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Rationale for using incentives and rewards

Employees are damaging their health through their own behaviors, and employers are paying the price. Seventy-five cents of every dollar spent on healthcare goes to the treatment of a preventable chronic condition that is rooted in behavioral or lifestyle choices. Chronic conditions can be largely prevented or minimized by changing four common behaviors: tobacco use, insufficient physical activity, poor eating habits and excessive alcohol use. Although workplace wellness programs are now commonplace, their impact is hampered by limited participation by employees with the greatest need.

Incentives and rewards in the market

Incentives and rewards have been used for over a decade, to increase participation in wellness programs and drive employee behavioral change. As multiple research studies have shown how incentives increase participation in biometric screenings, health risk assessments and other wellness and health management programs, employers have recognized the benefits of using them. According to a 2009 survey of 372 employers, ranging from small to large firm sizes, 66% of employers who offered wellness programs also offered incentives (Health2Resources, 2009). Employers reported that one of their main reasons for offering incentives was to encourage participation in programs (Health2Resources, 2009).

Employers have used incentives and rewards to influence outcomes as well as to increase participation. Prompted by rapidly increasing health care costs, employers have turned to wellness programs to help improve employee health and thus control costs (WebMD Health Services, 2007). Companies that have been moderately successful at controlling expenses, with health care cost increases of 1%, were 21% more likely to use financial incentives for health programs than companies with typical health care cost trends of 10% (Using Incentives to Drive Wellness, 2008).

Which incentives work best?

An incentive is a short-term, event-driven inducement. Rewards, on the other hand, are an element of a strategic longitudinal program to motivate long-term behavioral change. Both incentives and rewards have a place in an effective workplace wellness program.

Although incentives increase participation in programs and can affect outcomes, not all incentives yield equal participation or result in behavioral change. Typically, the greater the value of the incentive, the more widespread is the employee participation. For example, in a 2005 WebMD book of business analysis, a rewards program that offered \$158 or more (\$176 equivalent in 2011), had over 60% participation, compared with programs that offered



\$50 or less, which attracted less than 30% participation. Similarly, other studies have found that the incentive value has a direct impact on participation rates (Wilhide et al, 2008; Seaverson et al, 2009; Taitel et al, 2008) and better outcomes (Volpp et al., 2008; Herman et al., 2006).

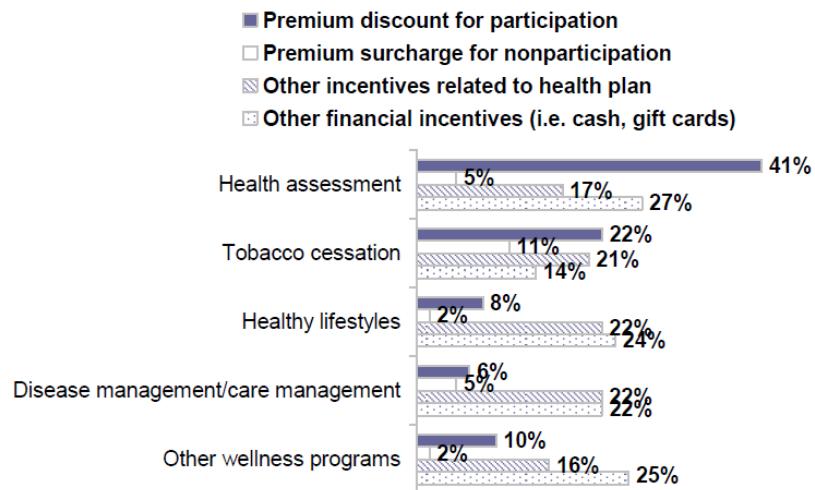
The average amount that employers are spending on rewards programs is increasing. The National Business Group on Health surveyed 49 large employers on the incentives they are offering for healthy lifestyles and/or participating in wellness programs. The average incentive offered to employees in 2010 was \$386, with a median of \$250; the average for dependents was \$271, with a median of \$203. This represents an increase from 2009, when the average incentive offered to employees was \$318 (National Business Group on Health, 2010).

Not only is incentive value significant, but the type of incentive also drives participation. Mayo Clinic Health Solutions found that employers who offered incentives linked to benefits had higher participation rates than those who offered gift cards. In the 2009 Health2Resources employer survey, the most common incentive used in 2008 and 2009 for health and wellness programs was premium reductions, which were offered by approximately 29% of employers. Similarly, in the National Business Group on Health survey, premium discounts were the most prevalent type of incentive for participation in wellness programs in 2010.

In the 2009 Health2Resources employer survey, gifts cards were the second most popular incentive, offered by 24% of those surveyed. The percentage of employers offering gift cards decreased from 2008 to 2009, while the percentage of employers offering premium reductions increased. This move suggests that employers are switching from offering gift cards to benefit-linked incentives. As illustrated in the following chart, the National Business Group on Health Survey provides a more detailed analysis by type of program and by the extent to which employers are penalizing employees for nonparticipation. Among programs attached to incentives, the most common is the health assessment, with 90% of employers providing one or more incentives or surcharges, such as premium discounts (41%) or other financial incentives, such as cash or gift cards (27%). Penalties were most often associated with nonparticipation in smoking cessation programs.

Figure 17: Incentivizing/Penalizing Employees

(Sample Size=63)



Note: Respondents were allowed to select more than one option.

Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

Finally, research has shown that one-time incentives are not as effective as long-term rewards programs. In a 2004 study of workplace performance in the WebMD book of business, rewards program with a duration over six months led to higher work place performance than those that lasted less than six months. Other studies have found that stand-alone rewards are not as effective as an incentive strategy that links rewards over time (Capps, 2007; Disease Management Advisor, 2007).

Implementing a strategy

Implementing a successful incentive strategy to improve participation and drive outcomes consists of more than just offering long term, well-paying rewards. Three key components are essential to success: (1) rewards and incentives must be relevant to the employee population; (2) wellness programs must be well communicated; and (3) programs must be supported by organizational leadership. In order to design relevant incentives for the population, employers should gather information through surveys, focus groups or other means to identify what drives their target audience. Moreover, they must communicate wellness programs and the associated rewards programs effectively and on an ongoing basis. Multiple studies have demonstrated that participation in wellness programs is associated with the quality of the communications strategy. The quality of the messaging is key - as is the method of deploying the information. Messages have to reach the audience in order to have the intended effect. Studies have found that participation increases with more communications about the programs (Taitel, 2008; Seaverson, 2009; Wilhide, 2008). Finally, the third key to program success is executive sponsorship. Studies show that organizational support of the programs influences participation rates. In a study by Mayo Clinic Health Solutions, clients

with more than 50% participation in a health risk assessment were more likely to have senior leadership support, and the program goals were more likely to be tied to corporate goals.

Regulatory Considerations

Depending on the design and content, reward and incentive programs are likely subject to a number of legal, regulatory and general compliance rules. These include the non-discrimination rules of the Health Insurance Portability and Accountability Act (HIPAA), the Genetic Information Nondiscrimination Act (GINA), the Americans With Disabilities Act (ADA), the Age Discrimination in Employment Act, Title VII of the Civil Rights Act of 1964, the National Labor Relations Act, Medicaid, state and federal tax code provisions as well as cafeteria plan and health savings or health reimbursement account rules. Acknowledging this complexity as potentially being a disincentive to establish rewards and wellness programs, health care reform has codified rules for HIPAA regarding incentives, and affirmatively recognizes that the “nondiscrimination provisions were not meant to prevent a group health plan or an issuer from establishing premium discounts or reduced co-payments or deductibles in return for adherence to programs of health promotion and disease prevention.” (Int. Rev. Code § 9802(b)(2); Employee Retirement Income Security Act § 702(b)(2); Public Health Service Act § 2709(b)(2)).

The nature of wellness programs and the structure of rewards programs are defined in the Patient Protection and Affordable Care Act. Programs classified as participation-only must be available to all individuals with similar full-time status. However, standards-based programs that provide rewards according to a health factor are permissible only if they meet specific requirements. Individuals must be given the opportunity to qualify for the rewards at least once per year. Rewards also must be available to “similarly situated individuals” and alternatives must be “made available for those whom it is reasonably difficult or medically inadvisable due to a medical condition to satisfy the standard.”

For example, suppose a program would like to offer reduced premiums to employees with a cholesterol level of less than 200 mg/dL. An exception would be required for an individual under a physician’s care for hyperlipidemia and whose cholesterol level remains elevated. This individual would be entitled to follow a reasonable alternative, such as by following a low fat diet. Another strategy for complying with this regulation is to offer many programs from which employees can choose to fulfill the goal requirements. For instance, if an employer provides a tobacco cessation program for smokers, non-smokers should have an opportunity to earn a reward by participating in a different program, such as weight loss counseling. Finally, HIPAA regulations state

that the amount of the reward cannot exceed 20% of the cost of total employee coverage. (If incentives are available to dependents, the total value may include family coverage.) The current cap is set to increase in future years. (Employee Benefits Institute of America, 2010).

Cammack LaRhette's best practice strategies

Cammack LaRhette recommends an incentive and rewards strategy that builds over three years and moves progressively toward rewarding employees for outcomes. For example, we suggest rewarding participation in biometric screening in the first year of the program to establish an important behavior and build trust in the integrity of the program. By year three, rewards should be transitioned to employees with specific low risk biometric values, such as normal blood pressure (note prior discussion of required alternatives). In the interim period leading to outcomes-based rewards, expectations must be regularly communicated to employees and resources should be made available to support the desired outcomes.

Senior leadership is involved in strategy formation and approves a preliminary budget for each of the first three years. In our experience, a multi-year strategy and implementation plan is critical. Securing the involvement of senior leaders in the process enhances the prominence of the program and encourages greater uptake by employees. It also means that once health and wellness programs are on their radar screen, leadership will be more likely to hold people accountable for results.

The challenge of changing ingrained health behaviors requires a broad strategy that involves health plan design, population health analysis, targeted program development or enhancement, data collection tools with an information management system, and an effective communications plan. The questionnaire below is derived from lessons learned from our successful experiences and highlights some of the key decisions.

Program planning fundamentals

- o **Road blocks**
 - Have key decision-makers been briefed on the value proposition and provided preliminary approval to design a program?
 - Will unions block incentives for their membership? If so, what is the impact on the program?
- o **Carrot vs. stick**
 - Will senior leadership approve use of penalties/disincentives, e.g., health plan premium differentials, co-pays or job sanctions?
 - What balance of incentives and disincentives is acceptable in your culture?
- o **Budget**
 - Will the program be structured as cost-neutral, where disincentives pay for incentives, or will additional funds be allocated?
 - If funding is needed, will it be added to the working rates of the health plan (for self-insured employers)?
- o **Program design**
 - How will the program be structured, e.g., annual health premium differentials, premium holidays, co-pay reductions, health account contributions, paid time off, gift cards, raffles or prizes?
 - How will the timing of incentive fulfillments be designed?
 - o Do employees earn points over 12 months before seeing a payout? If so, can raffles or prizes be offered in the interim to sustain interest?
 - o To maintain momentum over the 12-month earning period and to prevent last minute “cramming” for points, can milestones be divided into quarters? For example, identify points available to be earned only in a specific quarter. (However, the most important behaviors, like biometric screening or an annual wellness visit, should be eligible for points all year.)
 - Will the honor system be used for tracking any behaviors, e.g., will employees be required to sign an attestation of non-smoking or agree to random nicotine testing (not permissible in some states)? What will be the consequences if employees are caught lying?
- o **Incentive value**
 - How will the value of incentives be determined?
 - o The type of incentive will influence the optimal monetary value. Premium reductions should be a higher value than gift cards, as the premium offset is spread throughout the year. If the size of the premium reduction is small, consider a premium holiday to enhance recognition by employees.

- o What is the participation goal? Although engagement is influenced by many factors, monetary value is one of the most important. If the participation goal is set at a very high level, such as 70%, a premium incentive will be required in order to drive high participation. Conversely, lower targets can be met through more modest investments.
- o What are the compensation levels of targeted participants? Incentive value has a direct association with pay grade. For instance, if you are targeting hourly workers because their participation is typically poor, you can set the value lower. Aim for the higher paid employees through complementary strategies, such as competitions or by highlighting participation among leadership.
- o How does your incentive program fit within your organization? Do you have a robust health and wellness program with visible support from senior leadership and strong brand awareness and communications? If so, the incentive required to move employees towards the cultural center is less than it would be otherwise.
- o **Program elements**
 - What behaviors do you want to reward? Have you performed a population health analysis to identify your chief concerns?
 - What programs existing support risk reduction and the incentive plan?
 - o Does an adequate mix of onsite, online and telephonic programs reflect individuals' different constraints and preferences?
 - o Are you satisfied with the quality of the programs? Do existing programs need to be upgraded or new ones added? If so, who will be eligible for participation? Will the fees be subsidized or waived upfront or upon completion?
 - o Does an existing communications infrastructure support this program? Is there an established brand for health and wellness? Will the incentive program use the same brand or are changes needed?
 - o Who will be directly responsible for communications? Do you have the full support of the departmental vice president or director?
 - How will the incentive program be evaluated? How will success metrics be defined and how will data be collected?

In summary, Cammack LaRhette's best practice programs include the collaboration of senior leadership and committed stakeholders, whose governance structure should focus on improving employee health and reducing expenditures for the plan as well as for employees. We view incentive and rewards as a critical component of the overall strategy, and not as a stand-alone program. An investment in incentives will not generate desired outcomes without robust health and wellness programs and an ongoing communications plan. Before designing an incentive program, we recommend performing a population health analysis in order to target behaviors with the greatest potential impact. And finally, an incentive program should have a rigorous evaluation plan, with some metrics viewed monthly and others either quarterly or on an annual basis. Results should be available for a timely review, in order to make changes rapidly and maintain flexibility, for tangible improvements and results.

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