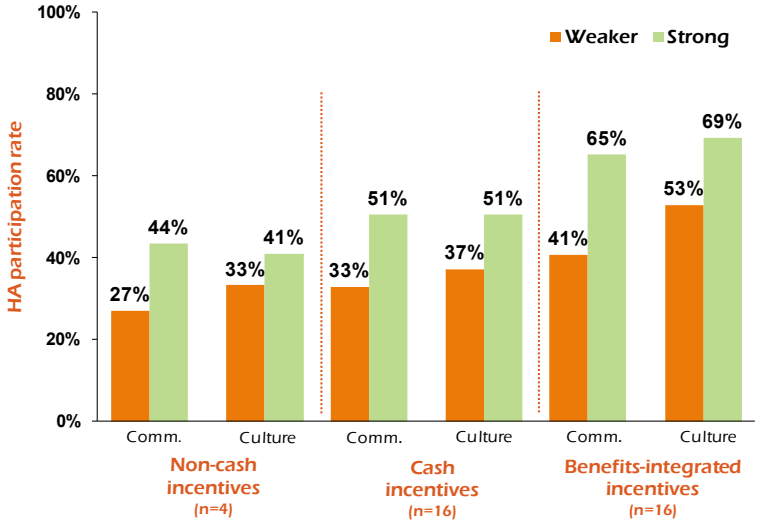
that while financial incentives for HA completion are effective, a supportive culture and strong communications greatly increase their effectiveness (Seaverson, Grossmeier, Miller, & Anderson, 2009). This research showed that incentives, communications and culture all were positively related to greater HA participation.

Incentives and HA participation



Source: Anderson D, Grossmeier J, Seaverson ELD, Snyder D. The Role of Financial Incentives in Driving Employee Engagement in Health Management. ACSM'S Health & Fitness Journal. 2008;12(4):18-22.

Incentives, communication and culture



Source: Seaverson ELD, Grossmeier J, Miller TM, Anderson DR. The role of incentive design, communication strategy and worksite culture on health assessment participation. American Journal of Health Promotion, 2009; 23: 343-352.

Other researchers also have shown the vital interaction between organizational characteristics and the use of incentives. For example, a study by Taitel and colleagues investigated factors associated with HA participation rates (Taitel, Haufle, Heck, Loeppke, & Fetterolf, 2008). This study found that value of incentives, communications, and level of organizational commitment are the strongest predictors of HA participation rates. Specifically, this study used regression analysis to demonstrate that to achieve a 50-percent HA participation rate, employers with low levels of organizational commitment and weak communications would need an incentive value of approximately $120

compared to only $40 to achieve this rate of participation with strong commitment and communication. These results mirror our own in demonstrating that incentive effectiveness is highly dependent on both culture and communications (Seaverson et al., 2009).

A similar study of 87 employer groups showed that incentives paired with a wide variety of communications strategies produced the greatest participation levels (Wilhide, Hayes, & Farah, 2008). Larger incentives (i.e., greater than $50) led to higher participation, but communication strategies such as "high blast" repeated emails and health fairs had a significant impact on both program participation and completion. To be sure, money alone can drive participation — if enough is offered for what is being asked. For example, one analysis showed that HA or biometric screening participation rates increased by about 10 percentage points for each $100 increase in financial incentives and reached universal participation at a $600 incentive (Nyce, 2010).

Our recent study that explored predictors of program enrollment demonstrated that participants were 40 percent more likely to enroll in a health coaching program when there was an incentive to do so (Grossmeier, 2010).

Our research also has shown incentives to be a strong predictor of health coaching enrollment. Our recent study that explored predictors of program enrollment demonstrated that participants were 40 percent more likely to enroll in a health coaching program when there was an incentive to do so (Grossmeier, 2010). However, incentives do not seem to influence active participation or retention even though most of the organizations included in the study tied the incentive to program completion rather than enrollment. In other words, the incentive influenced the simple act of enrolling in a coaching program but had no direct impact on program participation or completion. Our research also indicated that strong communications and a comprehensive program design were significant predictors of enrollment, and that the enrollment decisions of women were more influenced by incentives while men were more influenced by strong communications.

Given these results, we know that incentives are effective in increasing rates of simple behaviors, like completing an HA, that do not require sustained motivation (Anderson et al., 2008; Seaverson et al., 2009; Taitel et al., 2008). However, the cost-effectiveness of incentives needs to be compared to other strategies. Long-term change and risk reduction require helping participants achieve and maintain a high level of motivation (i.e., commitment or "engagement") 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. It is common for individuals to take six months to a year to establish new habits, and this daily attention to a healthier lifestyle often needs to be sustained over a lifetime for risk factors like obesity (Prochaska, Norcross, & DiClemente, 1994).

The evidence on using financial incentives as rewards for behavior change demonstrates that, while incentives provide external motivation that can initiate attempts to change, they may also decrease the intrinsic motivation required for changes to be sustained (Ryan & Deci, 2000). 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. While incentives tied to achieving health outcomes have intuitive appeal, the required alternative standard ties the success of outcomes-based models to their ability to sustain health behavior change.

We have concluded that incentives, particularly those tied to health plan premiums, are just one component of a comprehensive "best practice" strategy for reducing population health risks and curbing health care costs (Grossmeier, Terry, Cipriotti, & Burtaine, 2010; Terry, Seaverson, Grossmeier, & Anderson, 2008).

StayWell recommends that incentives always be applied within the context of the communications, climate and culture of the organization. According to Buck Consultants, only 33 percent of participants believe they have a culture of health today, but 81 percent intend to pursue it for the future (Buck Consultants, 2010). The importance of this trend is underscored in the research by StayWell and others described above, showing that the impact of incentives on employee behavior is closely bound to the workplace culture in which they are used (Grossmeier, 2010; Seaverson et al., 2009; Taitel et al., 2008). In the right circumstances, initial compliance can indeed become long-term engagement. In fact, most major social changes have required the smart pairing of culture change, communications and policy-related incentives. Our nearly universal acceptance and use of seat belts, the vigilance of our children in recycling, the decades-long and continuing saga and success story in reducing tobacco use — these all provide great examples and reasons for hope in our ability to fashion the right combination of education, policies and incentives to tackle today's formidable health issues. StayWell has concluded based on the research that each of these elements serves as a pillar supporting overall engagement, where culture is the most important pillar followed by communications and then incentives. Not only is each of these three pillars of engagement important, our experience indicates that how well they are strategically and operationally aligned is critical to maximizing engagement and, ultimately, health outcomes.

Best practices in engagement

Too often the term "engagement" is used in health management circles when referring to the percent of individuals who participate in programs. At StayWell, we are interested in advancing a much more robust definition of engagement, where "engaged participants" attend programs because they are intent on improving their health and are excited about contributing positive energy and productivity to their companies, families and communities. As the extensive focus of this paper on incentives attests, StayWell believes well-designed incentives can play a valuable role in this more robust type of engagement. However, beyond incentives alone, StayWell has studied the role of incentives in the context of other relevant program components. We have concluded that incentives, particularly those tied to health plan premiums, are just one component of a comprehensive "best practice" strategy for reducing population health risks and curbing health care costs (Grossmeier, Terry, Cipriotti, & Burtaine, 2010; Terry, Seaverson, Grossmeier, & Anderson, 2008).

Like the focus of the national employee health survey conducted by Towers Watson (Towers Watson & National Business Group on Health, 2011), StayWell views employee health programs as an important part of building a high-performance workforce. To capitalize on the potential market advantage that healthier employees can provide, corporate leaders should view the use of incentives in the context of a range of promising investments in employee health. Measurement and evaluation tools are readily available to help CEOs and CFOs build a strategic advantage based on improved employee health. Yet, despite the availability of these tools, there is a large gap between employers that know what they should do and those that are actually doing it. When it comes to employing industry best practices in employee health management, such as using incentives in the context of multiple intervention modalities, measuring program outcomes, tracking financial impact and, especially,

engaging leadership in creating healthy workplace culture, that large gap becomes more like a quality chasm.

Organizational leaders who consider using incentives of any kind (e.g., compensation strategy, bonuses, recognition programs) usually do so with a goal of creating a more productive and efficient workforce. They also have the tenacity to execute on the best practices they strongly believe will build and maintain a workforce that out-produces and out-innovates competitors. In his best-selling book "Good to Great," Jim Collins describes a formula for success followed by a select group of distinguished companies that is both simple and compelling (Collins, 2001). Their core business principles and practices include having a clear and compelling vision, having willful but humble leadership, and staunchly supporting the metrics that really matter for the business.

It is this distinction — achieving continuous improvement based on routinely collected measures — that will ultimately determine the best-practice incentive strategies that play a role in realizing the market advantage offered by a healthy, high-performance workforce.

Similarly, health management researchers have gathered together some of the longest running programs with the greatest success in improving employee health. Among the best examples are employers chosen as winners of the C. Everett Koop National Health Award (i.e., Koop Award). Applicants for the prestigious Koop Award are judged according to corporate culture and leadership commitment, strategic planning, communication and marketing, how health programs are integrated with benefit design, use of incentives, program coordination and data management. The Koop Award's orientation toward scientific rigor is evidenced in the requirement that programs are evaluated primarily for their ability to provide documented evidence of improving health status and reducing health care costs. The Wellness Council of America (WELCOA), a long-standing advocacy group for employee health, offers similar "rules of the road" for a results-oriented workplace wellness program that includes CEO support, wellness teams, data, an operating plan, a supportive environment and careful evaluation of outcomes.

Moving from good to great in health management may start with pulling these ingredients together, but the difference between top performers and the rest of the pack always has far less to do with what they do and more to do with how they do it. Many employers are eligible to apply for the National Business Group on Health's Best Employers for Healthy Lifestyles Award, but very few can prove they have found the regimen needed to beat secular trends presently driving poorer health and higher health care costs. To do so, an employer must demonstrate it has high-level executive support as well as a dedicated steering committee or team to advance initiatives. Employers also must show that they have conducted health risk assessment or claims analyses to collect population-specific data, and implemented programs or services that support healthy lifestyles. The highest recognition level is reserved for organizations that use data based on their populations to continue to innovate and improve their overall program and strategy for health improvement.

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Laying the foundation for using incentives

How can we distinguish best practices in the use of incentives in employee health management? This question led StayWell researchers to conduct a study that explored

whether implementation of defined best practices would definitively lead to program success as measured by participation rates and health improvement trends (Terry et al., 2008). We also aimed to establish benchmarks for quality in employee health management programs based on implementation of quality program components.

Nine best practices

Biometric health screenings

Comprehensive program design

Dedicated onsite staff

Integrated, comprehensive communication plan

Integrated incentives

Multiple program modalities

Population-based awareness-building activities

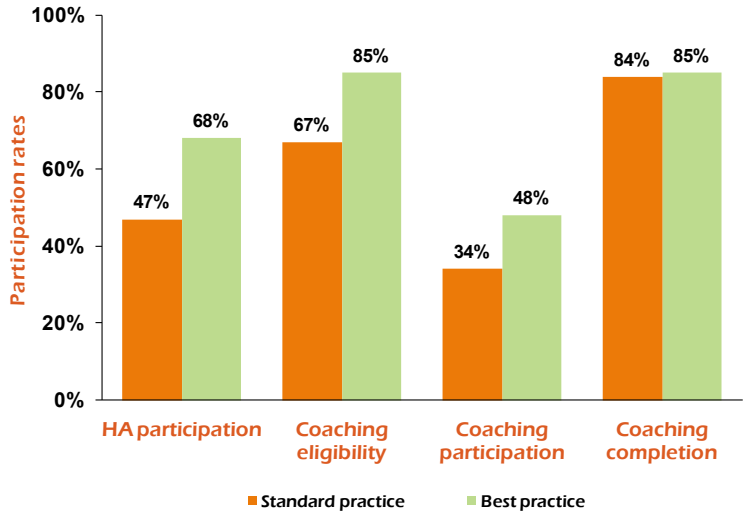
Strong senior management support

Vendor integration

All of the employers studied were rated on nine components identified as best practices for worksite population health management by researchers, award programs and experts in the field (see sidebar) (Terry et al., 2008). Based on a rigorous ranking methodology to derive cut-points based on the quality of delivery, we determined that six of the 22 employers included in the study stood out as a "best-practice group" based on these nine components. This best-practice group of employers was compared to a "standard-practice group" composed of the other 16 employers, all of which still included incentives and comprehensive programs in their health management strategy. This is important to consider when reading reports that employee health programs often achieve poor employee participation rates. Such reports are not surprising given how few employers can attest to anything resembling a well-designed, fully funded and long-term strategy for employee health management. In fact, one national survey concluded that fewer than seven percent of all worksite health programs could be described as comprehensive (Linnan et al., 2008).

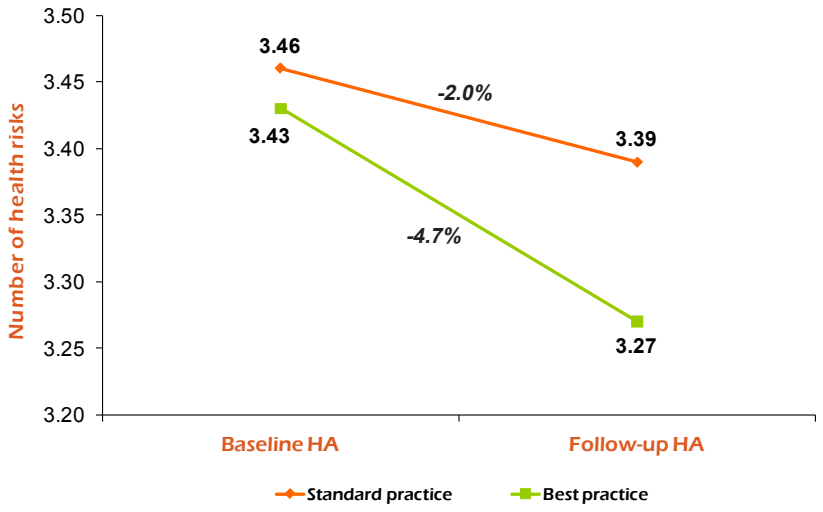
And did the best-practice employers excel when it came to results? Absolutely! Starting with the basics, the best-practice employers got 44-percent greater HA participation than the standard-practice employers (68 percent vs. 47 percent). Additionally, best practice employers achieved 41-percent greater participation in health coaching programs designed to support their employees in improving their health habits (48 percent vs. 34 percent). Did this greater program engagement also produce a better bottom line? Again, the best-practice employers got a much bigger payoff in employee health. Specifically, the standard-practice employers in our study achieved a two-percent risk reduction, which is a level that, for many employers we've analyzed, can yield a positive return on investment. In comparison, the best-practice organizations achieved nearly a five-percent risk reduction, yielding about 2.4 times as much improvement in this key measure of organizational health (Terry et al., 2008).

Engagement among best-practice and standard-practice organizations



Source: Terry PE, Seaverson EL, Grossmeier J, Anderson DR. Association between nine quality components and superior worksite health management program results. J Occup Environ Med. Jun 2008;50(6):633-641.

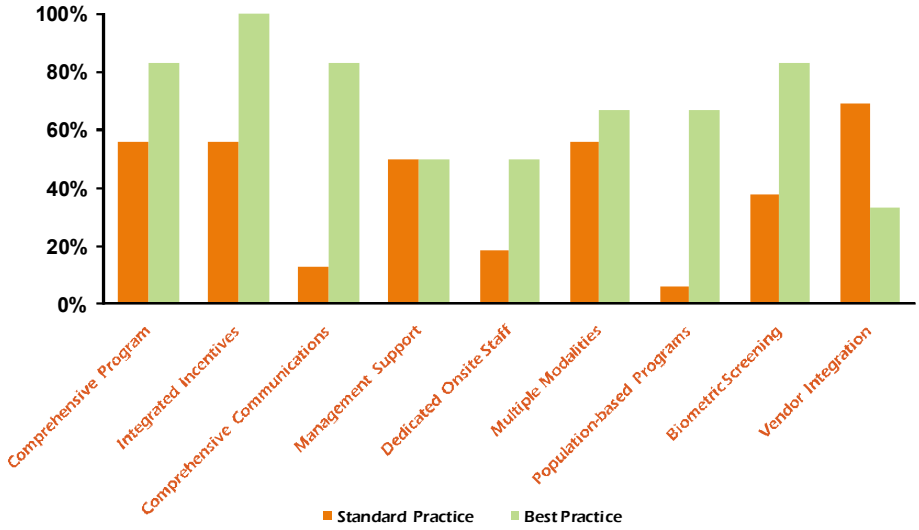
Population-level health risk change among best-practice and standard-practice organizations



Source: Terry PE, Seaverson EL, Grossmeier J, Anderson DR. Association between nine quality components and superior worksite health management program results. J Occup Environ Med. Jun 2008;50(6):633-641.

The healthy competitive advantage achieved by the best-practice employers in this study was not solely due to incentives but, rather, was the cumulative result of a full range of integrated quality components all adding up to much better organizational health improvement. Nevertheless, it is notable that 100 percent of the best-practice organizations had integrated incentives into their health plan, compared to only 56 percent of the standard-practice organizations (Terry et al., 2008). This integration suggests that these best-practice employers also were more likely to be using incentives to establish the link in their employees' minds between their personal health behaviors and the cost of their health care coverage.

Implementation of best practices



Source: Terry PE, Seaverson EL, Grossmeier J, Anderson DR. Association between nine quality components and superior worksite health management program results. J Occup Environ Med. Jun 2008;50(6):633-641.

Current trends in employer use of health-related incentives

It is important to separate trends for incentives for simple actions like participating in an HA or screening from incentives that encourage more complex activities, like enrolling in and completing a behavior change program (e.g., health coaching) or those for incentives for meeting a health standard such as a healthy body weight. Use of incentives for simple actions has been growing for the past decade among StayWell clients and now is pervasive, with more than 90 percent offering such incentives. Incentive use for more complex long-term behaviors has grown more slowly during this time (Buck Consultants, 2007, 2010) but also is quite common, with about 40 percent of StayWell clients also offering these kinds of participation-based incentives. In contrast, very few employers tied incentives to meeting health standards in 2007 (Buck Consultants, 2007) before the passage of the 2010 health care reform bill, but that number is expected to grow very rapidly (Buck Consultants, 2010). The inclusion of health standards has grown from almost nonexistent to about 10 percent of StayWell clients in the past year, and we project usage will exceed 20 percent in 2012.

... our client experience suggests that most companies incorporating health standards into their incentive are testing a mixed model with employees who do not achieve the health standard being able to earn the full incentive through participation in program activities.

A common refrain in health care reform has been that containing health care costs will require more personal responsibility by consumers. It is quite reasonable for employers to anticipate that as employees bear more of the financial cost of unhealthy choices, they will become more motivated to stay well. A small number of employers are adopting a "tough love" approach of tying sizable incentives solely to attaining a health standard, except for employees whose physician signs a waiver stating that they have a medical condition preventing them from doing so. Still, if employees believe that incentives are merely being used as a tactic for shifting costs to those in poor health, wellness program planners become cast as purveyors of financial penalties for the least healthy rather than as advocates for preventing illness by offering engaging and popular programs. Accordingly, our client experience suggests that most companies incorporating health standards into their incentive are testing a mixed model, with employees who do not achieve the health standard being able to earn the full incentive through participation in program activities.

As they are asking more responsibility of their employees by introducing health standards into incentive designs, more employers also are signaling their understanding of their shared responsibility by instituting policies aimed at creating a healthy work culture and environment. One such illustration is provided in a Towers Watson report showing organizations most effective at controlling health care costs also offered significantly healthier food options in cafeteria/vending machines compared to those that were less effective (69 percent versus 39 percent, respectively) (Nyce, 2010; Towers Watson & National Business Group on Health, 2010).

Recent trends in types and amounts of incentives

While some companies are adding outcomes-based incentives to their strategy, the overall value of incentives also is growing. Surveys by major consulting firms show gradual increases in average incentive dollar amounts in recent years (Buck Consultants, 2010; Hewitt Associates, 2010; Marlo, Dan, & Lykens, 2010). This likely is because of studies by StayWell and others demonstrating the positive relationship between incentive amounts and program participation rates.

According to the National Business Group on Health (NBGH), the amounts used range widely from $50 to $1,200 (Marlo et al., 2010). For most organizations, the amount of incentives grows as programs mature, with decreasing incentive amounts used over time for completing an HA (although the HA usually is required to be eligible for additional amounts) and increasing amounts directed toward completion of a coaching program or attaining a health standard. Escalating incentive levels will continue to test the observation in the Towers Watson report that, "The impact of financial incentives is less noticeable for 'action based' programs like weight management and smoking cessation which require ongoing commitment from individuals" (Nyce, 2010). The wide range in the size of incentives also may be related to the wide variation among employers in how much emphasis they put on the role of incentives compared to culture for engaging employees in health promotion. The analysis from Towers Watson concluded that healthy culture tactics such as engaged leaders and simple environmental supports can increase participation in an employee HA as much as a $140 financial incentive.

The typical value of incentives used by StayWell clients has increased substantially over the past ten years, from the $10 to $50 annual range per employee ten years ago to the $100 to $1,700 range today (Appendix A).

The typical value of incentives used by StayWell clients has increased substantially over the past 10 years, from the $10 to $50 annual range per employee ten years ago to the $100 to $1,700 range today (Appendix A). These larger incentives also are being tied to a growing list of program requirements, representing higher expectations about what is required to earn the maximum incentive. As incentives have grown in value, the type of incentive most commonly used also has migrated from tokens, such as T-shirts and water bottles worth less than $25, to cash or equivalents like gift cards worth $25 to $100, to health plan incentives like premium reductions or contributions, to health savings accounts totaling $200 to $1,000 or more.

Trends among StayWell clients are consistent with national patterns. Hewitt Associates reported, for example, that use of cash payouts for completion of an HA nearly doubled between 2009 (35 percent) and 2010 (63 percent) (Hewitt Associates, 2010). NBGH reports that the average incentive amount in 2010 was $386, up from $318 in 2009 (Marlo et al., 2010). The average annual incentive expenditure by U.S. employers reported by Buck Consultants in its annual global wellness survey more than doubled from $100 per employee in 2007 to $220 in 2010 (Buck Consultants, 2007, 2010).

StayWell clients are increasingly using point systems to administer their incentive programs, with the growing menu of activities available to earn incentives representing an effort to make participation in employee health programs a robust and continuous process rather than merely a once-a-year HA or screening activity. Incentive points can be earned by participating in education classes, campaigns or contests, and through completing coaching programs, volunteering in the community or helping with wellness committee work.

Current trends in what is rewarded in employee health

Beyond driving employee participation or "engagement" in health-promoting activities, incentives increasingly are being used to recognize specific levels of goal attainment, such as adhering to a chronic condition management program or achieving a health standard. According to a survey of the top tactics planned for 2012, financial incentives or penalties represent five of the top 12 changes in health plan options being implemented in 2011 by best-performing employers (Towers Watson & National

Business Group on Health, 2011). Current approaches to providing health-related incentives are quite variable among companies, which may be driven by the newness of this balancing act of increasing employee responsibility for health while still providing popular and competitive benefits. Towers Watson summarizes the trend by noting that, "While employers are clearly raising the bar for earning wellness program financial rewards, few seem willing to penalize employees via premium surcharges, with exceptions for smokers/tobacco use."

Despite widespread interest in incentives tied to health standards, recent surveys indicated that employer use of such incentives is not yet the norm.

Most benefit consulting firms are now monitoring the use of incentives (see Appendix B). However, comparisons across surveys are challenging due to differences in measurement and terminology, as well as definitions of incentives and program components. The Mercer survey suggested that the use of incentives increased slightly in the past year (Mercer, 2010), while the Buck Consultants survey reported that 25 percent of their respondents plan to add incentives in coming years (Buck Consultants, 2010). In contrast, Hewitt Associates reported that the role of incentives as a key "component of health care strategy" declined from 57 percent in 2009 to 44 percent in 2010. Perhaps related to this decline is their finding that "promoting employee accountability" also has waned as a key strategy while "offering competitive benefits" is now the top benefit strategy. On the other hand, the same Hewitt Associates report found that about half (47 percent) of those surveyed planned to impose penalties for nonparticipation in health programs either in 2010 or in the next three to five years, which is up from 18 percent presently imposing such penalties (Hewitt Associates, 2010).

Despite widespread interest in incentives tied to health standards, recent surveys indicated that employer use of such incentives is not yet the norm. The Buck Consultants and Hewitt Associates surveys reported that 23 percent and 17 percent of companies, respectively, include an outcomes-based standard in their incentive strategies (Buck Consultants, 2010; Hewitt Associates, 2010). Towers Watson reported only one percent of companies presently require employees to achieve a healthy weight, blood pressure or cholesterol value to qualify for a preferred health plan option (Nyce, 2010; Towers Watson & National Business Group on Health, 2010). It also is unclear how many organizations will move in this direction in the near future due to the variability in estimates reported in various consultant reports. For example, Towers Watson reported that 92 percent of companies have no plans to implement outcomes-based incentive strategies (Towers Watson & National Business Group on Health, 2010), whereas Buck Consultants reported 33 percent of companies (Buck Consultants, 2010). What is more clear is that higher premiums will be the choice when penalties are imposed, with Hewitt Associates reporting that 81 percent indentified this as a current or planned "disincentive type." Larger deductibles and co-pays also are methods being used or considered as penalties for nonparticipation in employee health programs (Hewitt Associates, 2010).

Opportunities and threats of outcomes-based incentives

The possibility that outcomes-based incentives could take population health to a new level of impact is an empirical question well worth testing (Halpern, Madison, & Volpp, 2009), but testing new engagement methods with busy working adults is bound to suffer from the usual vagaries of innovation through trial and error. Some have argued that well-intentioned users of incentives often produce the opposite of their desired results or that their efforts backfire in other ways (Kim, Kamyab, Zhu, & Volpp, 2011; Kohn, 1993; Pink, 2009; Volpp et al., 2008; Volpp et al., 2009). Regardless of whether incentives tied to actions or outcomes ultimately prove helpful in improving population health, complex issues face those contemplating their use. This section reviews the economic rationale for tying incentives to health outcomes, identifies opportunities presented by the health care reform act, summarizes legal and ethical issues of the increasing use of incentives, and provides information that human resources professionals may find helpful in guiding policies on incentives.

If the standard is viewed as unachievable by those most in need of health improvement (who tend to be the older, less educated, highest-risk segments of the population), then the planned carrot may actually be perceived as an unfairly used stick that alienates rather than motivates the highest-risk individuals who drive the greatest portion of health care costs.

The economic rationale

Those moving from incentives for participation to basing incentives as much as possible on achieving health outcomes are undoubtedly motivated by a desire to get more bang for the incentive bucks, whether through rewarding success or punishing failure or complacency. Tying a financial reward directly to a desired result has a logical appeal because the dollars only will be spent for those who actually achieve a health standard associated with better health and lower health care costs. Proponents also argue that an outcomes-based approach will motivate more people to improve their health, and that it is fair because those who choose not to do so should be responsible for the additional cost of their unhealthy choice (O'Donnell, 2010).

Concerns about outcomes-based incentives

Despite their apparent appeal, there are several concerns about the ultimate effectiveness as well as the efficacy of outcomes-based incentives. People begin from very different starting points relative to a health standard. If the standard is viewed as unachievable by those most in need of health improvement (who tend to be the older, less educated, highest-risk segments of the population), then the planned carrot may actually be perceived as an unfairly used stick that alienates rather than motivates the highest-risk individuals who drive the greatest portion of health care costs. Incentives tied solely to outcomes may inadvertently overcompensate some (e.g., the young or socioeconomically advantaged) while effectively disenfranchising many of those most in need. In public health parlance, finding the right balance is referred to as "doing the greatest good for the greatest number." Regrettably, with obesity rates over 30 percent of many populations and morbid obesity (body mass index above 40) representing the fastest growing segment of obese people (Flegal, Carroll, Ogden, & Curtin, 2010), the starting point for attaining recommended health standards may be moving too far from the goal for financial incentives alone to address. This underscores the need to plan incentives in concert with a best-practice approach to population health management.

Incentives, HIPAA and the Patient Protection and Affordable Care Act

Empirical evidence supporting the use of incentives for increasing participation in programs is persuasive (Anderson et al., 2008; Grossmeier, 2010; Seaverson et al., 2009; Taitel et al., 2008; Wilhide et al., 2008). Studies concerning the effects of outcomes-based incentives in employee health programs still are scarce and, while findings to date suggest a short-term benefit, there is not yet solid evidence that they yield sustained population health improvement (Volpp et al., 2009). Aside from the lack of research to guide incentive policies, employers also must weigh important legal and ethical issues in deciding about such benefit approaches. One trend is clear — employers will increasingly share the responsibility for solving the growing health care cost burden with their employees. As the Hewitt Associates report states, "the deal between employers and employees is changing" (Hewitt Associates, 2010). Many employers believe the most generous benefits should be provided to those taking good care of their health, with 81 percent of those surveyed by Hewitt Associates naming higher insurance premiums as "the penalty of choice" for those not taking good care of their health (Hewitt Associates, 2010). Employers pursuing this approach, however, should include in their planning the concerns of the 32% of employees in the recent Towers Watson survey who "would not feel comfortable if my employer increased the premium costs for workers unwilling to take steps to manage their illness or lower their health risk" (Towers Watson, 2011).

The unpredictability of the current legal and regulatory climate regarding benefit design weighs every bit as heavily on employers as the challenges of employee relations. Congress and the EEOC have sent mixed messages, countering what they give with what they may take away.

Though the Equal Employment Opportunity Commission (EEOC) has signaled concerns about voluntariness and the potential of wellness programs to discriminate against higher-risk employees ("Regulations Under the Genetic Information Nondiscrimination Act of 2008," 2010), recent surveys indicate that the average incentive level still is less than $400 (Buck Consultants, 2010; Marlo et al., 2010; Towers Watson & National Business Group on Health, 2010). At this incentive level, it appears the legal definition of voluntariness is not a concern for most employers testing outcomes-based incentives. In addition to achieving budget neutrality by integrating these incentives into their group health plan, doing so also enables employers to comply directly with the limit on rewards of 20 percent of health care coverage costs specified in the HIPAA regulations and codified in the health care reform act (a.k.a., the Patient Protection and Affordable Care Act or PPACA) ("Health Insurance Portability and Accountability Act," 1996; "PPACA," 2010). Employers and researchers are just beginning to evaluate the effectiveness of benefits-integrated incentives for program participation versus outcomes. As such, it remains to be seen which approach ultimately will prove more effective in controlling employee health care utilization and claims costs.

The unpredictability of the current legal and regulatory climate regarding benefit design weighs every bit as heavily on employers as the challenges of employee relations. Congress and the EEOC have sent mixed messages, countering what they give with what they may take away. They have provided employers encouragement and support for tying significant financial incentives to individual health status factors under the HIPAA regulations and, more recently, the PPACA non-discrimination rules ("Health Insurance Portability and Accountability Act," 1996; "PPACA," 2010). But, the EEOC issued rules under the Genetic Information Nondiscrimination Act (GINA) limiting the collection of family history information to calibrate HA participant

risk status when incentives are tied to participation ("Regulations Under the Genetic Information Nondiscrimination Act of 2008," 2010). In addition, future EEOC rules under the Americans with Disabilities Act (ADA) may limit the use of incentives for HAs that include disability-related questions, a move that would render these tools much less effective in assessing individual risk and supporting participants in improving their health.

Like debates concerning whether health care in America is a privilege or an entitlement, employers' views of the role for incentives or disincentives varies across the political and ideological spectrum.

Over 250 medical and public health groups, including the American Public Health Association, the American Cancer Society and the American Medical Association, supported the GINA regulations, arguing in a letter that wellness programs "need not collect and retain private genetic information to be effective" and that wellness programs should not be exempted from the law ("An open letter to the Secretaries of Treasury, Health and Human Services, and Labor," 2009). But other groups, including Health Promotion Advocates and the Care Continuum Alliance, have opposed the new GINA rules and argued that using family-history information provides vital program planning, risk identification and program management data intended to make wellness more accessible and effective for employees.

Unsettled benefits landscape: The debates go on

HIPAA and PPACA requirements for employers providing wellness programs include a provision that outcomes-based incentives must offer a reasonable alternative or waiver to those who cannot meet the health standard due to a medical condition. Such language signals a caution that employees should not be "punished by rewards" they cannot achieve. Indeed, the varying language used in different consultant firm surveys illustrates the unsettled benefits landscape concerning whether outcomes-based incentives constitute penalties or rewards. For example, one survey of employers asks questions about "health premium increases" that are characterized as penalties and the same survey asks similarly worded questions about an employer's plans for using "health premium reductions" that are positioned as rewards (Buck Consultants, 2010). For a wellness program nonparticipant, whether his or her decision not to participate leads to a premium increase or to ineligibility for getting a premium reduction may seem all the same. In a behavioral economics context, however, studies suggest avoiding a loss may actually be a more powerful motivator than seeking a gain (Kahneman, Knetsch, & Thaler, 1990; Tversky & Kahneman, 1991).

The level at which a financial incentive is considered voluntary versus coercive or punitive versus supportive will be only partially answered by researchers. Although the EEOC allows that an HA is permissible as part of a voluntary wellness program, it has not yet clearly established financial size limits on incentives that could be offered without rendering the program involuntary. Like debates concerning whether health care in America is a privilege or an entitlement, employers' views of the role for incentives or disincentives varies across the political and ideological spectrum. Consider other health policy changes in recent years, such as smoke-free restaurants and bars, motorcycle helmet laws or hand gun regulations. There is predictable variation among states. In many communities restrictive regulations passed by one legislature have been repealed by the next, more libertarian-leaning body. In the end, the intent of incentives will be a function of one's values and beliefs. As Halpern and colleagues note, for example, "we may properly condemn programs that would charge fees to restrict

insurance eligibility for people who fail to attain targeted results (Halpern et al., 2009). However, whereas such disincentive programs may deprive those most in need of help and widen welfare gaps among employees or citizens, offering positive incentives for better health can only promote individuals' well-being." But, even this selective, widely held endorsement of "positive" incentives is countered by some who view incentives as problematic or even inherently counterproductive (Kohn, 1993; Pink, 2009).

To inform both the financial and policy questions, StayWell researchers, along with other behavioral and health sciences experts across the country, continue to focus on what size and what form of incentives are most likely to evoke and sustain health actions and behavior change.

A new precedent concerning ADA and the voluntariness standards

Until very recently, the question of whether a wellness program that connected a financial penalty for non-participation would violate the ADA was an open question. This year, U.S. District Judge K. Michael Moore dismissed a Florida case against a Broward County health plan that assessed employees a $20 bi-weekly surcharge if they declined to participate in a "voluntary" wellness plan ("SEFF v. Broward County," 2011). The program required that employees attend a health screening that used a finger-stick blood sample along with the completion of an HA. In his ruling, Moore held that the wellness program fell under the "safe harbor" provision of the ADA and wrote, "It is clear to this court that the wellness program is not a subterfuge; it was not designed to evade the purpose of the ADA."

Although the Broward County health plan ruling could be appealed, it responds to concerns of Health Promotion Advocates and other health promotion groups that possible interpretations of the ADA could pose a serious threat to the ability of employers to use incentives and deliver wellness programs effectively. However, it is important to note that the decision did not explicitly address the "voluntariness standard" about which the EEOC has expressed concern. The EEOC notes that it still is studying the issue and has indicated it understands that this issue concerns many health promotion advocates.

What behavioral science says about incentives

Whether premium differentials that shift costs to higher-risk health plan enrollees are sustainable is a problem that actuaries will need to monitor. Similarly, debates about the fairness of insurance cost-shifting according to community or individual risks are far from new and are likely to continue into the future (Terry, 1994). To inform both the financial and policy questions, StayWell researchers, along with other behavioral and health sciences experts across the country, continue to focus on what size and what form of incentives are most likely to evoke and sustain health actions and behavior change. We also understand that research findings about the role for incentives in facilitating behavior change must be placed in the context of what is most cost-effective for employers designing these programs (Appendix B).

As with most value-based budgeting, planners want to produce the greatest impact achievable at the lowest cost possible. The StayWell research described above showed a positive but gradually diminishing effect of financial incentives on participation in an HA (Anderson et al., 2008). This relationship provides a basis for evaluating cost-effectiveness despite the fact that the primary "costs" when incentives are integrated into a health plan design are not financial but, rather, opportunity costs versus other incentive options in a value-based benefit model.

There is an analogous question regarding the relationship between the size of financial incentives and behavior changes. Although there are very few studies offering guidance on this issue, it is clear that the relationship between incentives and sustained behavior change is much more complex than for simple actions at a single point in time. When it comes to tying incentives to sustained behavior changes, there is little evidence that such incentives are more effective, much less more cost-effective, than the results produced by best-practice alternative engagement strategies. The challenge of creating cost-effective incentive strategies tied directly to daily behaviors is one of the reasons interest is shifting toward tying incentives directly to outcomes or measurable progress toward achieving them.

... our recommendation is that incentives tied to behavior change programs be kept modest – just large enough to tip forward those teetering on the edge of engaging while not so much as to reduce their already considerable intrinsic motivation.

The psychology of reward

Although incentives play a well-established role in eliciting compliance with simple actions like completing an HA or screening, or enrolling in a coaching program (Anderson et al., 2008; Grossmeier, 2010; Seaverson et al., 2009; Taitel et al., 2008; Wilhide et al., 2008), it is less clear whether incentives can play a role in establishing and, more importantly, sustaining more complex behavior change. Psychologists often refer to the vital importance of "intrinsic motivation" for successful behavioral adaptations. Financial incentives, which are "extrinsic" rewards, are enticing but not typically salient (Ryan & Deci, 2000).

A striking illustration of these concepts comes from a recent randomized controlled trial that tested the effectiveness of a $750 incentive in smoking cessation (Volpp et al., 2009). Though short-term (i.e., three to six months) quit rates were significantly higher for the incentive group compared to a control group (21 percent vs. 12 percent), 36 percent of the incentive group participants relapsed back to smoking over the long term. Volpp and colleagues noted that relapse rates in their study group were higher than in current evidence-based standards for smoking cessation, suggesting that "relapse rates differ according to whether smoking cessation occurs in the presence or absence of incentives." In a process evaluation of participants in this same research program, Kim and colleagues interviewed both quitters and nonquitters in the incentive groups (Kim et al., 2011). Interestingly, 87 percent of the quitters said they would have quit for less money. Conversely, among participants who were offered the incentive, the median amount nonquitters reported would have motivated them to quit was $1,500, double the $750 used in the study. A significant proportion (36 percent) reported that amounts greater than $3,400 would be needed to motivate them to quit (Kim et al., 2011). This is noteworthy because the authors cited $3,400 as the increased annual medical cost per current smoker, suggesting it may not be cost-effective in the short term to pay people to quit smoking. These findings also highlight the powerful nonfinancial motives sustaining both healthy and unhealthy habits.

At StayWell, our own research and practical experiences have revealed this same bimodal distribution when it comes to making long-term behavior changes. Some employees are willing to engage in changing behaviors for little or no financial reward, while others are not likely to comply without being offered a very large extrinsic reward. In between are those who are happy to complete programs to earn an incentive but have no intention of making sustained behavior changes. Accordingly, our recommendation is that incentives tied to behavior change programs be kept

modest — just large enough to tip forward those teetering on the edge of engaging while not so much as to reduce their already considerable intrinsic motivation. Unless the form of this incentive is a cost-neutral plan design reward, our preliminary data to date suggest that even a modest incentive is quite costly per additional risk reduced.

Behavioral economics research

It is both counterproductive and ironic, then, when employers use incentives to make connecting with a health coach easy, but do not confront the workplace stumbling blocks that make healthy behavior change hard for these same employees.

The emergent field of behavioral economics uses social, cognitive and emotional factors in understanding individuals' economic decisions, with a primary focus on the relationship between rational and actual decisions. The work of behavioral economists has had a significant positive influence on the thinking of population health management practitioners, as evidenced by efforts to create work sites "where the healthy choices are the easy choices." Whether it is the food available in the workplace, opportunities to take breaks or the personal support from co-workers and leaders, health promotion practitioners with training in psychology have long been aware that interpersonal and physical environments influence behaviors and that behaviors, in turn, shape environments. Behavioral economists have built on these well-established concepts by showing how economic policies can influence behavioral choices.

When aligned with environmental and educational strategies, economic incentives have played important roles in changing attitudes and practices across behaviors as diverse as smoking, seat belt use and littering. It is both counterproductive and ironic, then, when employers use incentives to make connecting with a health coach easy, but do not confront the workplace stumbling blocks that make healthy behavior change hard for these same employees. An example of making healthy choices the easy choices is subsidizing healthy foods in cafeterias and vending machines while increasing prices for unhealthy alternatives. Another is a policy change, investing in "exercise breaks" during work hours while discouraging smoking breaks by banning smoking on company property.

These subtle monetary and nonmonetary "rewards" and "costs" that nudge people in socially valued directions are the grist of behavioral economics. Researchers in this field are exploring a wide variety of monetary contingencies to determine which are most effective in eliciting and sustaining change. One example is a randomized trial designed to test the differential impact of two forms of incentives in achieving a weight loss goal of 16 pounds over 16 weeks: a lottery where participants could earn rewards based on their weight loss achievements compared to a deposit contract where participants invested their own money (Volpp et al., 2008). Those in the lottery condition who met their goals were eligible for daily prizes randomly ranging from $10 to $100. Those in the deposit contract condition could earn as little as $0 and up to $252 per month depending on their attainment of weight loss goals and the amount they had risked via their deposits. About half of those in both incentive groups achieved the 16-pound weight loss goal after 16 weeks compared to only 10 percent of those in the control groups. These differences in net weight loss between the incentive and the control groups were sizable but not statistically significant.

It is noteworthy that the amount of money participants earned in the study by Volpp et al. focusing on one risk factor ($378 and $273 for the incentive conditions) is essentially the same as the average level of incentives employers are using to motivate employees to participate in a much wider variety of interventions. The authors note that their study

population consisted of voluntary participants who "were likely more motivated than the average obese patient." It also is important to contrast this experimentation on the relative merits of lotteries and deposit contracts with the compliance-oriented incentive systems used by most employers to date. A growing interest in the principles of behavioral economics, such as those summarized so well in the book "Nudge" (Thaler & Sunstein, 2009), suggest that mechanisms to induce behavior change identified in behavioral economics research warrant further investigation within the context of employer incentive designs.

For recommended readings about behavioral economics and the impact of incentives on intrinsic motivation see Appendix C.

Like the broader health care reform movement that has influenced current changes in employer incentive programs, the stakes are high relative to the impact of benefit changes on health care costs and the impact of reforms on human lives.

Framework and guidelines for incentives: A progress-based approach

Because benefits designed to encourage participation and, more recently, employee health behavior change are still in a fledgling stage, population health program planners have based their changes on a mix of science, guesswork and bandwagon-hopping. To encourage a balance of evidence-based planning with a proactive, **progress-based** approach that offers all employees an opportunity to earn incentives regardless of where they are on the health continuum, we offer the following framework and guidelines for incentive design. Like the broader health care reform movement that has influenced current changes in employer incentive programs, the stakes are high relative to the impact of benefit changes on health care costs and the impact of reforms on human lives. Accordingly, we have embraced the tenets of the influential report from the Institute of Medicine, "Crossing the Quality Chasm" (Institute of Medicine & Committee on Quality of Health Care in America, 2001), and have adapted the core features of its reform strategy into a framework for incentive redesign. We align each component with guidelines that are evidence-based and consistent with behavior change and health improvement principles.

Incentive strategy	Incentive tactics
Safety	**Safety**
• HIPAA rules relating to the use of incentives include providing a reasonable alternative standard for those for whom an outcomes-based health standard, such as achieving a target body mass index (BMI), is either unreasonable due to a medical condition or not medically advisable. Like a wrestler attempting to make weight, anecdotes depicting participants purging themselves to attain an incentive highlight	• Encourage employees to review health goals with their physician but avoid putting doctors in a policing role. As one expert observer suggests, "Requiring physicians to certify an employee's medical unsuitability for an incentive scheme or to attest to their achievement of a target might introduce an adversarial element into the doctor-patient relationship" (Schmidt, Voigt, & Wikler, 2010; Terry, 1993).

Incentive strategy	Incentive tactics
Safety (continued)	**Safety (continued)**
the caution needed in designing incentive levels and criteria for rewards. Similarly, studies of the detrimental effects of weight recycling show the importance of adapting the target to the starting point of the individual. • A **progress-based** incentive strategy as an interim step before adopting an outcomes-based strategy may provide a safer, risk-adjusted approach to achieving health goals and related incentives. In a **progress-based** model, the attainment of a reasonable target based on current guidelines, such as losing 10% of body weight in a year, offers all participants a reasonable chance to earn incentives regardless of how far away they are starting from the recommended standard.	• Consider the demographics and living conditions of employees if considering outcomes-based incentives. In setting individual health goals, factor in variation in circumstances such as age-related metabolic changes, family environment, living in unsafe neighborhoods, working extra shifts, or dealing with other physical or environmental disadvantages beyond their control.
Effectiveness	**Effectiveness**
• Provide incentives based on scientific evidence and avoid designs that fail to motivate some due to too little reward for great effort or over-reward others for little or no effort. Evidence suggests that incentives are effective for enlisting participation in transactional events such as completing an HA or enrolling with a health coach, particularly when the program is well communicated in a supportive culture. • Using incentives for achieving a health goal is likely to prove more cost-effective than tying incentives to adherence to a prescribed regimen, such as completing a certain number of coaching sessions. Because everyone has a different starting point and learning needs and styles vary considerably, an effective regimen	• Institute alternative ways to achieve an incentive if targeted health standards are out of reach for some participants. • Provide a multi-faceted approach to the use of incentives rather than single-strategy designs, such as purely "participation based" or purely "outcomes based" systems. That is, provide incentives for a range of activities and attainments that provide rewards for participation, as well as for progress toward or achievement of health outcomes. This formula provides individuals with as much choice as possible regarding how they meet incentive requirements. It also recognizes individuals' efforts to achieve meaningful health

Incentive strategy	Incentive tactics
Effectiveness (continued)	**Effectiveness (continued)**
for one individual may not match the needs of another.	improvements both within and outside the formal program.
• Evidence still is insufficient concerning whether incentives can induce and sustain significant health behavior changes for large populations. More research is needed to determine whether incentives can effectively support the attainment of a population-based guideline, such as a healthy blood pressure, especially for individuals with chronic and significant health problems.	• While keeping the overall incentive approach as clear and simple as possible, vary incentive levels and consider strategies including use of a lottery, attainment of incentives and contract incentives over time to appeal to the broadest range of participant motives and needs. Adjust incentive strategies over time as the culture is ready in order to keep the population engaged and progressively moving toward better health.
• When considering outcomes-based incentives, the issues of measurement effects and sensitivity to "false positive" findings can become keen. For example, participants who need to attain a blood pressure target to earn a large incentive may experience measurement stress that increases their blood pressure reading.	• Do not hesitate to change incentives over time as you build new program features. For example, some organizations have stopped providing incentives for taking an HA and now apply that incentive amount to other activities. Taking the HA simply becomes an eligibility requirement for other new activities or attainments that earn incentives.
• Incentives are most effective when used in conjunction with broad-based culture change and strong communications about the value of health to employees and the company. For example, consider using incentives to encourage healthy eating while also making access to healthy food choices very easy in work settings that align corporate values and individual actions. To provide incentives for weight loss while sponsoring vending machines with no attractive healthy options is self-defeating and may be perceived as insincere.	• For biometric health screening, only use Clinical Laboratory Improvement Amendments (CLIA) certified screeners and confirm that those taking blood pressures are using American Heart Association blood pressure measurement protocols (i.e., wait times before taking the blood pressure, no sleeves, legs uncrossed, repeated measures).

Incentive strategy	Incentive tactics
Participant-centered	**Participant-centered**
• Provide incentives that are respectful of and responsive to the needs and values of employees. Incentives can be used to address an organization's unique epidemiological trends along with those risk factors for which employees indicate a higher readiness to change. Participant-centered organizations, like patient-centered health care systems, include participants in decision-making concerning program design and gather information from a representative cross-section of participants to best understand how employees will embrace or resist changes. Creating your incentive strategy with employees rather than imposing it on them will go a long way toward building a sense of shared accountability in the workforce.	• Provide varied and stimulating choices that give individuals autonomy in qualifying for incentives. Include a mix of learning modalities that respond to learner differences, such as offering choices among phone, online or face-to-face interventions. • Incentives tied to specific interventions will increase participation even among those for whom the intervention is not appropriate. Offering a range of program options, supported by incentive and triage strategies that encourage individuals to choose activities most appropriate to their current needs, maximizes the impact of the program on population health in the most cost-effective manner.
Timeliness	**Timeliness**
• Wherever practical, minimize waits or delays between the attainment of goals and the receipt of rewards. Behavior modification research also indicates that varying rewards over time is more effective than giving rewards on a predictable schedule. • Previewing the next tenet concerning "efficiency," timeliness needs to be balanced with the practical need to keep incentive systems simple and understandable. When incentives are integrated into benefit plans, for example, it often is most efficient to tie current-year accomplishments to next year's premiums. Attempts to make plan-integrated incentives more timely sometimes have created complexities that are administratively inefficient	• Employ a phased approach to the use of incentives. Begin with simple strategies such as using incentives for a transactional event like completing an HA. Incorporate additional requirements gradually over a number of years, only as the population internalizes a shared responsibility for health. • Use tracking systems for rewards that enable and encourage participants to keep routine records of their progress toward goals. • Especially for rewards that will be provided some time in the future (e.g., next year's premium reduction), offer regular visual cues or other monitoring systems that

Incentive strategy	Incentive tactics
Timeliness (continued)	**Timeliness (continued)**
and difficult to communicate. Fortunately, unlike the animals that many behavior modification principles are based upon, humans are quite good at linking current behaviors to future rewards. • Since intrinsic motivation is the main predictor of long-term behavior change, the primary role of an extrinsic motivator like a financial incentive is to serve as a short-term catalyst for initiating action that is ultimately sustained by intrinsic motivation. Accordingly, aim incentives at creating the inertia to begin a program for those who have been "chronic contemplators" and offer interventions that engage the participant in ways that shift the motivation to intrinsic factors.	make record keeping easy and interesting to participants and remind them of the reward to come. • Modest rewards can be effective if they are immediate, and smaller rewards are less of a threat to intrinsic motivation. Future rewards need to be larger to make the wait seem worthwhile. To maintain intrinsic motivation when larger incentives are used, build cultural support for and focus communications on shared responsibility rather than a "do this, get that" focus on the reward.
Efficiency	**Efficiency**
• Avoid wasting employee and administrative time and effort. Compliance with a requirement is far from employee engagement in a health improvement campaign. • Incentive dependency needs to be avoided. If not designed carefully and communicated strategically, incentives may create a compliance response. Long-term behavior changes generally depend on intrinsic motivation, since it may not be cost-effective to continue offering incentives large enough to support maintenance of the behavior. This limitation does not apply to outcomes-based incentives, since they are only paid if the outcome is attained. Similarly, it may not apply if incentives are integrated into the health plan, since the "costs" are	• Integrate incentives into your health plan design rather than using direct cash-equivalent rewards. Assuming actuarial assumptions about the percentage of enrollees earning the incentive are correct, this strategy makes incentives cost-neutral (aside from opportunity costs). • Ensure that incentives improve the outcome you are seeking. For example, if incentives are used in program activities to improve population health outcomes, this should be based on evidence that the incentive is effective and cost-effective in achieving that goal. • Communicate about incentives early and often. Focus your

Incentive strategy	Incentive tactics
Efficiency (continued)	**Efficiency (continued)**
opportunity costs rather than incremental expenditures.	messaging on shared responsibility rather than a "do this, get that" emphasis that encourages compliance rather than engagement. Keep rules and criteria for earning a reward simple so they are readily understood by all employees regardless of their education and reading level. This also helps participants focus on their health rather than incentive rules. • Clearly align environmental and cultural changes such as healthy vending machines, regular break times and health education offerings with the activities or outcome standards that will be rewarded. • Healthy leaders and healthy leadership are vital for bringing consistent and congruent support to employee health improvement efforts. • Avoid invalidating HA results. Incentives tied to HA completion are effective in increasing completion rates. Incentives tied to HA results, however, should generally be avoided because they may intentionally or unintentionally influence HA responses.

Incentive strategy	Incentive tactics
Equity	**Equity**
• Incentive strategies should take into account employee differences such as ethnicity, geographic location and socioeconomic status. The increase of a premium differential to the new 30% threshold will amount to about $1,500 for individual health care coverage or $4,000 for family coverage. Such cost differences would "disproportionately hurt lower-paid workers, who, generally, are less healthy than higher-paid workers and thus in greater need of health care, less likely to meet the targets, and less likely to afford higher premiums and deductibles" (Voight & Schmidt, 2010). Considerable research shows that those living with chronic conditions such as hypertension or diabetes are less able to manage their health when their costs related to insurance coverage are too high ("American Heart Association Position Statement on Financial Incentives within Worksite Wellness Programs," 7/18/2011). • Not only do people have different starting lines concerning their capacity to afford and manage their health, wide variations in genetics and physiology create a complex relationship between behavior and outcomes. For example, one recent study showed that, when following identical exercise regimens, some participants showed significant improvements in aerobic capacity, some showed only moderate improvement, and others showed little or no improvement (Karavirta et al., 2011). Similarly, a post-menopausal	• Communicate early and often about the relationship between the health of the business and the health of employees. Position personal responsibility for health as an equitable exchange for valuable health benefits and employer support for healthy lifestyles. • Use a multi-faceted incentive model rather than narrow strategies such as pure outcomes-based designs. As suggested in the Towers Watson report, with a third of employees opposed to outcomes-based incentives: "more aggressive approaches could have unintended consequences, ultimately undermining one of employers' primary goals — cultivating a healthier and more productive workforce" (Nyce, 2010). • Consider a **progress-based** incentive strategy instead of a pure outcomes-based design. That is, reward attainment of progress toward a recommended standard such as losing 10 percent of body weight for all those who do not meet targets even if they do not have a medical condition. • Incentives tied to specific interventions will increase participation even among those for whom the intervention is not appropriate. Offering a range of program options with incentives indexed to program intensity, along with a strategy for triaging

Incentive strategy	Incentive tactics
Equity continued	**Equity continued**
woman will have a much greater challenge losing weight than a young man. A single parent will have a much greater challenge finding the time and energy to commit to lifestyle changes than an individual with family support or a single individual. • This complexity, as well as health disparities linked to education and income, is likely to keep many employers focused on tying incentives to participation with very judicious consideration of outcomes-based incentives, especially given all of the legal, ethical, social, behavioral and practical entanglements such a direction entails.	individuals into appropriate activities, is essential for maximizing participation. • Consider moderating standards according to the risk level of participants, especially in the first few years of the program. Examples include setting more lenient targets (e.g., BMI < 30 versus < 25) or requiring participants to meet a subset of the health outcome targets (e.g., meet the standard by achieving three of four targets). • Minimize use of "do this, get that" compliance-focused communications, and maximize the use of "shared responsibility" themes in communications. • Consider requiring multiple activities throughout the year in lieu of achieving outcomes. Do not tie a large incentive to completing a single activity (e.g., a coaching program). • For outcomes-based or **progress-based** incentive designs, consider a lower incentive tier for participation (e.g., earn the full incentive for outcomes or progress and a partial incentive for participation).

Conclusions

Health care reform comes with extraordinary new opportunities to elevate wellness and disease prevention efforts to a new level of effectiveness, contributing both to the improved productivity of citizens and to renewed health and competitiveness for American business. There is much to learn about how best to align financial incentives and new health benefit strategies with employers' goals to compete and win in the global marketplace. The use of financial incentives will accelerate as research demonstrating their effectiveness is produced. We hope such evidence will emerge in advance of the implementation of poorly designed incentive strategies.

A progress-based incentive strategy can provide a safer, more effective, participant-centered and equitable approach to achieving population health goals.

Although some employers already are considering eliminating rewards not tied to health outcomes, several factors argue against the exclusive use of biometric outcome targets as an effective strategy for producing populationwide health improvements. Since health status is not solely the result of lifestyle but also genetic and physiological factors, what works for one person may not work for another who makes exactly the same lifestyle changes. Demographic, socio-economic and environmental factors also influence a person's ability to achieve certain outcomes, which creates further equity concerns. An incentive strategy needs to take these other factors into account, possibly by rewarding meaningful effort as well as health outcomes. For example, setting and achieving individually tailored health improvement goals or participation in multiple activities throughout the year could be considered meaningful effort. Even if the incentive is set at a lower value than the full outcomes-based incentive, rewarding meaningful effort draws people into the program. Confining rewards only to those who hit all of the outcome targets risks alienating those at highest risk, who have the furthest to go and generate the highest costs to the organization.

A progress-based incentive strategy can provide a safer, more effective, participant-centered and equitable approach to achieving population health goals. In a **progress-based** model, the attainment of a reasonable, individually tailored health goal, such as losing 10 percent of body weight, offers every participant an opportunity to earn incentives regardless of how far from the recommended health standard they begin their journey.

The concepts and recommendations in this paper are largely derived from the scientific and health policy literature. At the same time, employers who are early innovators in health benefits design are essentially providing "natural experiments" into what works and what doesn't in employee health management. Appendix D offers recent case studies from progressive employers who we consider to be achieving a good balance between investing in their culture of health and abetting that effort with a judicious use of financial incentives.

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Appendix A

StayWell client incentive case studies

The table below is a sampling of case studies of incentive strategies and participation rates utilized in recent years by StayWell clients. All of these case studies incorporate incentives into some aspect of health benefits.

Industry category	Eligible population	Program description	Incentive used	Participation rates*
Finance & insurance	5,000 – 9,999	Online and paper HA delivered with a comprehensive wellness strategy. Customized communications along with one health action campaign and three modules. A high level of vendor integration also is a key component.	10% medical premium reduction for HA with an additional incentive for follow-up programs ($210 per year). Employees and spouses are eligible for the incentive.	59% employee participation
Finance & insurance	5,000 – 9,999	Online and paper HA delivered with a comprehensive wellness strategy. Customized communications along with one health action campaign used.	$20 per paycheck reduction in medical premium for employees ($520 per year).	93% employee participation
Finance & insurance	20,000+	Online and paper HA delivered with a comprehensive wellness strategy.	$20 per paycheck reduction in medical premium for employees ($240 per year).	62% employee participation
Finance & insurance	20,000+	Online and paper HA with phone, mail, and online-based health improvement programs.	$104 annual medical premium reduction. Employees and spouses are eligible for the incentive.	71% employee participation
Finance & insurance	1,000 – 4,999	Online HA with population-based online Healthy Living Programs delivered with internal wellness program.	$120 monthly medical premium reduction for employees.	81% employee participation
Finance & insurance	1,000 – 4,999	Online and paper HA delivered with a comprehensive wellness strategy.	HA participation required to be eligible for medical plan.	~99% overall participation (Note: previous strategy included $50 cash-based incentive for participation in the HA with opportunity to earn additional incentive upon completion of follow-up program. Design resulted in voluntary 81% participation.)

StayWell client incentive case studies (continued)

Industry category	Eligible population	Program description	Incentive used	Participation rates*
Manufacturing & mining	20,000+	Online and paper delivery of HA with a comprehensive, onsite delivery model.	$240 in flex dollars for HA and biometric screening for non-bargaining employee population. An additional $240 for tobacco- free credits are awarded to non-tobacco users and to tobacco users who agree to complete a focused tobacco cessation intervention program.	77% non-bargaining unit (NBU) (Note: NBU HA participation nearly doubled with implementation of the NBU incentive program; previous incentive was a themed T-shirt)
Manufacturing & mining	5,000 – 9,999	Online and paper HA delivered with a comprehensive wellness strategy.	$10 monthly reduction in medical premium for employees ($120 per year).	53% employee participation
Manufacturing & mining	5,000 – 9,999	Online and paper HA and onsite screenings delivered as a comprehensive wellness strategy including interventions.	$100 annual medical premium discount for completion of HA, biometric health screening, and follow-up program.	50% employee participation
Manufacturing & mining	20,000+	Online and paper HA with phone- and mail-based health improvement programs.	$60 medical premium reduction.	32% employee participation
Manufacturing & mining	10,000 – 19,999	Online and paper HA delivered with a comprehensive wellness strategy.	$60 medical premium reduction.	52% employee participation
Manufacturing & mining	20,000+	Online and paper HA delivered with a comprehensive wellness strategy.	Medical premium reduction; value ranges from $200 to $600 and varies by participant. Both employee and spouse are required to participate in the HA to receive incentive.	83% overall participation
Manufacturing & mining	1,000 – 4,999	Paper HA delivered via onsite processing in conjunction with comprehensive wellness components.	$1,000 medical premium reduction for employees who sign participation pledge, complete the HA, biometric health screening, and receive follow up from a disease management vendor, if recommended.	91% overall participation

StayWell client incentive case studies (continued)

Industry category	Eligible population	Program description	Incentive used	Participation rates*
Retail	5,000 – 9,999	Online and paper HA along with phone-based NextSteps, creating a comprehensive wellness strategy.	$15 to $30 monthly reduction in medical premiums with a $100 gift certificate for enrolling in the Healthy Pregnancy Program ($180 to $360 per year).	44% employee participation
Retail	5,000 – 9,999	Online HA along with phone-based NextSteps, creating a comprehensive wellness strategy.	$10 per pay period medical premium reduction ($240 per year).	71% employee participation
Service	5,000 – 9,999	Online and paper HA delivered with a comprehensive wellness strategy	HA is mandatory for employees to receive medical benefits. Employees will receive 25 points towards an internal incentive program if they complete a NextSteps phone program (3 calls).	97% employee participation
Service	10,000 – 19,999	Online and paper HA delivered with a comprehensive wellness strategy.	Eligible for richer benefit plan plus $200 employer contribution to FSA for completion of HA and biometric screening. HA participation required for premier medical benefits. Both employee and spouse required to participate to receive incentive.	96% overall participation
Utility	10,000 – 19,999	Online and paper HA delivered with a comprehensive wellness strategy. A high level of vendor integration also is a key component.	$100 medical premium discount and gift certificate for non-bargaining population. Employees and spouses are eligible for the incentive.	67% non-bargaining employee participation
Utility	10,000 – 19,999	Online and paper HA delivered with a comprehensive wellness strategy.	Election of a PPO plan with a $200 reduction in medical plans for single, $400 reduction for employee and spouse plan. Employee HA participation required to be eligible for medical plan. Both employee and spouse are required to participate to receive incentive.	89% employee participation

* Participation rates are based on employees only and are highly dependent on incentive offered, communication/promotion plan and company culture.

Appendix B

Trends in the use of incentives for population health management

	Mercer, 2010	Towers Watson (Nyce, 2010)	Buck Consultants, 2010	Hewitt Associates, 2010	NBGH (Marlo et al., 2010)
Use of financial incentives	21% to 27% of employers offered incentives in 2010 to encourage participation.		62% of employers presently offer incentives and 25% plan to offer them.	Employers offering incentives to engage employees decreased from 57% in 2009 to 44% in 2010.	
Outcomes-based incentives	28% of employers offered lower premiums for nonsmokers in 2011 (up from 23% in 2010).	6% of employers are considering having employees achieve a standard to be eligible for a preferred plan option. (1% of respondents currently do this) 92% are not considering it.	Employers implementing health insurance premiums based on achieving a standard: today, 15%; next year, 8%; in two to three years, 11%; no plans, 68%.	18% of employers are currently using penalties and 47% intend to use them in the next three to five years.	For employers offering health savings accounts, 29% use incentives for healthy behavior as a contribution strategy.
Size of incentives	From token gifts to $180 average premium reduction.	Larger financial rewards are strongly linked to higher participation rates. The link is especially robust with HAs, biometric screenings and health coaching. Completion rates for HAs rise by nearly 11 percentage points for every $100 increase in financial incentives. Participation in biometric screenings increases by about 10 percentage points for a similar reward. HAs reach universal participation given a $600 incentive.	Global average of $220 in 2010 (up from $163 in 2009).		Average in 2010 of $386 (up from $318 in 2009). Range from $50 to $1,200.

	Mercer, 2010	Towers Watson (Nyce, 2010)	Buck Consultants, 2010	Hewitt Associates, 2010	NBGH (Marlo et al., 2010)
Building a culture of health		Strengthening the focus on a healthy workplace culture (by adding four additional tactics) can boost HA participation by as much as offering a $140 financial incentive.	Only 33 percent of employers believe that they have a culture of health today, but 81 percent intend to pursue it for the future.	"Keeping employees healthy" (82%) has been the number-one workforce issue for the last two years (surpassing worker satisfaction and safety).	
Cost-sharing trends	32% of employees report "I would not feel comfortable if my employer increased the premium costs for workers unwilling to take steps to manage their illness or lower their health risk."		Employee cost sharing as a strategy has increased from 33% in 2008 to 43% in 2010. Per disincentives, 81% of employers name higher premiums as penalty of choice.	Most often reported as the three most effective tactics for containing plan costs were wellness initiatives (56%), disease/condition management (47%) and pharmacy benefit design (39%).	

Appendix C
Recommended readings and resources

Recommended readings

As described in the previous sections, some components of health care reform support an employer's increased use of financial incentives for wellness. At the same time, employee protections against health discrimination, such as those provided by HIPAA, are written to ensure incentives are used judiciously. There never has been a more vital time to carefully study the opportunities and threats posed by incentives. Thankfully, there also is new thinking, particularly related to behavioral economics, that practitioners can use as resources when making incentive policies. Here are four books StayWell recommends:

***"Nudge"* by Richard Thaler and Cass Sunstein** (http://nudges.org) (Thaler & Sunstein, 2009) — This book is having an impact on health promotion professionals by supporting their efforts to "make healthy choices the easy choices" — a common phrase in current conferences and periodicals. If you only read one book on behavioral economics, this is the best at providing credible evidence for how to balance individual versus social responsibility for health. The authors capture this in their clever but provocative idea that policymakers need to be "paternalistic libertarians," meaning we are duty-bound to set policy that advances the public good, while assuring we don't interfere with fundamental individual freedoms.

***"Drive: The Surprising Truth About What Motivates Us"* by Daniel Pink** (www.danpink.com) (Pink, 2009) — If you like Malcolm Gladwell's writing and the way he weaves interesting research together with instructive anecdotes, you'll love Daniel Pink's ability to knock you upside the head with studies that drive home his thesis: When it comes to behavior change, there can be no substitute for intrinsic motivation, and well-intentioned incentives can backfire. Not only does this book offer scientific justification for limiting the use of rewards to simple behaviors, like showing up for something, Pink also smartly illustrates how incentives too often diminish motivation. Health coaches will resonate with his conclusions that successful self-changers almost always manage to connect new habits to long-held personal passions.

***"Predictably Irrational"* by Dan Ariely** (http://danariely.com) (Ariely, 2008) — If you liked Dubner and Levitt's "Freakonomics" (Levitt & Dubner, 2005) you will like Ariely's penchant for using obscure but useful studies to change your assumptions about the supremacy of money. What's more, if you subscribe to the common-sense idea that when given the "right" financial or policy incentives, we will make rational choices that advance our personal interests, think again. Ariely offers multiple examples where people make the irrational choice, meaning policy makers need to take these predictable human foibles into account. In contrast to "nudges," if Ariely had his way, the "paternalistic libertarianism" movement would tilt strongly in favor of "father knows best."

***"Punished by Rewards"* by Alfie Kohn** (www.alfiekohn.org/index.php) (Kohn, 1993) — If you are not persuaded by the above scholars that rewards come with landmines attached, Kohn may tip you over the edge. Though Kohn's book selectively highlights

studies advancing his condemnation of incentives, his case for caution is compelling and, at minimum, thought-provoking. If you supplement Kohn's conclusions with those of scientists like Albert Bandura, James Prochaska or Marshall Becker, who clearly have mapped the path where rewards for small steps can be catalysts for larger changes, then this book offers useful caveats concerning the usual path to successful change. Moreover, Kohn has an enthusiastic following in education reform circles and has been a leader in preventing ill-considered use of incentives.

Together, these books lead to the following basic guidelines for health promotion practitioners.

- Make incentives a catalyst or a means to an end. Financial incentives can lead a horse to water, but intrinsic motivation is what makes it drink for a lifetime.
- Focus on intrinsic rewards. Once you have led them to water, make sure they are reminded how sweet it has been for those who've chosen to drink. Tell success stories early and often.
- Keep participation-based incentives as modest as possible. The larger the reward, the more the focus shifts from doing what I think may be good for me to resenting attempts to control my personal choices.
- Create a culture of shared responsibility for health. Balance demands for greater personal responsibility with organizational support for healthier behaviors.
- Introduce larger **progress-based** incentives into a prepared culture. A culture of shared responsibility increases acceptance of larger incentives tied to achieving outcomes or making progress toward better health.
- Consider reward reductions for nonparticipation. Research consistently demonstrates that losing a benefit we already enjoy is more powerful than gaining a benefit we don't currently have.
- Keep it simple. There's nothing more counterproductive than employees struggling to understand complicated incentive rules rather than focusing on the real work: setting goals and adopting new health behaviors tailored to their needs and values.

Appendix D

Case studies of the role of incentives in population health management

StayWell worked with Wachovia Corporation, a national banking and financial services company with 110,000 employees in 49 states, to fashion a participation-based incentive program consistent with the company's goals and benefits strategies. Wachovia launched its wellness program in 2004 and encouraged completion of the HA by conducting a drawing for a $50 gift certificate, with multiple winners. In year one, only 10 percent of incentive-eligible employees completed the assessment. In 2005, Wachovia dropped the incentive and likewise, saw its program participation rate drop to just five percent of eligible participants.

According to Donna Shenoha, who was vice president and senior consultant of health and welfare for Wachovia, the company's success was a result of its ability to understand its employee population and corporate culture, as well as its strategic use of employee communications and program monitoring.

Then, in 2006, the company began offering a $75 cash incentive for all eligible employees who completed the HA, with the incentive delivered through the employee's paycheck. Participation reached an all-time high of 66 percent. Wachovia expanded its incentive program in 2007 to include all benefit-eligible employees, spouses and domestic partners. Employees received a $75 incentive for completing the HA and an additional $50 incentive if their covered spouse or domestic partner completed it.

According to Donna Shenoha, who was vice president and senior consultant of health and welfare for Wachovia, the company's success was a result of its ability to understand its employee population and corporate culture, as well as its strategic use of employee communications and program monitoring. "We really wanted our employees' first experience with an incentive of this type to be positive and easy to understand," said Shenoha. "The participation level showed that employees were pleased with the incentive amount and type, and the aggregate results from 2006 allowed us to refine our health management strategy so it truly fit our culture and demographics."

Shenoha added that Wachovia supported its wellness program with a comprehensive communications strategy that included intranet articles, desk-top videos, employee newsletter articles, and email announcements and reminders. In addition, employees who started but did not complete an HA received a separate, tailored communication. Wachovia continued to build and refine its program in 2008 by focusing its incentive strategy on the "next steps" to a healthier lifestyle; namely, participation in lifestyle change and disease management programs.

Applying best practices

The term "best practices" exists for a reason. We watch and learn from the success of companies like Wachovia, and try to apply similar principles or practices to our own situations. When it comes to best practices for using incentives, a clear pattern has emerged over the past several years. At StayWell, we have identified four key successful

incentive strategies that are present in health management programs:

- Use incentives as a reward for completing an HA.
- Use incentives as a reward for completing related follow-up activities to the HA (e.g., health behavior change programs).
- Use a points system that is tied to a menu of program activities to give employees opportunities to participate in activities that are appropriate for their stage of readiness to make behavior changes. Reward such healthy behaviors as attending smoking cessation classes.
- If considering outcomes-based incentives, retain incentives that reward effort and progress toward the outcomes of interest so as not to lose the hardest-to-reach employees.

Examples of the types of incentives that have been used in these campaigns include:

- Money or cash equivalents
- Health plan premium reductions
- Increased company contribution to the employee's medical spending account
- Opportunity to enroll in a richer plan design

Other incentives that often are used, and that appear to have the potential to be effective are:

- Company-branded merchandise like tote bags and jackets
- Culturally significant "tokens," such as the chance to win a prime parking spot
- Employee recognition by management and peers
- Reduced co-pays or deductibles

Incentives that have proven to be the least effective include stand-alone drawings and healthy rewards with limited choices. These incentives typically do not work because they appeal to people who already are in the healthy segment of the population, and not those who need the most help. Granted, what works in one setting may not work in another, so the key to effective incentives is identifying a meaningful reward for your employees.

Putting best practices to work

So, how do you identify the most appropriate incentive strategy for your company and then roll it out to your workforce? Your wellness partner ultimately will provide guidance regarding the use of incentives as part of your overall program design and strategy. But at StayWell, we have identified five key guiding principles for incorporating incentives into a wellness program:

- Make the reward — and what the employee has to do to earn the reward — easy to understand and easy to communicate.

- Choose a reward that has a perceived value by all or most employees. Like Wachovia found, a simple cash reward delivered via the employee's paycheck may be the most appropriate and appealing incentive.
- Make sure the effort or activity required to receive the reward is reasonable compared to the value of the reward.
- Test the program to make sure employees are unable to "beat the system" to get the reward without full program participation.
- Choose an incentive and an approach that can be sustained over time. Remember that it is much easier to add to an incentive rather than reduce it over time.

Perhaps the most important rule when using incentives is to remember that incentives are just one part of the equation. Ask yourself these questions: What is your objective for using incentives? How would an incentive fit into your overall long-term wellness program? What do your employees value? Are you able and willing to maintain the incentive?

In addition to these thought starters, here are some tips for rolling out your wellness program to make it more effective and increase participation.

1. Direct the program to all employee mindsets, from the program champions to the grassroots supporters and even the detractors.
2. Assess your program on a regular basis.
3. Continually nurture a culture of health within your workplace.
4. Position your program so everyone, from leadership to front-line employees, realizes the value of the effort.
5. Target your employee communications with clear and simple messaging.
6. Conduct one-on-one employee outreach.
7. Offer a menu of intervention options to reach employees at all stages of change.
8. Use incentives wisely.
9. Regularly track and monitor key participation indicators.
10. Establish specific program goals and measure against them.

The key to ongoing successful incentives will be to implement them as part of the overall wellness package and use them in ways that make sense within a positive and healthy company culture.

Connecting incentives to your overall strategy

What does the future hold for employers who currently are using incentives and those who are looking to adopt incentives in the coming years? Incentives will undoubtedly continue to hold a significant place in wellness and population health management. The key to ongoing successful incentives will be to implement them as part of the overall wellness package and use them in ways that make sense within a positive and healthy company culture. Here is how Bob Ihrie, senior vice president of employee rewards and services for Lowe's companies frames the challenge: "For Lowe's,

success is a combination of having a great program and the ability to reach people. Our employees are spread out at retail locations across the country, so if a program doesn't effectively reach and engage employees at all locations, it won't last. The keys to measuring our employee health management program at Lowe's really boil down to the effectiveness of the program, the ability to reach employees in our spread-out world, employee satisfaction, and some form of ROI."

Incentives and return-on-investment (ROI)

The ultimate measure of incentive effectiveness will be whether increased participation produces greater total risk reduction in the organization. Related to this, the total spending on incentives will need to be reconciled against the value of risk reduction. Researchers at StayWell have conducted such studies to help employers quantify the relationship between reduced employee health risks and costs. Most well-known have been the formative research papers by Dr. David Anderson, senior vice president and chief health officer at StayWell. Anderson's studies were the first to codify the relationship between health risks and health care costs based on very large data sets merging medical claims codes with health risk assessment data (Anderson et al., 2000; Goetzel et al., 1998). The results showed how a lower-risk older employee essentially had the "health age" and medical spend of a higher-risk younger employee. And while many wellness programs remained focused on cardiovascular health improvement, this StayWell research clearly highlighted how psychological risk factors like stress and depression were far more costly than previously had been thought. Accordingly, an incentive strategy that can guide you to ROI requires routine (usually annually) collection of HA data that is broadly gauged and robust enough to capture physical, mental, social and cultural drivers of health care costs. This explains the current trend toward offering a "health plan" as an alternative to the usual sick-care insurance model. In such a health plan, completing a comprehensive employee HA is a gateway for eligibility to the preferred health promotion and disease prevention coverage.

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But reduction in health care costs alone may not be enough to justify significant investments in an incentive strategy. StayWell recently published a case study of a large manufacturing company that not only illustrates the pathway to a positive ROI, but provides a best-practices evaluation methodology that can produce the more formidable "value of investment" (VOI) (Grossmeier et al., 2010). After adjusting for plan design changes, inflation and factors like age, union status and other baseline utilization patterns, we found that the program, which included an evolving incentive strategy, did indeed "bend the trend." Over the two-year intervention period, medical spending had increased by five percent among employees who did not participate in the programs. Conversely, costs decreased by three percent for health program participants. This difference produced a $3.1 million savings from the program, but the overall value of the program far surpassed the impact on the bottom line. More engaged employees, higher self-esteem, fewer health risks, greater satisfaction with the company and many other readily measurable gains continue to guide the ongoing program strategy. These results also provided reinforcement that the programs are accruing value for the company and its employees each step of the way.

Measures that matter

Aligning incentives not only with the wellness program but with a total rewards and benefits philosophy will require data credible enough to illustrate that the use of incentives is about much more than improving your employees' health and productivity. You also need to choose measures that clearly demonstrate how your investment in health is making your company run leaner, allowing you to recruit and retain better talent and insuring that you can out-innovate and out-execute your competitors.

Bob Ihrie sums up the benefits of strategic planning and measurement in a way that a CEO intent on excellence can readily appreciate. "For a large employer like Lowe's, the investment in measuring our program is small compared to the large return that we get from this effort, both in terms of using that information to guide what we do and improving our ability to choose programs that are effective."

Data-driven program administrators always keep their eye on the whole dashboard. "Our medical spend drives a lot of our planning, but I often remind senior leaders that we need to cast the net broadly to be successful at containing health related costs," says Tammy Green, director of health management at Providence Health Systems in Anchorage, Alaska. "In some respects, medical costs are easier to predict and intervene on than workers' compensation, FMLA, disabilities, productivity and absenteeism. The impact of poor health will show up somewhere and it's not always the doctor's office."

Though much more difficult to quantify than ROI, it is possible to monetize the contribution of incentives to employee health improvement as well as to employee productivity. In quality improvement circles, it is obvious that if you cannot measure something, you cannot improve it. To this end, StayWell has been studying how health improvements affect both productivity and "presenteeism," a measure of how engaged someone is on the job, even when dealing with a health problem. StayWell consulted with leading researchers from Harvard University and Tufts University, who developed health and productivity questionnaires that have been used widely enough now that companies can benchmark their level of productivity loss due to poor health against other like companies.

Smart use of such survey data affords leaders the ability to determine wage replacement costs, the costs of lost production and absence costs for the company, including losses due to specific claims such as workers' compensation or short-term disability. In cooperation with groups such as the Integrated Benefits Institute (IBI) or the Health Enhancement Research Organization (HERO), employers are beginning to complete productivity calculators and best-practices scorecards that illustrate the size of their health and productivity problems and opportunities.

When it comes to deciding the size of an incentive investment and the overall health management strategy, it helps to know the size of the problem we are trying to solve. StayWell researchers quantified the difference between the productivity of workers with poor health habits and chronic conditions, and those without (Riedel et al., 2009). Not only did we monetize these differences, we provided key benchmarking data about which employees are most affected by their health risks and which are most willing and able to improve them. The results we found are troubling, but the opportunity also looms large. We examined health and productivity data from a sample of 106 employers

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from five industry sectors. Employees in this study averaged 2.4 risks, such as back pain, smoking, overweight or lack of exercise. We found that there is normal productivity impairment of 3.4 percent independent of health risks. Obviously, even the healthiest of us can't be 100-percent productive 100 percent of the time. But we also found that those with the average number of risks lost 8.4 percent of their productivity on the job. That is five percent less productivity or, viewed another way, nets out 2.6 weeks of lost work time annually.

According to our estimates, those with three health risks cost $4,480 more per year in on-the-job productivity loss than those with normal impairment. More alarming still, we showed that a person at risk for all eight risk factors reportedly was 24% less productive. An analysis of the various productivity detractors showed back pain as the largest contributor, but depression, stress and tobacco use also are serious impediments when it comes to health issues that tax a company's productivity.

"We're beating them a bit with a carrot."

That is how Tammy Green describes her strategy to tune up financial incentives at Providence Health and Services in Alaska in a way that increases employee accountability while supporting employees with more tools to help them improve their health. Green, who has a background in epidemiology and experience in statewide public health practice, tracked numerous sources of company health metrics to hone in on heart disease and stroke as top cost drivers. "I advise our CEO and senior leaders to keep expectations realistic and make the long-term commitment to employee health. That means it's less about financial penalties and more about behavioral economics. Matching our incentive strategy with robust offerings tells our employees we're prepared to meet them halfway. My goal is to quickly switch employee reliance on extrinsic motivators like financial incentives to the more lasting intrinsic motivation that will come with their participation in effective programs." It is a philosophy that has Providence piloting, among other things, a pre-hypertension management project. Green notes that blood pressure is among the most tangible risk factors to monitor, and following a cohort over two to three years will give Providence insight into trends in related risks such as obesity, tobacco use and fitness.

StayWell advises companies to consider incentives in the context of their ROI objectives. Our experience suggests that the ratio of incentives compared to the intervention costs is about four to one.

This penchant for using data to set strategic priorities and then move quickly to launching tactical projects also has been in the heart of leaders at Lowe's. "We're always looking at the ROI, so when we're considering a program change, we look at the five disease stages and our 10 highest risk factors," says Bob Ihrie, "then we determine where it makes the most numeric sense to implement changes."

How much should you invest in incentives?

Though the use of incentives is too new to offer a formula for success, StayWell advises companies to consider incentives in the context of their ROI objectives. Our experience suggests that the ratio of incentives compared to the intervention costs is about four to one. That is, for every one dollar spent on providing employee health education, four dollars are spent encouraging them to participate. If organizations are focused on the overall "value of investment," then larger incentives focused on greater participation

can be justified and a four-to-one ratio may be appropriate, although more research is needed to test this hypothesis. For organizations more focused on health care cost trends, a ratio that focuses more of the total health promotion budget on programs and less on incentives should be considered.

For employers interested in considering their incentive investments in the context of savings, StayWell offers clients a cost impact model that estimates cost and productivity savings based on reductions in employees health risks. Similarly, many of the consulting firms produce annual reports against which you can judge your progress and build a case for continued and deeper investment in incentives and employee health programs. According to the 2007/2008 Watson Wyatt "Staying@Work® Report" (Watson Wyatt & National Business Group on Health, 2008), companies with the most effective health management programs can see:

... it is likely that incentives with long-term staying power will increasingly emphasize a carrot, rather than a stick approach to engaging employees.

- 2.4 percent versus 11.0 percent health care cost trend
- 20 percent more revenue per employee
- 16 percent higher market value
- 57 percent higher shareholder returns

As noted earlier, it is likely that incentives with long-term staying power will increasingly emphasize a carrot, rather than a stick approach to engaging employees. We will see tools and technology that better tie incentives to specific participation goals and requirements. For instance, at StayWell we offer an online point tracker that allows employees to track their program participation and their progress toward their goals. Additionally, we will become more sophisticated about having just the right incentive at just the right time to support just the right goals in the behavior-change process.

In the end, good health is its own reward. Still, with a well-chosen reward here and a nicely presented recognition there, before we know it, our spending on incentives will pay dividends in employee health and productivity.

Resources

NBGH: Best Employers for Healthy Lifestyles Award.
http://www.businessgrouphealth.org/lightenup/lightenup/Best_Empl_Award09_WEB_nonmembers.pdf

The C. Everett Koop National Health Award
http://www.thehealthproject.com/

Well Workplace Awards
http://www.welcoa.org/wellworkplace/index.php?category=19