Guidance for a Reasonably Designed, Employer-Sponsored Wellness Program Using Outcomes-Based Incentives

Consensus Statement of the Health Enhancement Research Organization, American College of Occupational and Environmental Medicine, American Cancer Society and American Cancer Society Cancer Action Network, American Diabetes Association, and American Heart Association.

Objective: To provide guidance regarding appropriate use of outcomes-based incentives as part of a reasonably designed wellness program designed to improve health and lower cost while protecting employees from discrimination and unaffordable coverage. **Methods:** The process included reviewing the literature, regulations, case studies, and other resources while developing consensus through numerous group discussions. **Results:** We offer guidance on the elements of a reasonably designed wellness program that should be in place if outcomes-based incentives are deployed and identify strategies to help ensure that effective and fair programs are put in place and evaluated. **Conclusions:** We strongly encourage employers using outcomes-based incentives as part of wellness initiatives to incorporate these elements of a reasonably designed wellness program and consider this guidance for the design, implementation, and evaluation of such programs.

This work represents the collective guidance of various stakeholders who previously expressed different perspectives—some urging support and others expressing caution—in the discussion of outcomes-based incentives used in connection with employer-sponsored wellness programs (hereafter referred to as wellness programs).

Our primary goal in providing this guidance is to help employers to implement programs that engage their workforce, improve employee health, and potentially reduce health care and other related costs over time while also protecting employees from discrimination and unaffordable coverage. We believe that 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 because any resulting decrease in access to care would be in direct conflict with the primary objective of improving employee health. This consensus statement is neither meant to serve as legal advice nor to advocate for an outcomes-based incentive approach over a variety of other strategies available for increasing employee engagement in wellness programs. A careful review of the potential risks and benefits along with a thorough evaluation from legal counsel should be conducted before implementing any incentive design.

Approximately 150 million people in the United States receive their health care coverage through employer-sponsored group health plans.[1] Employers spent more than $8500 per active employee on health care coverage in 2011, 76% of the $11,176 total cost, with employees covering the balance. As health care cost increases continue to outstrip inflation, employers and employees alike are struggling with rising costs.[2] Many employers are shifting a portion of these additional costs to employees, which is why employee contributions have increased 45%, on average, from 5 years ago compared with a 36% average increase for employers during the same period.[1]

The Centers for Disease Control and Prevention[3] estimates that as much as 75% of all US health care spending is for people with chronic conditions. Moreover, just four modifiable health risks (tobacco use, poor nutrition, lack of physical activity, and excessive alcohol consumption) are responsible for much of this chronic disease burden.

It makes practical sense for employers to play a positive role in influencing the health behaviors of their workforce.* Improvements in employee health can reduce health care costs, disability, and absenteeism, as well as increase employee productivity.[4,5] Thus, many employers have added wellness programs (also known as employee health management programs) to their health plans and there is growing evidence for their benefits.[6] Some employers, however, report low levels of employee participation in such programs.[7] Because employers are seeking new ways to increase engagement in wellness programs and, ultimately, influence employees to change health behaviors, interest in outcomes-based incentives has never been higher.[8]

Studies indicate that financial incentives can increase simple behaviors such as completing a health assessment or preventive screening.[9,10] Nevertheless, incentives alone may not be a practical tactic for sustained improvements in population health.[11–13] The evidence suggests that long-term lifestyle modification or risk factor management requires more than financial motivation.[14,15] The key to a successful worksite wellness program capable of sustaining behavioral change is the creation of a culture and environment that supports health and wellness.[9,14,16] Within this context, the role of an extrinsic motivator—like an incentive—is to activate employees to learn about health and wellness, engage in wellness program

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*Worksite wellness programs also make sense from a public health perspective because: (1) most people spend a majority of their day at work; (2) worksite factors (eg, group processes, policies, environmental resources) can support individuals in changing health behaviors; and (3) family members also can be reached.

components, and begin selected behavior changes.[17]

While the deliberations continue, many employers are forging ahead with varied incentive approaches. According to a recent annual market survey, about 35% of companies reported using rewards or penalties based on smoking or tobacco-use status in 2012, and another 17% of companies plan to add such incentives in 2013.[18] Other categories of outcomes-based incentives (eg, achievement of weight control or target cholesterol levels) are less common, according to the same survey, with only 10% of companies using them in 2012. Nevertheless, that number is poised to triple with another 23% of companies planning to implement such incentives in 2013.[18]

Given this shift in the marketplace, we engaged in a constructive process that identified considerable common ground on ways to ensure that effective and fair programs are put in place and evaluated. This consensus statement offers our shared guidance to employers who are implementing or planning to implement outcomes-based incentives, which encompasses any approach in which a reward or penalty is tied to an individual achieving or making progress toward a standard related to a health status factor. Because evidence for the ability of outcomes-based incentives to change health behaviors is not yet adequate,[13,19] we conclude by identifying key questions for future research that would enhance our understanding of this emerging field.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT REQUIREMENTS FOR WELLNESS PROGRAMS

The nondiscrimination provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) generally prohibit a group health plan or group health insurance issuer from charging one individual a higher premium than another based on a health factor. Nevertheless, HIPAA allowed a specific exemption for premium discounts or rebates "in return for adherence to programs of health promotion and disease prevention."[20] This exception was further defined in the Final Wellness Rules for Group Health Plans issued in 2006, which were then codified into the Public Health Services Act through the wellness provisions of the Patient Protection and Affordable Care Act (PPACA) passed in 2010.

The regulations and statutory provisions clarify that premium variations or other financial incentives tied to participation in a wellness program are not subject to restrictions under HIPAA as long as they are available to all similarly situated individuals.* For a group health plan to use incentives tied to the attainment of or progress toward a standard related to a health status factor (ie, outcomes-based), five HIPAA requirements must be met:

1. The total amount of all rewards (or penalties) contingent on satisfying a health standard must not exceed 20% of the total cost of coverage applicable to those who may participate fully in the wellness program. (PPACA increases this to 30% in January 2014.)
2. The program must be reasonably designed to promote health and wellness.
3. Individuals must be offered an opportunity to qualify for the reward under the program at least once per year.
4. The reward must be available to all similarly situated individuals. If the standard is unreasonably difficult due to an employee's medical condition or if it is medically inadvisable for an employee to attempt to satisfy the standard during the period allotted, the individual must be offered a reasonable alternative standard or waiver of the applicable health factor standard.
5. All program communication materials that describe the terms of the incentive must clearly disclose the availability of the reasonable alternative standard or the possibility of a waiver.

The stated goals of the regulations are to help individuals "succeed at improving health habits and health" and "to ensure that the exception for wellness programs does not eviscerate the general rule contained in HIPAA's nondiscrimination provisions."[21] To that end, the rules are explicitly designed to reduce the risk that programs using an outcomes-based approach to incentives would merely shift costs to high-risk individuals or create premium differentials so large as to discourage enrollment, deny coverage, or create an excessive financial penalty.[22]

Employers should be aware that other state and federal laws may also be applicable to the use of financial incentives tied to health status. The impact of incentives on people with disabilities under the Americans with Disabilities Act (ADA) is of particular concern, and employers must be careful to ensure ADA compliance.

We believe that the HIPAA rules governing outcomes-based incentives most in need of further clarification are those using subjective terms such as *reasonable* or *unreasonable*. Thus, this document provides recommendations and guidance to employer health plan sponsors that choose to implement outcomes-based incentives on two key interrelated questions:

1. What are the elements of a reasonably designed wellness program that incorporates outcomes-based incentives?
2. Within a reasonably designed wellness program, what are the considerations in assuring a HIPAA-compliant outcomes-based incentive design that provides a "reasonable alternative standard" to those who cannot meet the health standard?

ELEMENTS OF A REASONABLY DESIGNED WELLNESS PROGRAM

Successes in tackling formidable societal issues that require individual behavior change (eg, seat belt use, worksite safety, recycling, and smoking cessation) have often used financial incentives such as fines or user fees, but always within a broader strategy focused on capacity building, education, culture, and policy change. The same holds true for incentives in worksite wellness programs.[23,24] According to the regulations, employers may vary employee-health-plan premium contributions or benefit levels based on a health factor "only in connection with wellness programs."[25] A reasonably designed wellness program is defined as one that has a "reasonable chance of improving the health of or preventing disease in participating individuals." Research has shown, for example, that creating a healthy culture and work environment is a fundamental best practice for increasing employee engagement in healthy behaviors and health improvement.[16,26–29]

A range of resources are available from Health Enhancement Research Organization (HERO),[30] American College of Occupational and Environmental Medicine (ACOEM),[31,32] American Cancer Society,[33,34] American Diabetes Association,[35] American Heart Association (AHA),[36] and others[37–41] to help employers to identify best practices** for worksite wellness programs. This section summarizes what we view as a reasonably de-

*According to a 2010 Congressional Research Service report entitled Wellness Programs: Selected Legal Issues, the HIPAA regulations do not define the phrase "similarly situated" but do permit a plan or issuer to treat participants as two or more distinct groups of similarly situated individuals if the distinction is based on a "bona fide employment-based classification consistent with the employer's usual business practice." Bona fide classifications can include full-time versus part-time status, geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. See 29 C.F.R. § 2590.702(d)(1);45 C.F.R. § 146.121(d)(1); 26 C.F.R. § 54.9802–1(d)(1).

**In this document, the phrase "best practices," means evidence-based or experience-based practices that are generally agreed by wellness industry authorities to represent current best practice. Given the current evidence base and state of development of wellness programs, practices considered best practice are likely to evolve over time.

signed wellness program based on evidence-based best practices, models, and theories identified in these resources. We used the basic components delineated in the HERO Best Practice Scorecard* as a framework and, through an iterative process, developed consensus on specific guidance and examples that reflect our combined experience and expertise. We also recognize that there are many other known elements of work environment and culture that influence health, such as the organization of work itself,[42] but that these elements are beyond the scope of this guidance.

Strategic Planning

Strategic planning is the process of defining the overall wellness program direction and purpose, and making decisions on allocating sufficient resources to pursue this strategy. It includes conducting an organizational assessment, setting goals, determining the eligible target population, and designing the wellness program. Table 1 provides guidance for determining the key elements of a strategic planning process.

Cultural Support

Creating an organizational culture and work environment that makes it easy, convenient, and acceptable for employees to engage in behaviors that support health promotion (ie, wellness) and health protection (ie, safety) is critical to long-term success.[43] Building a healthy culture requires leadership and grassroots support, a healthy workplace environment, and supportive policies and benefits design. Table 2 provides guidance for the various components involved in creating a culture of health at the worksite.

*The nonprofit HERO created the HERO Best Practice Scorecard in Collaboration with Mercer as a free on-line survey to help guide employers through identifying best practices and to help them assess the status of an existing program against accepted industry best practices.

Programs

Assessment and Screening

A voluntary tool or process, such as a health-risk appraisal and biometric screening, may be used to assess health status at organizational and individual levels. This information is used by the health plan or third-party vendor to identify opportunities for improvement and interventions at the aggregate and individual levels. Elements of general health assessment or screening should be relevant to risk factors that lead to chronic disease. Preventive health screenings can be made available to all individuals through their physician, health plan options, worksite/near-worksite resources, certified clinical laboratory, or at home by a qualified third party. Key characteristics of a well-designed worksite screening activity include the following:

- Screenings should follow consistent protocols for all participants in a target population.
- Screenings should adhere to industry standards and scientific/clinical guidelines regarding quality, accuracy, privacy, and safety.
- Screenings should follow referral protocols based on established national guidelines for individuals whose results are out of the normal range.
- Screenings should have an established process for having results communicated to the participant's physician.

Any individually identifiable medical information obtained through the assessment and screening process is considered protected health information and is subject to the same privacy, storage, and security requirements as any other sensitive medical information. The ADA, for example, requires that medical information be kept apart from general personnel files and HIPAA prohibits employers from using protected health information for employment-related reasons (eg, firing, promotion).[24,44,45] Unless an employer can maintain a HIPAA-compliant "firewall" between the non–health care component of the organization and any health care component(s) to protect against improper use or disclosure, employers are advised to use qualified third parties to provide these programs and to handle the resultant individually identifiable information.[46,47] For screening activities associated with outcomes-based incentives, a well-defined appeals, dispute, and retesting process should be in place because some tests vary in their ability to produce reliable and valid results at a single point in time (eg, blood pressure). To optimize confidentiality and credibility, employers should strongly consider having appeals independently adjudicated by a qualified vendor that specializes in this activity.

Behavior Change Interventions

These interventions include evidence-based programs, activities, and information designed to improve individual lifestyle habits and, ultimately, health status for all

TABLE 1. Strategic Planning Components of an Employer-Sponsored Wellness Program

Component	Description	Examples or Key Considerations
Organizational assessment	An assessment of worksite culture and environment for health and wellness in addition to aggregate employee health status to establish a baseline and determine program direction and purpose.	Environmental/policy assessment: safety, tobacco use, access to healthy foods, accessible stairwells. Aggregate employee assessment: medical/pharmaceutical claims; health risk assessment; biometric health screening; disability data; workers' compensation data; absence data; employee interests.
Goals	A document stating wellness program goals and success criteria to guide program direction and opportunities.	Sample aggregate goals might include: participation changes in health risk; changes in clinical measures; changes in productivity; medical/pharmaceutical claims cost impact; changes in workers' compensation incidence and cost; changes in unscheduled absence.
Target population	Access to wellness programs and resources including at least all employees covered by the health plan, and ideally including some other categories of individuals (eg, part-time employees, spouses, and retirees). Many employers offer the wellness program to individuals not enrolled in the health plan to facilitate communicating and creating a culture of health.	Any "off-site" participants who are eligible for an incentive should have equivalent access to services and resources comparable with those offered to support on-site employees in achieving incentive requirements.
Design	In addition to interventions for the target populations, a population-based approach is applied to the wellness program design through program components and environmental support intended to reach the entire population (including healthy, at-risk, and those with chronic conditions).	–

TABLE 2. Cultural Support Components of an Employer-Sponsored Wellness Program

Component	Description	Examples or Key Considerations
Leadership support	Senior leaders endorse and support the wellness program.	Involvement in employee communications; active participation in the incentive and other aspects of the program; creating a corporate vision/mission statement that acknowledges the value of a healthy workplace culture.
Champions	A wellness committee, champion and/or ambassador approach is implemented to help to design and advance the wellness program throughout the organization.	Organized network of employees serving as wellness champions; wellness committee with representatives from across the organization; volunteers who support wellness events.
Environment	A physical work environment that supports engaging in healthy lifestyle behaviors and emphasizes safety.	Healthy food options, fitness centers, walking paths, lactation rooms.
Policies	Organizational policies that support a healthy workplace.	Tobacco-free workplace/campus; flex-time to participate in wellness programs or to exercise; healthy food options in vending machines, cafeterias, and meetings.
Health benefit design	Coverage and access is offered or available for preventive services, and for acute and chronic health care services for all individuals.	24×7 access to nurse hotline; First dollar coverage of preventive care; Resources for risk factor management.

employees regardless of risk. All participants subject to incentive provisions should have equivalent access to services and resources offered by the wellness program.[47] Program delivery methods should be readily accessible and appropriate for the target population(s).[48] Topics may include smoking cessation, weight management, nutrition, physical activity, stress, and mental/emotional well-being or other issues consistent with the needs of the population. Delivery methods may include telephone-based coaching; web-based and mobile coaching tools; on-site one-on-one coaching, group classes, or activities; printed educational materials; individual or team challenges; and population-wide campaigns. Employers should consider qualified third parties to deliver such programs and services. Since some of these delivery methods may not be feasible for small and midsized employers, they may consider leveraging targeted mailings and reminders of preventive services and interventions covered by their health plan.

Engagement Methods

Communications

Building employee awareness and acceptance requires a variety of means to regularly relay wellness program information to all segments of the workforce. Table 3 provides guidance for creating an effective communication strategy.

Incentives

Employers implementing or planning to implement outcomes-based incentives that are the focus of this consensus statement may also want to consider additional types of monetary or nonmonetary incentive approaches designed to increase participation in specific program offerings. Examples of such participation-based incentive opportunities include the following:

- Reimbursement for all or part of the cost of memberships in a fitness center;
- Reward for participating in a diagnostic testing program;
- Waiving an otherwise applicable deductible or copayment to encourage preventive care;
- Reimbursing the costs of smoking cessation programs;
- Reward for attending a monthly health education class;
- Recognition in company-wide communications or on a wellness "wall of fame";
- Competitions among individuals or company departments or business units;
- Allowing company time for participation in wellness activities; and
- Token giveaways recognizing wellness achievements.

Any incentive that provides a cash benefit or that is offered outside the health plan may have tax implications for the employee, employer, or both and should be designed carefully to avoid violation of discrimination laws.

Measurement and Evaluation

Employers should establish an evaluation process to assure that the program is implemented effectively and to assess whether it is achieving health and financial goals. Evaluation results should be accessed by employers only in aggregate form to protect employee privacy. Basic aggregate evaluation measures valuable for all employers include the following:

- Assessment of the wellness program using a third-party tool;
- Participation/engagement/retention rates in activities, overall and broken down, to the extent feasible, by health and income groups;
- Participant satisfaction based on anonymous survey data;
- Improvement in targeted health risks and health status factors.

Ideally, employers should also track key aggregate measures related to the program's impact on insurance affordability and access (eg, group health plan retention rates). Additional aggregate measures may include (subject to the stated program goals included in the strategic plan) health care claims/costs, workers' compensation claims/costs, disability claims/costs, occupational and/or nonoccupational absence, and productivity. Because these financial measures are statistically complex, larger employers should consider having independent third-party researchers conduct methodologically rigorous analyses to assure validity of cost-outcome estimates.

Guidance for HIPAA-Compliant, Outcomes-Based Incentives

When employers design an outcomes-based incentive as part of their overall wellness program, multiple regulatory provisions must be navigated. This section provides guidance and recommendations relevant to HIPAA compliance.

Incentive Design

The rules are unclear regarding the types of health factors considered reasonable as health status factor standards (ie, health standards) other than they should be related to health promotion or disease prevention, not be overly burdensome, not be a subterfuge for discrimination, and not be highly suspect in the method chosen. We recommend as guidance the four examples of biometric target categories provided in a 2008 *Field Assistance Bulletin* issued by the Department of Labor, that is, weight, cholesterol, blood pressure, or tobacco use targets.

TABLE 3. Communication Strategy Components of an Employer-Sponsored Wellness Program

Component	Description	Examples or Key Considerations
Channels	Multiple communication channels and media with proactive communications occurring at least on a quarterly basis.	Newsletters, direct mailings, Web site, e-mails, text messages, podcasts, and face-to-face employee meetings.
Branding	Wellness program branding with a name/logo for ease of recognition and visibility.	–
Status updates	Regular program status updates to eligible participants and senior management provided two or more times per year.	–
Messaging	Culture-appropriate communications include messaging that addresses the overall value and purpose of the wellness program to the organization and to the individual.	Examples include population-based health education resources, materials that explain how improving health helps to reduce health risks and improve quality of life while potentially reducing health care costs, and information about how to appropriately access and utilize the health care system and available health benefits.

These categories are, by far, the most commonly used by employers. According to recent results from an annual market survey, 90% of companies with an outcomes-based program use a weight-related standard and 75% use blood pressure, cholesterol, and tobacco use.[15] We believe the use of a medical or physical illness, disability, or largely nonpreventable conditions would not be considered a reasonable design and likely would violate antidiscrimination laws. Instead, financial incentives should be tied only to health status factors that are modifiable for many individuals through changes in health behaviors (eg, weight, cholesterol, blood pressure, and tobacco use).

Employers should factor in potential financial and time burdens for participants when determining the specific standard an employee is asked to meet. If the amount of time allotted to reach a health standard would require certain employees to take actions deemed medically unsafe (eg, rapid weight loss) or opt for medical intervention (eg, prescription medication), then such employees are eligible for a reasonable alternative standard or a waiver under the rules (see next section, Reasonable Alternative Standards). The regulations specify that a program might not be reasonably designed to promote health if the time commitment involved in meeting a standard is "overly burdensome" for an employee.[49] Our guidance regarding "blended" and "flexible" designs, given later in this consensus statement, can help to address time constraints associated with achieving ideal biometric targets.

Employers also should consider whether their incentive design is likely to place a greater economic burden on one race or ethnic group of employees than another. If so, the program may be at risk for potential violations of various civil rights and employment laws. Those in certain income and race/ethnic categories are likely to have higher rates of risk on the health status factors being addressed by outcomes-based programs.

Reasonable Alternative Standards

The stated goal in the regulations for creating the reasonable alternative standard provision is to "reduce instances where wellness programs serve only to shift costs to higher-risk individuals and increase instances where programs succeed at helping individuals with higher health risks improve their health habits and health."[50] Under the rules, an employer must offer a reasonable alternative standard to individuals for whom it would be unreasonably difficult to achieve a health standard because of a medical condition or who have a medical reason making it inadvisable to attempt to do so within the allotted time. This provision also applies to those who need prescription medication, physician supervision, or both to meet the standard.[51] These regulations provide the following options for devising a reasonable alternative standard:

- Lower the threshold of the existing standard;
- Substitute a different standard;
- Waive the standard;
- Have an employee follow the recommendations of his or her physician regarding the health factor at issue.[52]

Neither the time nor the financial resources required to achieve an alternative standard should be a barrier or burden. An employee must be able to satisfy the alternative standard without regard to any health factor, which means that "if the alternative standard is health-factor related (eg, walking 3 days a week for 20 minutes a day), the wellness program must provide an additional alternative standard (eg, following the individual's physician's recommendations regarding the health factor at issue) to the appropriate individuals."[52]

We recommend that employers defer to the views of the individual's health care provider for setting and achieving a reasonable alternative standard (or providing a waiver) for those with a medical condition. The health care provider's care plan may be supported by the company-sponsored wellness program (eg, health coaching), and coordination of worksite wellness activities can be an important support mechanism and assure medical appropriateness. Individuals also should be provided information about available wellness programs to help them achieve the reasonable alternative standard.

The employer is allowed to seek verification of an employee's need for an alternative standard, such as a physician's note. Such requests may raise privacy-related and other concerns with employees. Any process that seeks documentation, particularly from a physician, of an employee's specific medical circumstances should be administered consistent with all legal requirements (eg, HIPAA, state regulations) to assure personal health information is adequately protected. Employees may not be required to disclose a disability protected by the ADA, and any medical information obtained as part of a wellness program that could identify a disability must be kept confidential.

Incentive Size

The regulations only require that the total amount of all rewards (or penalties) used for an outcomes-based incentive not exceed 20% of the total cost of coverage (ie, sum of employee plus employer contributions). If another class of dependents (eg, spouses) is included in the program, then the total cost of the coverage category in which the participant is enrolled can be used. This amount represents the maximum allowable differential between participants who satisfy wellness program standards and those who do not, or the financial differential between the person who scores the highest and the person who scores the lowest on a set of health status factors. Effective January 1, 2014, PPACA increases this maximum amount to 30%.

The regulators gave specific reasons for establishing the current 20% cap. They sought to avoid a reward or penalty so large as to have the effect of discouraging enrollment based on health factors, denying coverage, or creating too heavy a financial penalty on

individuals who do not satisfy an initial wellness program standard.[49] We strongly recommend that employers take these factors into consideration when determining the amount of their incentive and attempt to stay within the spirit of the rules. The incentive amount should be based on a value that is intended to promote health or prevent disease rather than an estimation of the cost associated with certain health risk factors.[47]

The extent to which incentive amounts at or approaching the maximum allowable percentage for outcomes-based designs are more or less effective remains unknown. 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. There is ample anecdotal evidence, as well as some research evidence,[11,12] that these more modest incentive amounts can be effective and that substantially increasing the incentive amount within the HIPAA limits would add minimally to their effectiveness. Significant financial incentives may also cause individuals to ascribe behavior changes to extrinsic motivation, which may decrease the development of internal or "intrinsic" motivation[17] normally needed to sustain behavior change for an extended period of time.[53]

We believe the following questions also are worth careful consideration when determining the incentive amount:

- Does the incentive amount fit with your culture?
- Will the incentive amount drive behavior change in your population? Is there any evidence to support that conclusion?
- If penalties are used, will they have a disproportionate financial impact across different income levels or racial/ethnic groups within the company? This circumstance could lead to a higher proportion of a penalty or differential being paid by lower income workers or certain ethnic/racial groups who potentially have the least access to the tools and resources necessary to improve health status unless they are made readily accessible through the wellness program.
- Is the incentive so large that it results in significant cost shifting to nonparticipating or nonattaining employees, jeopardizing their ability to afford coverage? Any strategy designed in a way that eliminates a participant's access to group coverage would run counter to the fundamental goal of a reasonably designed wellness program to promote health.[54]

Conditions for Applying the Incentive

Although the rules allow employers to use "ideal" health goals and to tie the entire incentive amount to passing or failing one specific category (eg, cholesterol less than 200 mg/dL), our guidance is that employers avoid such designs. The regulations were intended to avoid approaches in which few employees would be eligible for a reward or too many would be subjected to a penalty. If an ideal goal, such as a body mass index less than 25, is known to be an objective that most individuals would fail to achieve without significant intervention and lifestyle modification over a long period of time, then such a goal may be viewed as being "merely a way to shift costs" to those with certain risk factors and inconsistent with the spirit of the regulations. Moreover, a program that sets targets that either penalize or deny significant financial rewards only for people with a condition that is a "disability" under the ADA, such as obesity, diabetes, or hypertension, may also be considered a "subterfuge for discrimination" under both HIPAA and the ADA.[55] The guidance provided in this section and elsewhere in this consensus statement is intended to mitigate such risk.

We suggest consideration of a design that uses goals that are more flexible than "ideal" targets. One possible approach is a blended design that provides rewards not only for "ideal" scores but also (the same reward or substantial portion thereof) for meeting less stringent goals or for making meaningful progress toward the goals.[56,57] Rather than applying the entire incentive to one category, employers may distribute the amount across multiple categories so that even those who fail one or two categories are still rewarded for meeting standards or making progress in other categories. Other companies may tie an incentive to overall population outcomes, challenging employees to work together to decrease the company smoking rate or to reduce the average body mass index over the next year.

Another approach we suggest employers consider is to provide all employees with options for attaining the incentive rather than only offering alternative standards for those with a medical circumstance, particularly in the first years of an outcomes-based incentive plan. For example, an employee could receive an outcomes-based incentive either by reaching a particular health standard, by making progress toward the health standard,[56,57] or by changing their health status to a degree that evidence indicates yields health benefits* or based on some other standard or criteria. This approach is especially important for employees who have legitimate hardships that, irrespective of their medical circumstances, make it overly difficult to meet a health factor standard.[47,57,58] The regulations anticipate that a plan's "initial standards may be such that no participant would ever find them unreasonably difficult" enough to warrant the need for a formal process for establishing alternative standards.[59]

An ideal approach would help employees to integrate behavior-change approaches into their own value framework by promoting individual choice so they are more likely to sustain healthy behavior changes over time.[57,60] Some companies encourage autonomy and personalization by using a health coach or other qualified health professional to tailor a standard to an individual's circumstances or to provide follow-up support in pursuit of a standard.

Rewards Versus Penalties

The regulations allow both incentives and disincentives, such as penalties and surcharges. Employers should carefully consider the pros and cons associated with different approaches. Behavioral economics research suggests that people may be more motivated to avoid loss (ie, penalties or surcharges) than to make equivalent gains.[61] Others believe that rewards for healthy behavior are more consistent with a long-term strategy of creating a partnership culture. Whether the emphasis is on rewarding healthy behavior or penalizing unhealthy behavior will depend largely on the company's culture and leadership style. It is important that employers clearly and openly communicate the incentive program's relationship to any known or potential changes in employee health plan costs. Although the use of rewards and penalties may be designed to achieve the same goals or have the same financial impact, those that are perceived as punitive are more likely to risk employee goodwill and external scrutiny.

Areas for Future Research

The use of outcomes-based incentives is a relatively new practice. To better understand their effect, it is important to build our knowledge base regarding the impact of different incentive approaches on program effectiveness, employee health, health care costs, and access to and delivery of health care.

In the near future, through collaborative and focused research by employers, researchers, and service providers, the following key questions about outcomes-based incentives and other types of incentives should be addressed:

- Does tying a financial incentive to health plan premiums or other plan design elements change engagement, employee health behaviors, health outcomes, absenteeism, disability, productivity, and other costs related to health care or productivity? Changes in employer versus employee

*For example, according to the National Institute of Diabetes and Digestive and Kidney Diseases, for someone who is obese or overweight, "a weight loss of 5 to 7% of body weight may improve health and quality of life, and it may prevent weight-related health problems, such as type 2 diabetes."

health care costs should be evaluated in addition to overall cost changes.

- Are there differences in behavior change or health outcomes over the short and long term? Are there differences across different sectors and different-size employers or among different socioeconomic groups? What factors contribute to those differences?
- Is there an impact on the effectiveness of worksite wellness programming with the use of financial incentives tied to the health plan? Program effectiveness might be defined within domains such as participation, satisfaction, health impact, organizational support, financial outcomes, or value of investment.
- Is there an impact on access to health care or delivery of care with the use of these incentives? It will be important to assess the effect on enrollment if premiums are used and use of the health care plan if deductibles or copayments are used. Access to care and delivery of services should include preventive services, medication adherence, well visits, and disease management.
- What is the role of worksite culture and employer leadership support in improving participation, engagement, and outcomes? How do incentives fit within this cultural context? How do we best measure the culture within the workplace? Validated tools are not yet available to assess this aspect of the work environment.[27]
- Can the use of financial incentives result in higher overall costs or worse health outcomes? For example, can incentives lead to overuse or inappropriate use of screening tests and other health services where harms may outweigh benefits?
- What are the most effective ways other than financial incentives to influence health behaviors in an employed population? How does the impact of these alternatives compare with the impact of incentives?

Conclusion

Federal regulations and the PPACA give employers the opportunity to use financial incentives based on meeting certain health status factors (ie, body mass index, tobacco use, cholesterol, blood pressure). Employers are using this authority to implement more potent incentive designs intended to improve the health of their workforce, increase participation and engagement in wellness programs, and, ultimately, reduce health care costs and related business expenses. Because the evidence for the efficacy of these relatively new incentive strategies is not yet sufficient, employers should design programs that incorporate the basic elements described in this consensus statement to assure that access to health care is not diminished. Health insurance coverage including basic preventive care and chronic condition management is essential for overall health and wellness. It is hoped that the guidance presented in this consensus statement will provide employers with a foundation for strategic thinking, implementation, and evaluation of wellness programs in conjunction with the appropriate use of incentives that will ultimately contribute to improvements in the health of the US workforce and ultimately our nation's health.

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Health Enhancement Research Organization is a national nonprofit organization that serves as a leader in the creation of employee health management: research, education, policy, strategy, and infrastructure. For more information about HERO, visit www.the-hero.org.

American College of Occupational and Environmental Medicine provides leadership to promote optimal health and safety of workers, workplaces, and environments (www.acoem.org).

American Cancer Society helps people to take steps to prevent cancer or detect it at its earliest, most treatable stage. This is done through the educational efforts that help people to stop smoking, get the right screening tests, and live healthy lifestyles (http://acsworkplacesolutions.com/).

American Cancer Society Cancer Action Network is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, which supports evidencebased policy and legislative solutions designed to eliminate cancer as a major health problem (www.acscan.org/).

American Diabetes Association's mission is to prevent and cure diabetes and to improve the lives of all people affected by diabetes (www.diabetes.org).

American Heart Association is devoted to saving people from heart disease and stroke — America's No. 1 and No. 4 killers — teaming with millions of volunteers to fund innovative research, fight for stronger public health policies, and provide lifesaving tools and information to prevent and treat these diseases (www.heart.org).

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