PUBLIC HEALTH POLICY CHANGE

THE PROMISE AND POTENTIAL PITFALLS IN PROMOTING OUTCOMES-BASED INCENTIVES WITH WORKSITE WELLNESS INITIATIVES

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- Providing substantive public health policy knowledge, competencies & research in an interactive format
- Covering public health policy topics surrounding Tobacco, Obesity, School and Worksite Wellness, and more
- The first and third Tuesdays of every month from 12:00 p.m. to 1:30 p.m. Central Time
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Introductions

Mary Marrow
Staff Attorney, Public Health Law Center
Introductions

Chris Banthin, Esq.

Public Health Advocacy Institute
Northeastern Univ. School of Law
Boston, MA
(617) 373-8502
chris@phaionline.org
Introductions

Debbie Hornor

Community Obesity Policy Manager,
American Heart Association
Introductions

Laurie Whitsel, Ph.D.
Director of Policy Research,
American Heart Association –
National Center
Webinar Objectives

- Describe the role of worksite wellness initiatives in improving the health and wellness of workplaces.
- Identify promising practices in the development and implementation of successful worksite wellness initiatives.
- Discuss the role of incentives in worksite wellness initiatives.
- Recognize legal and policy issues impacting the implementation of worksite wellness initiatives.
THE AMERICAN HEART ASSOCIATION
Our 2020 Impact Goal

“By 2020, to improve the cardiovascular health of all Americans by 20 % while reducing deaths from cardiovascular diseases and stroke by 20 %.”
Cost to Society

- By 2030, 40 percent of all adult Americans will have some form of CVD
- By 2030, direct medical costs will triple from $273 billion to $818 billion
- Direct and indirect costs combined total $1.3 trillion in 2030 – nearly as large as the projected federal deficit for 2011
http://mylifecheck.heart.org/Multitab.aspx?NavID=3
U.S. Health Care Spending

Total health expenditures reached $2.6 trillion. This translates to $8,402 per person or 17.9 percent of the nation's Gross Domestic Product.

Rose 3.9 percent between 2009 and 2010.

Average Annual Worker Premium Contributions and Total Premiums for Covered Workers, Single and Family Coverage, by Firm Size, 2011

* Estimates are statistically different between All Small Firms and All Large Firms (p<.05).

Average Annual Worker Premium Contributions Paid by Covered Workers for Single and Family Coverage, 1999-2011

*Estimate is statistically different from estimate for the previous year shown (p<.05).

# Employer Healthcare Expenses

Heart diseases and stroke costs employers $304.6 billion

<table>
<thead>
<tr>
<th>$24 billion - lost productivity from morbidity</th>
<th>~25-30% of companies’ annual medical costs are spent on employees with major CVD risk factors but without clinical CHD</th>
<th>Major losses due to losses in productivity</th>
</tr>
</thead>
</table>
Burden associated with absenteeism and presenteeism

**Absenteeism**
- Employees with chronic diseases who are absent from the job
- Rates are estimated to range from 0 to 6.3%
- Responsible for 6% of total medical costs
- Reducing 1 health risk factor decreases absenteeism by 2%

**Presenteeism**
- Employees with chronic diseases who are present at the job, but productivity is impaired because of illness
- Rates ~ 1.3% to 25.9%
- Responsible for 63% of total medical costs
- Reducing 1 health risk factor decreases presenteeism by 9%
50% of US workers have no wellness programs due to small companies or distributed worksites. Of 4.9 million firms in US, 0.5% have > 500 employees. Small firms employ 36% of working population. Inadequate penetrance according to 2010 goals. Large firms (>250) employ 51% of working population. Inadequate penetrance according to 2010 goals.
INCENTIVES

Laurie Whitsel, Ph.D.
Director of Policy Research
American Heart Association
Health Reform

- Existing regulations allow employers in conjunction with a worksite wellness program to charge employees a different premium based on meeting certain health status factors (i.e. body mass index, tobacco cessation, cholesterol, blood pressure)

- The maximum differential was increased from 20% to 30% (starting in 2014) and allows the Secretaries of HHS and Treasury to increase to 50% over time if they deem appropriate
## Size of Potential Increase in Health Care Plan Cost

### HIPAA Premium Variation Under 20%, 30%, and 50%

<table>
<thead>
<tr>
<th></th>
<th>Total Cost of ESI Plan</th>
<th>20%</th>
<th>30%</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>$5,470</td>
<td>$1,094</td>
<td>$1,641</td>
<td>$2,735</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>$15,520</td>
<td>$3,104</td>
<td>$4,656</td>
<td>$7,760</td>
</tr>
</tbody>
</table>

Source: Average premiums for individual and family coverage in 2011 based on Kaiser/HRET annual survey of health plans
Employers are Moving in the Direction of Holding Employees Accountable for their Health Behaviors

A survey by Towers Watson:

- 62% of employers plan on switching from incentives for participation to incentives for improvements in health metrics.
- Employers see this approach as a means to control upwardly spiraling health care costs.
Concerns

- There is no clear definition of what constitutes a health status factor
- The regulations do not adequately define a “reasonably designed” wellness program or the alternative standard for those who cannot meet the health metric for health-related reasons
- There is limited evidence that the use of financial incentives results in sustained health improvements
Other concerns

- Premium variation based on health status may penalize people with pre-existing conditions or those who have a genetic predisposition
Impact of Higher Deductibles/ Premiums

- Evidence does show that individuals delay needed health care because of cost.
- High deductible benefit designs requiring significant cost-sharing may create real barriers to preventive care and disease management and lead to higher medical costs over the long-term.

Hall, JP. Carroll SL. Moore JM. Health care behaviors and decision-making processes among enrollees in a state high-risk insurance pool: focus group findings. *American Journal of Health Promotion*. May/June 2010. 24(1
Feedback on Employee Wellness Programs

Prepared for: American Heart Association
Objective & Methodology

- The American Heart Association (AHA) commissioned Ipsos to research consumer attitudes and behaviors related to employee wellness programs.
- Data collection utilized the Ipsos eNation omnibus service.
  - The eNation conducts 1,000 interviews each wave from the Ipsos i-Say panel.
  - Data are weighted based on key demographic characteristics to be representative of the US population of individuals age 18+.
  - Interviews were conducted online June 15-19.
- 490 respondents indicated they are employed and answered the questions for this study. This is a representative sample of employees across the country.
  - Results are shown in total and by gender and age where appropriate.
Executive Summary

- Employees recognize they should improve their diet and exercise habits and are open to wellness programs through their employer that make it easier for them to do so.
  - Early detections/screenings and physical activity programs are of strongest interest.

- Insurance discounts and cash prizes (rewards) for healthy habits will be perceived more positively than penalizing certain employees with higher rates based on negative health factors.
  - Most non-smokers favor having smokers pay more for their health insurance.
Most who are aware that their employer offers health screenings have taken advantage of this benefit and have positive feelings about it.

- Nearly two-thirds of those who have participated took some action to improve their health based on the results.
- Increasing participation could be driven by making the screenings available and effectively communicating the availability to employees.
- Rewards mentioned above may help convince those less interested to participate.
Where do we go from here?

- The American Heart Association, the American Cancer Society, and the American Diabetes Association joined with the Health Enhancement Research Organization (HERO) and the American College of Occupational and Environmental Medicine to develop consensus guidance to employers around the following issues:

  - What constitutes a reasonably designed program?
  - What is a reasonable alternative standard?
  - Future research questions that can improve our understanding of the use of these types of incentives
Guidance for a Reasonably Designed, Employer-Sponsored Wellness Program Using Outcomes-Based Incentives

Consensus Statement of The Health Enhancement Research Organization (HERO), American College of Occupational & Environmental Medicine, American Cancer Society, American Cancer Society Cancer Action Network, American Diabetes Association and the American Heart Association
Fundamentals

- The fundamental goal of any wellness program should be to provide opportunities for individuals to improve their health and wellness.

- A wellness program should not be used in a way that threatens an employee’s ability to maintain health insurance, as this would be in direct conflict with improving employee health.
Beyond Financial Incentives

- Evidence suggests that long-term lifestyle modification or risk factor management requires more than financial motivation.
- Success is based on intrinsic and extrinsic motivation.
- One of the keys to a successful worksite wellness program that is capable of sustaining behavioral change is a workplace culture and environment that supports health and wellness.
  - CEO/leadership buy-in and role modeling
  - Healthy environment (e.g. healthy foods, time to be physically active during the day, occupational safety, smoke-free)
Key Elements of a Reasonably Designed Program

- Strategic Planning
- Cultural Support
- Programs for Assessment and Screening
- Behavior Change Interventions (Programs, activities, information)
- Engagement (Communications, Incentives)
- Measurement/Evaluation
Incentive Design

- Should be related to health promotion/disease prevention
- Not be overly burdensome
- Should not be a subterfuge for discrimination
- Most common health metrics used – tobacco, weight, blood pressure, cholesterol
- Only health status factors that are modifiable for many individuals through changes in health behaviors should be considered
- Employers should factor in potential time and financial barriers
- Assure that the incentive design does not place a greater economic burden on one race or ethnic group than another
- Reward vs. Penalty
Important questions to ask around incentive design

- Does the incentive amount fit within your culture?
- Will the amount drive behavior change in the population?
- If penalties are used, will they have disproportionate financial impact across different income levels or racial/ethnic groups?
- Is the incentive so large that it results in cost-shifting to non-participating or non-attaining employees and jeopardizes the affordability of their health care coverage?
- Any design that eliminates a participant’s access to group coverage would run counter to the fundamental goal of a reasonably designed program to promote health
Reasonable Alternative Standard

- Offer a reasonable alternative standard to employees for whom it is unreasonably difficult to achieve a health standard due to a medical condition, or who have a medical reason that makes it inadvisable for them to do so within the allotted time.

- Employers should defer to the views of the individual’s health care provider for setting and achieving a reasonable alternative standard or providing a waiver.
Reasonable Alternative Standard

- Consider incentive designs that use goals that are more flexible than “ideal” targets.

- Be flexible when it comes to the use of alternative standards and use them to help individuals with higher health risks improve their health habits and overall health.

- Consider providing all employees with options for attaining the incentive rather than only offering the alternatives to those with a medical circumstance.

  ➢ This can be important for employees who have legitimate hardships, outside of medical circumstances, that make it difficult for them to meet a health factor standard.
Reasonable Alternative Standard

- Avoid using a reward or penalty that is so large it discourages people from participating because the goal or standard is out of their reach or the penalty is too stiff.

- Some industry experts suggest, based on extensive real-world experience administering such programs, that amounts in the range of $40 to $60 per month are capable of generating behavior changes by many participants, at least in the short run.
Reasonable Alternative Standard

- Consider an incentive design that rewards for progress toward the standard targets, instead of just rewarding employees who meet the goal.

- Consider strategies that will help employees integrate behavior-change into their personal value framework by promoting individual choice so they are more likely to sustain healthy behavior changes over time. (create tailored, individualized programs)
To Learn More:


- Free full-text access at [http://journals.lww.com/joem/pages/default.aspx](http://journals.lww.com/joem/pages/default.aspx)
Legal and Policy Issues Impacting Worksite Wellness Initiatives

Chris Banthin, Esq.
Public Health Advocacy Institute
Northeastern Univ. School of Law
Overview of Legal Considerations

- A brief history of employment law and tobacco use.

- Encouraging wellness, while avoiding discrimination based on health status.

- Access to and confidentiality of an individual’s health status
Employment and Tobacco Use


- Non-discriminatory on an individual basis because smoking is not protected under Federal or state discrimination law, and smoking is not a clinically recognized treatment for any health condition.

- Some states prohibit employers from having no-smoking rules for employees outside of work.

- Collective Bargaining
Tobacco Use

- Financial incentives affecting tobacco use are effective and longstanding. *E.g. Taxation by state governments, coupons by tobacco manufacturers.*

- Environment influences risk behavior and utilization of preventive services.

- Health disparity in tobacco prevention.
Wellness Programs  42 U.S.C. § 300gg-4

- Wellness Programs with No Conditions Based on Health Status:
  ✓ Pays for part of a gym membership,
  ✓ Waiver of co-pay for certain health services, or
  ✓ Health screenings with no incentives tied to results.

- Wellness Programs with Conditions Based on Health Status:
  ✓ 30% Discount on Health Insurance Premiums and up to 50% if authorized in the future by HHS.
  ✓ Our focus today.
Basic Legal Requirements of Plans

- Premium discount, co-pay waiver or the like up to 30% reduction in cost for establishing a health factor status standard. *(Examples: Smoking, blood pressure, cholesterol)*

- Must be tied to a “reasonably designed [wellness program] to promote health or prevent disease” with “reasonable alternative standards.”

- Available to all “similarly situated individuals”

- Maintain privacy of health information.

- No discrimination in any aspect of employment.
Federal Laws

- Federal law controls and preempts inconsistent state law.
- Patient Protection and Affordable Care Act (the Affordable Care Act).
- Health Insurance Portability and Accountability Act (HIPAA).
- Genetic Information Nondiscrimination Act.
- Americans with Disabilities Act.
Privacy Legal Concerns

- Health factor status and other health information of employee and family is confidential.
- Employee consent for obtaining and using health information is required.
- Employers may not have access to health information.
- Employers are not the keepers of health information in self-insured plans. HIPPA-compliant separation between health information and other employee information required.
Discrimination Legal Concerns

- ADA requires employers make “modifications or adjustments that enable a covered entity’s employee with a disability to enjoy equal benefits and privileges of employment as are enjoyed by its other similarly situated employees without disabilities” unless “such covered entity can demonstrate that the accommodation would impose an undue hardship on the operation of its business.”

- ADA prohibits employers from “requir[ing] a medical examination and [making] inquiries of an employee as to whether such employee is an individual with a disability . . . unless such examination or inquiry is shown to be job-related and consistent with business necessity.”
Discrimination Legal Concerns

- **Seff v. Broward Cnty., No. 10-cv-61437, slip op. at 3 (S.D. Fla. Apr. 11, 2011)** – Upheld a penalty for not joining a wellness program.

- **Safe Harbor:** “establishing, sponsoring, observing, or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law [of federal law].”
Next Webinar in the Series

Digging into Tobacco Documents: Real Life Examples of How to Advance Tobacco Control

Tuesday, August 7, 2012 - 12:00 p.m. – 1:30 p.m. CST
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