12th Population Health and Care Coordination Colloquium

Feb. 27-28, 2012, Philadelphia, PA

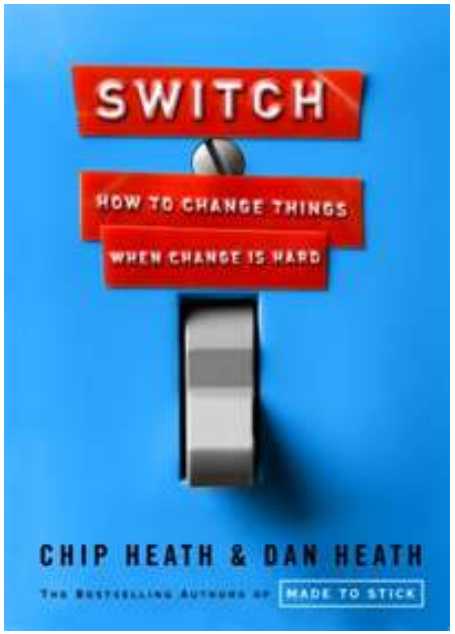
Progress Based Incentives

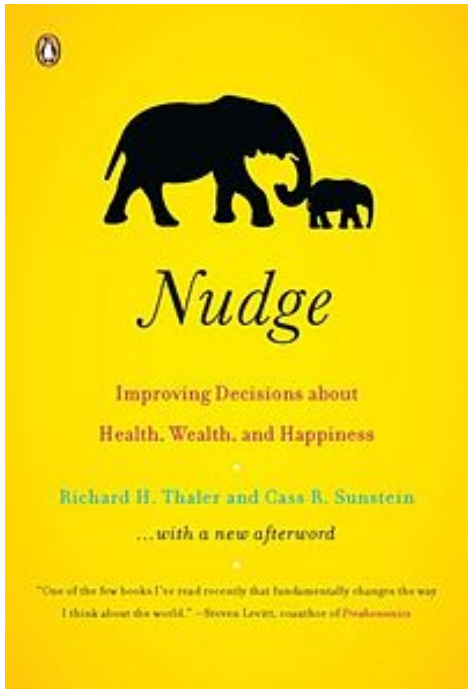
Presented by:

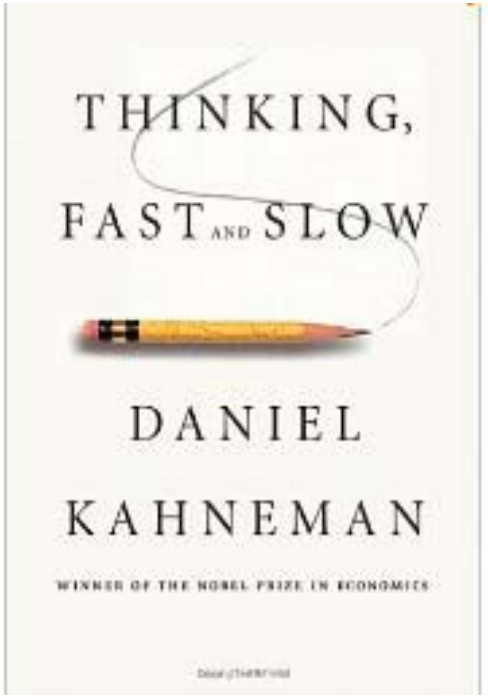
Paul Terry, Ph.D., StayWell Health Management

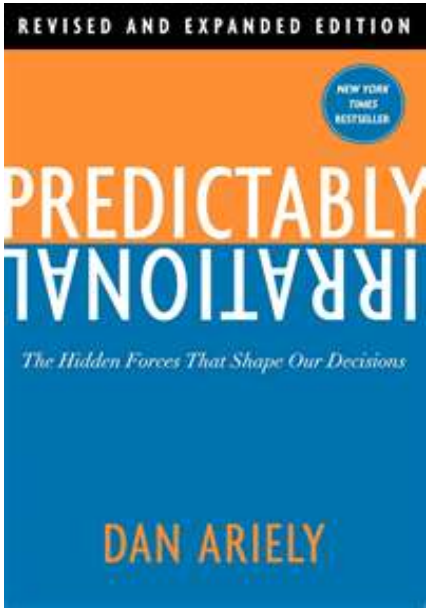
Behavioral Economics

http://staywellhealthmanagement.com/Newsevents/News/tabid/80/articleType/ArticleView/articleId/128/Are-outcomes-based-incentives-the-answer.aspx

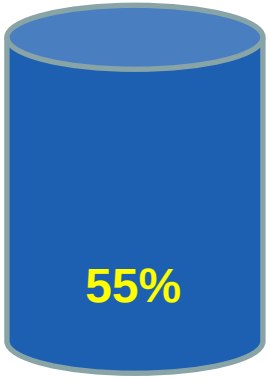




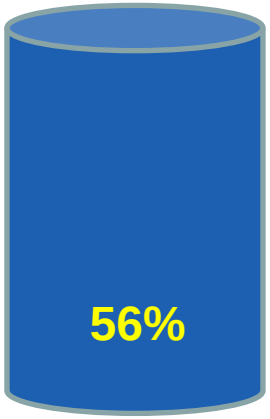




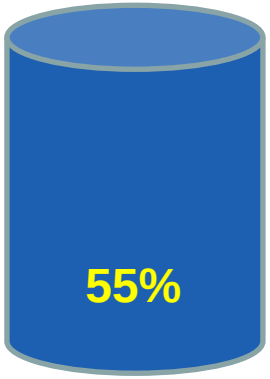
Adherence to Quality Indicators



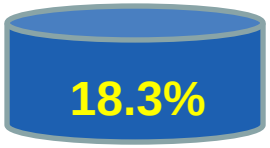
Recommended Care



Recommended Chronic Care



Recommended Preventive Care



Counseling/Education

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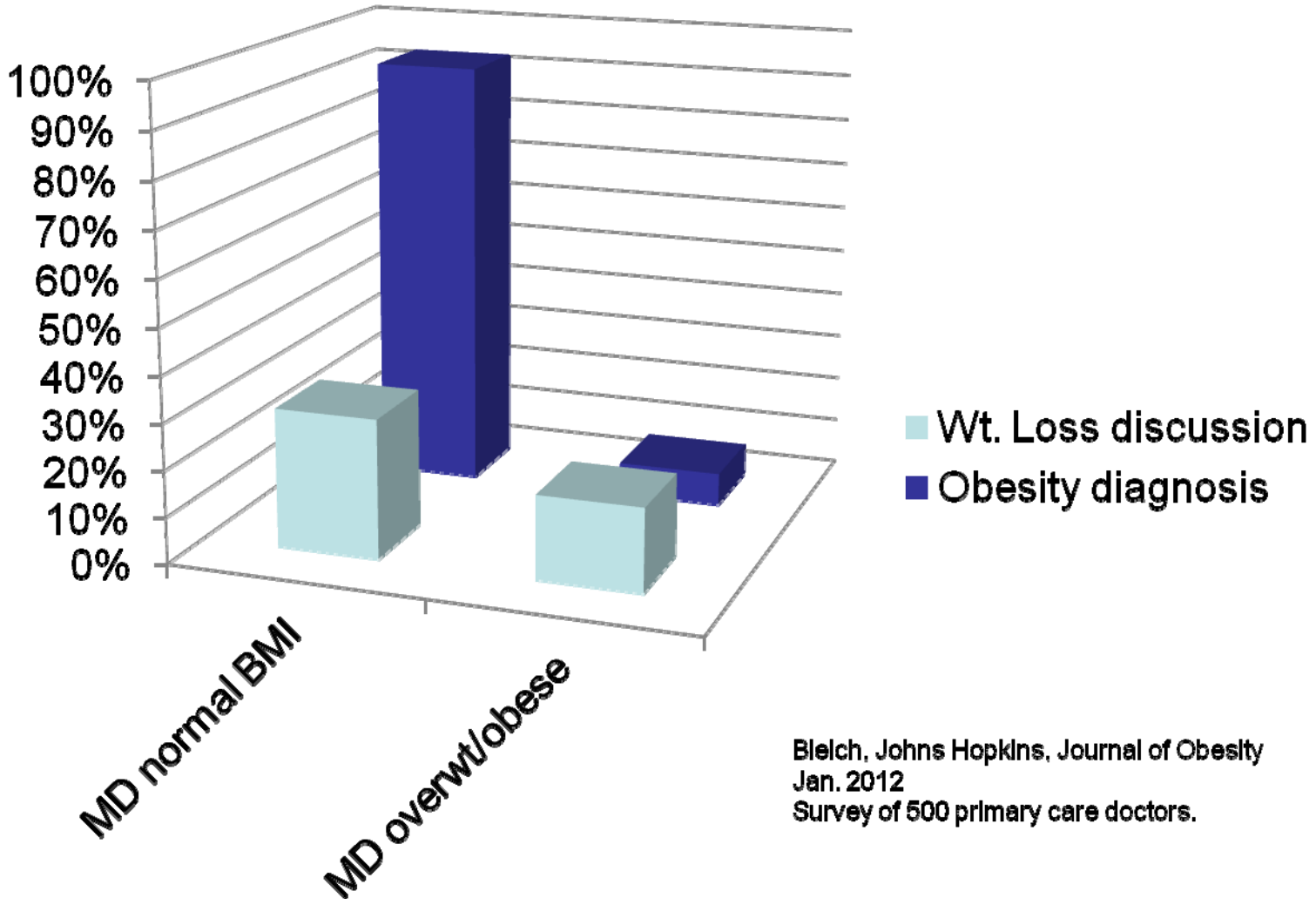
Source: N Engl J Med 2003; 349:1866-1868 November 6, 2003

Physicians: Obesity Diagnosis and Advise



Bleich, Johns Hopkins, Journal of Obesity
Jan. 2012
Survey of 500 primary care doctors.

By LISA ABEND

Beating Butter: Denmark Imposes the World's First Fat Tax

- The tax, the first of its kind in the world, imposes a 16 krone (roughly $3) hike per kilo of saturated fat on any food that contains more than 2.3%.
- "At the political level there was a high degree of consensus for this law," says Tor Christensen, chief consultant for Denmark's Ministry of Taxation.
- It's just going to push more people to buy cheaper industrially produced products, rather than good food. It's insanely stupid. Christian Puglisi, chef of Copenhagen's highly-regarded Relae

Effects of Risk Factors on Monthly Resource Use

(Seniors 65 and Older)

Variable	At Risk	Not at Risk	Sign Level
Smokers	$255	$258	NS
Excess Alcohol	$188	$291	NS
Obesity	$326	$264	.05
Physical Inactivity	$358	$238	.0001
Unhappiness	$424	$253	.0001

Terry, Am J Health Promot, May 1998

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“How Employee Well-Being Drives Profits”

HBR, Jan/Feb. 2012

StayWell's Best Practices Research

Rated customers on nine components of Best Practice

- Senior management buy-in: PM reports strong management support
- Comprehensive program design: Offer HA, targeted interventions & population-based awareness-building programs*
- Communications strategy: PM reports solid standard or best practice
- Integrated incentive strategy: Integrated into health plan design
- Multiple delivery modalities: Phone, mail and online
- Awareness-building: Offer campaigns, supportive policies, etc.
- Onsite element: Dedicated onsite staff
- Screenings: Offer worksite screenings
- Integrated program: Data transferred between vendors

Compared "Best Practice" versus "Standard Practice" groups

Source: Terry et al., Journal of Occupational & Environmental Medicine, June 2008

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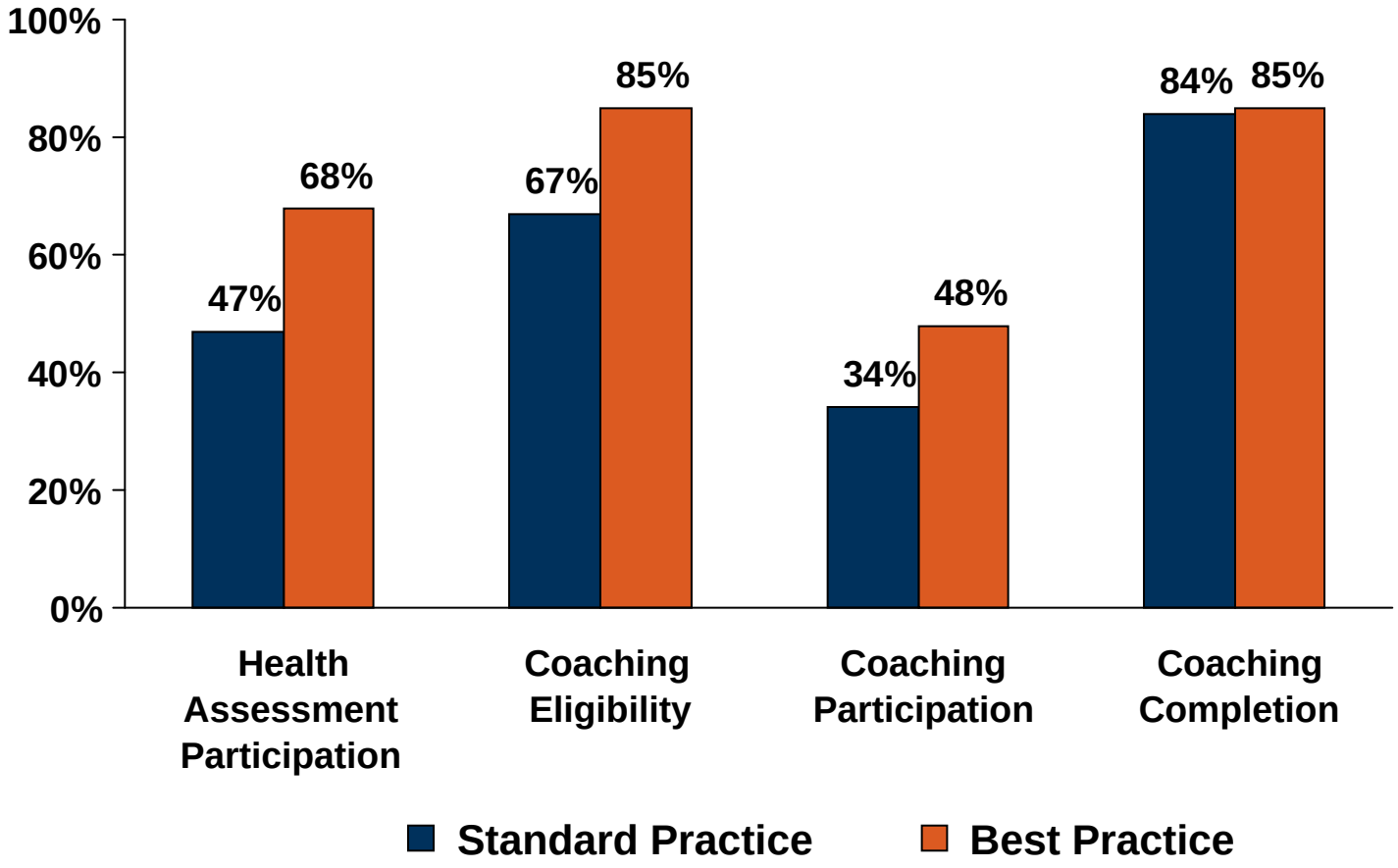
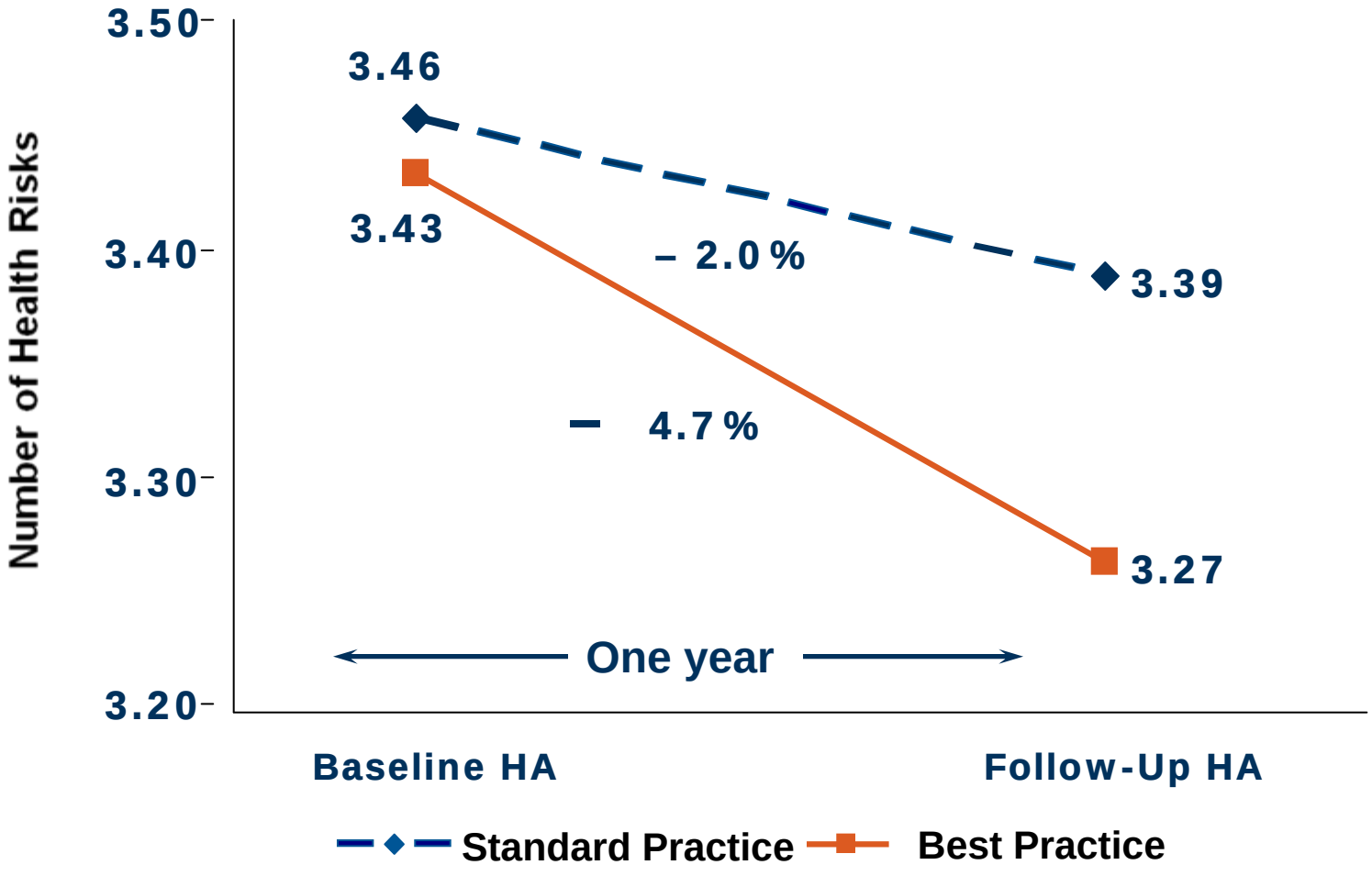
Best Practices Study – Engagement Rates



Source: Terry et al. *JOEM,* 2008.

Best Practices Study – Population-level Risk Change



Source: Terry et al. *JOEM*, 2008.

StayWell Research

Incentives and Screening

Culture Score Definition

- **Management Support**
  - Executive & mid-level management support
- **Infrastructural Support**
  - Demonstrated efforts around health policy, promotion of nutrition and/or physical activity, flexible schedule for wellness activities, company mission statement
- **Wellness Team**
  - Member of management actively participates in team
- **Integrated Program**
  - Data exchanged between vendors or warm-transfer of participants to additional services
- **Onsite Staff**
  - Dedicated onsite staff, including all vendors

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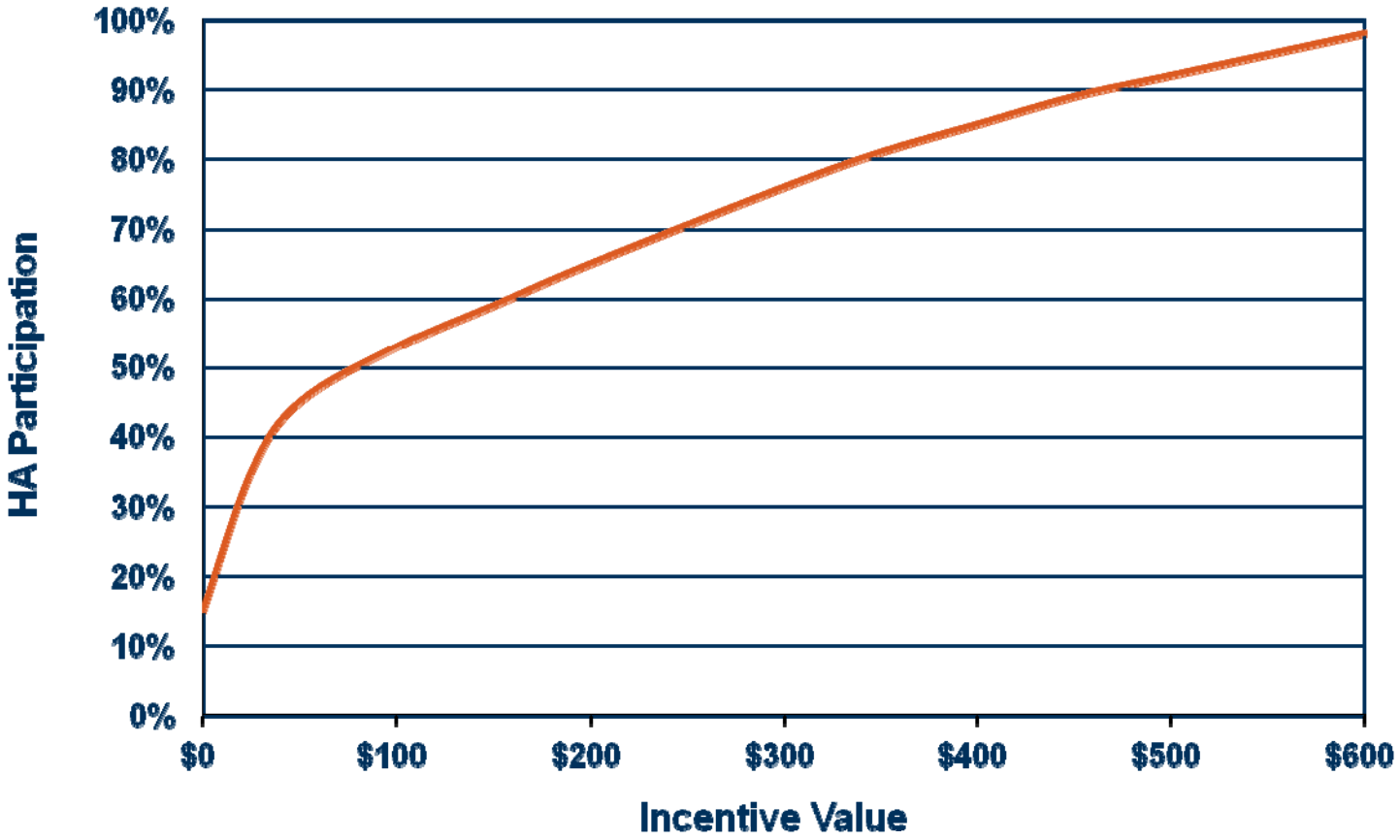
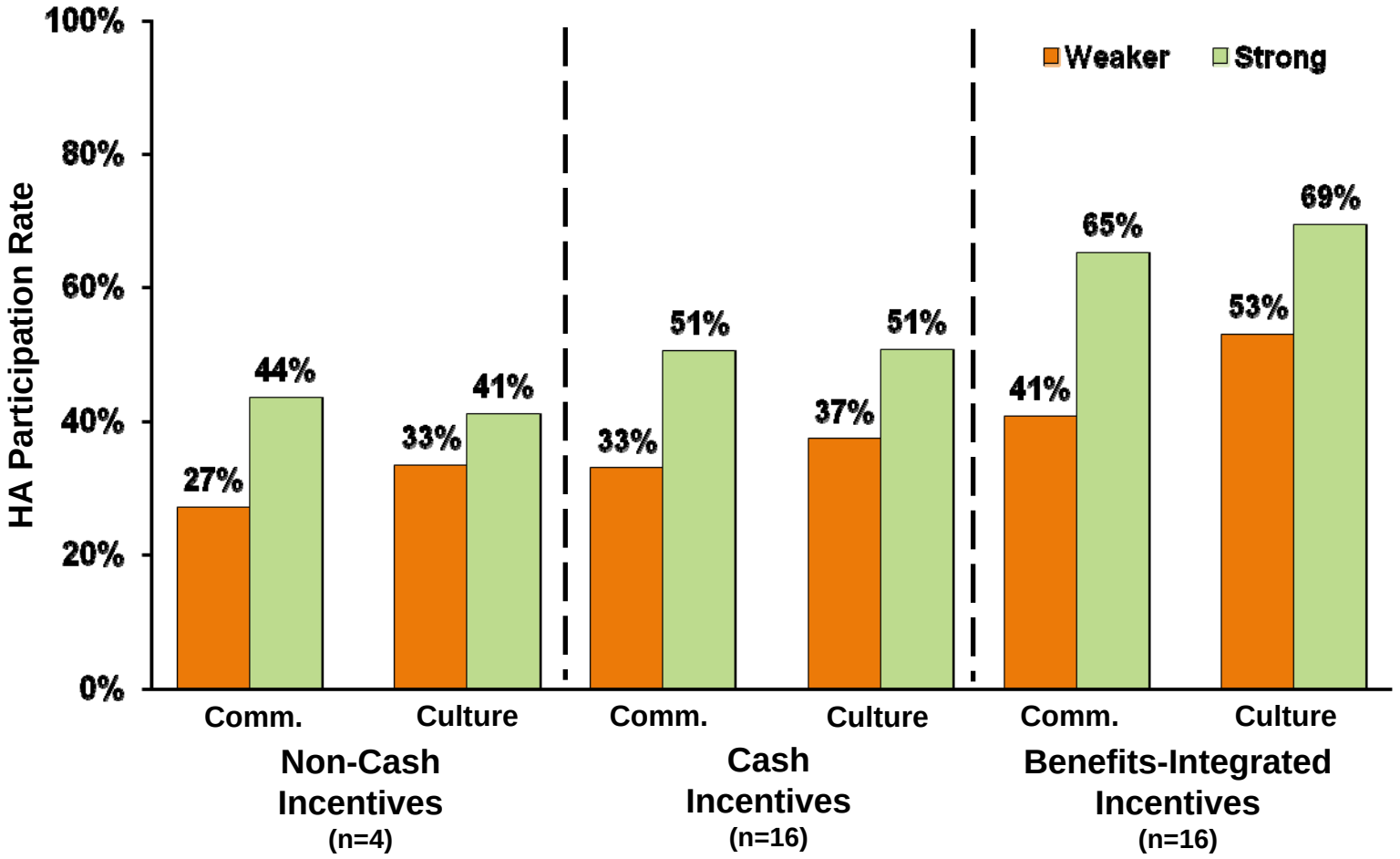
Incentives Drive Health Assessment Participation



N = 36 StayWell clients

Reference: 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.

HA Participation by Communication & Culture



Source: Seaverson ELD, Grossmeier J, Miller, TM, Anderson DR. The role of incentive design, communication strategy and worksite culture on health assessment participation. AJHP, June, 2009.

Incentives Health Coaching

StayWell Preliminary Research
Incentives & Engagement Rates

Role of incentive type on engagement in phone, mail, and online coaching programs

- **30 StayWell customers**
- **Incentives vs. No Incentives**
  - 16 companies offered incentives for NextSteps Programs
  - 10 also offered spouse incentives, 2 offered retiree incentives
- **Incentive Type**
  - 7 of 16 companies offered cash or a gift card incentives
  - 9 of 16 companies offered benefits-integrated incentives
  - Incentive type was consistent for employees, spouses, etc.

Source: StayWell unpublished study (preliminary results)

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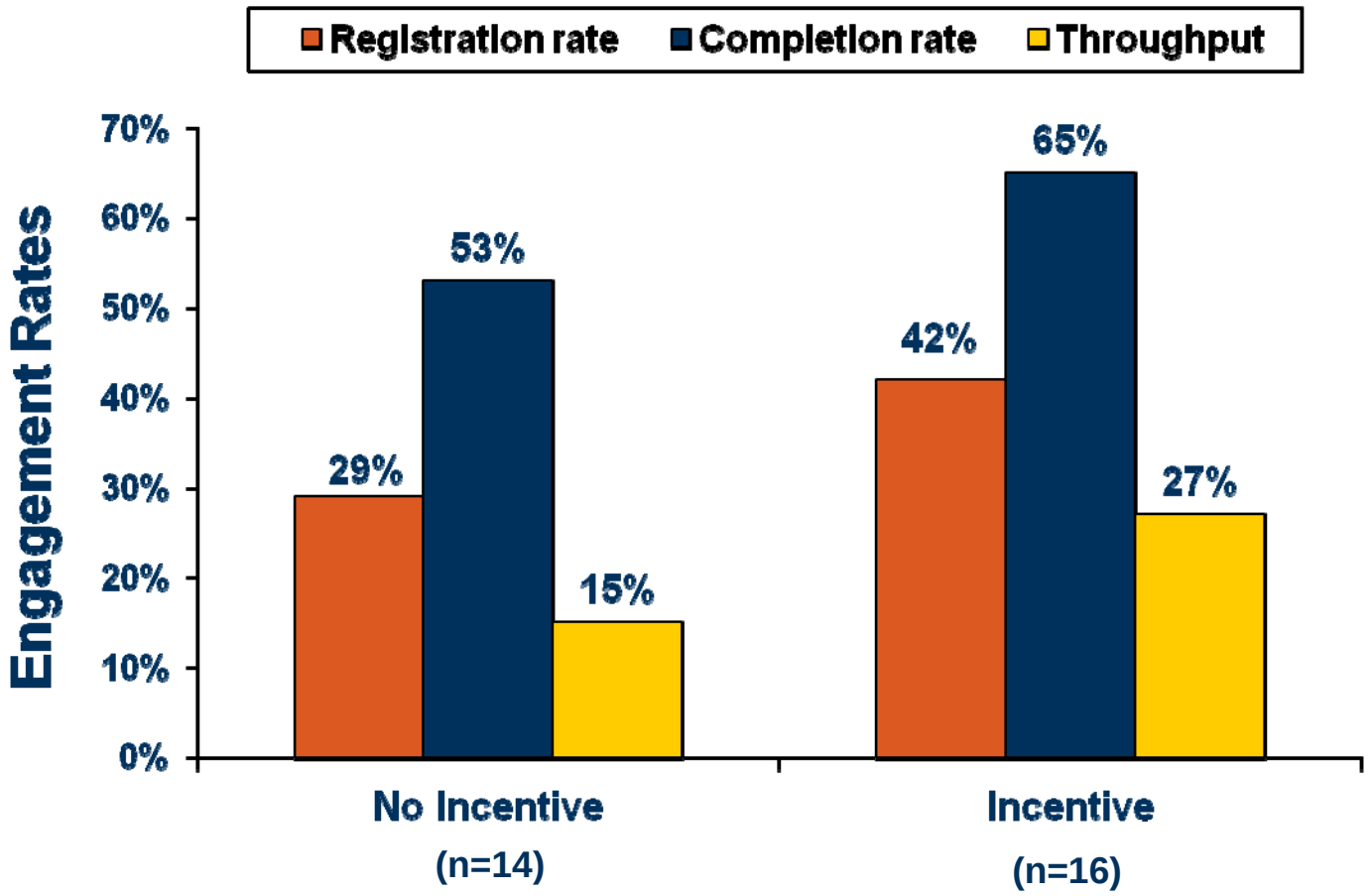
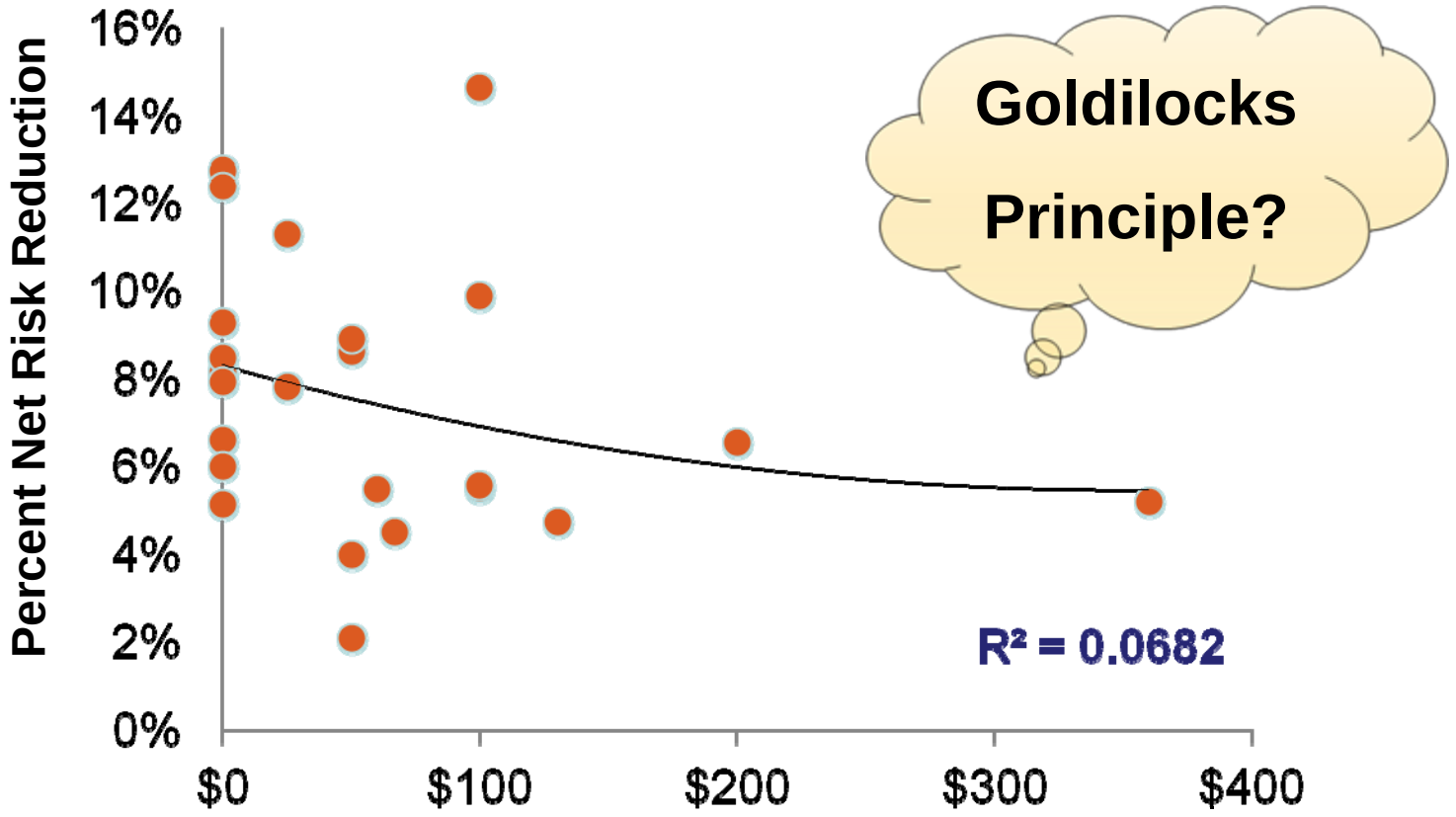
Incentives Increase Coaching Participation



Source: StayWell internal evaluation. Preliminary unpublished results.

Risk Change by Incentive Value



Source: StayWell unpublished study (preliminary results)

Progress Based Incentives

Terry, P.E., Anderson, D. R. (2011). Finding common ground in the use of financial incentives for employee health management: **A call for a progress-based approach.** *American Journal of Health Promotion*, Sept. 2011,

Vol. 26, No. 1, ev-evii.

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Value of Wellness Incentives – Large Employers

	Employee	Dependent
Average	$386	$271
Median	$250	$203
Minimum	$50	$50
Maximum	$1,200	$980

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

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Progression of Incentive Design

2004	+ Health Assessment
2005	2 Online Learning Modules
2006	1 Online Learning Module And any one of the following program options: Health Coaching Program, Health Campaign, Online Health Education
2007	Total of 100 Points: Health Assessment = 50 points and any combination of the following to earn 50 points: Health Coaching (25), Health Campaigns (25), Online Health Education (10), Online Healthy Living Program (25)
2008	Total of 100 Points: Health Assessment = 30 points and any combination of the following to earn 70 points: Medical Exam/Onsite Screening (25), Fitness Club Membership (25), Weight Mgmt Program (25), Health Campaigns (25), Online Health Education (10), Health Coaching Program (25); Online Healthy Living Program (25)
2009	Total of 100 Points: Health Assessment = 15 points and any combination of the following to earn 85 points (bonus of 150 points): Medical Exam (25), Onsite Screening (25), Flu Shot (15), Community Fitness Events (20), Nutrition Log (15), Physical Activity Log (15), Fitness Club Membership (25), Weight Mgmt Program (25), Health Campaigns (25), Online Health Education (10), Health Coaching Program (25); Online Healthy Living Program (25)

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Process Evaluation of Smoking Cessation Study, Kim and Volpp on Behavioral Economics

- Why are financial incentives not effective at influencing some smokers to quit?
- Assess awareness and attitudes about financial incentives in motivating smoking cessation
- Understand why, despite sizable incentives, 85.3% of study participants did not quit long term

Kim, JOEM, Vol 53, No. 1, Jan 2011, 62 - 67

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Results – Incentive Needed to Quit

Incentive group

- Non-quitters
  - 53.2% would not quit for double the incentive ($1500)
  - 65% would have quit if paid up to $3400
  - 35.5% required >$3400 to quit
- Quitters
  - 87.1% would have quit for less money – $20 average; range $ 0 - $500
  - 49% of quitters would have quit for no money

Control group

- Non-quitters
  - 36.3% would quit for financial incentive
  - Wide range of incentive estimate from $1 to $5M
  - 29.5% required >$3,400

Non-quitters – Incentive and control needing >$3,400

- Higher nicotine dependence scores
- 45.7% not thought about quitting
- 38.8% no quit attempt in last year

Kim, JOEM, Vol 53, No. 1, Jan 2011, 62 - 67

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HIPAA Rules for Wellness Incentives

- **HIPAA applies to wellness programs offered through a group health plan**
- **Incentives not tied to satisfying a "health factor" standard are very flexible**
  - Participation must be available to all "similarly situated" individuals
- **Incentives tied to "health factor" standards must meet five requirements**
  - Reward ***capped at 20%*** of health coverage cost
    - ***Increases to 30%*** in Patient Protection and Affordable Care Act (effective 1/1/14)
  - Must offer ***programs*** "reasonably designed to promote good health or prevent disease"
  - Must provide ***annual opportunity to qualify*** for reward
  - Reward must be available to all similarly situated individuals
    - Must allow ***"reasonable alternative standard"*** (or waiver) for individuals who can't meet health standard due to medical condition or for whom attempting to meet it is medically inadvisable
    - May seek verification (e.g. physician statement) of medical condition
  - Plan materials must ***disclose availability*** of reasonable alternative standard (or waiver)
- **PPACA mirrors HIPAA – but rules still to come**
- **Must also assure compliance with GINA, ADA, other laws**

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Potential Elements of Health Factor Standard

- **Body Mass Index (BMI)**
  - < 25 or < 27.5 or < 30?
  - Obese or strong? Waist size exceptions? Body composition?
- **Non-tobacco Use**
  - Pledge or testing?
- **Blood Pressure**
  - < 140/90? Testing effects? Normal fluctuation?
- **Cholesterol**
  - Total cholesterol: < 200 or < 240?
  - Cholesterol/HDL ratio (e.g., <3.5)?
- **Diabetes Risk**
  - Glucose: Fasting only (< 100) or non-fasting (< 140)? Worksite fasting?
  - HbA1c?
- **Other Metrics for Consideration?**

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Strategy for Progress-Based Incentives

- **Increase requirements as culture supports health**
  - Multi-year progression aligns personal responsibility with organizational support
- **Require annual screening *and* health assessment**
  - Screening satisfies required annual opportunity to meet health standard
  - HA provides key metrics and helps segment and engage population
  - Health awareness becomes the "key to open the incentive door"
- **Award incentive for meeting health factor standard**
  - "All-or-none" requirement may maximize impact of incentive
  - Overall model dictates if all-or-none or tiered outcomes-based incentive is better option
  - Consider starting with moderate standards and raising requirements over time
- **Award *progress-based* incentive as reasonable alternative standard**
- **Considerations if *participation* is progress-based alternative**
  - Link modest incentive to each of multiple participant-selected activities
  - Provide autonomy but make incentive value proportionate to effort required for activity
- **Considerations if *health goal* is progress-based alternative**
  - Award full incentive for individuals who achieve progress-based health goal
  - Participant works with health coach to set individual health goal tailored to circumstances
  - Require verification and minimize number seeking medical condition waiver

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Client Examples:

Cash and Benefits integrated designs

Incentive Design: Progressive Levels

Level 1 = $50 Cash

- Complete HA by specified date

Level 2 = $100 Cash

- Level 1 plus complete screening
- Onsite screening or recent physical results (90 days)

Level 3 = $500 Cash

- Level 2 plus meet all 5 health standards OR alternative goals set by physician
  - BMI ≤ 25 OR Waist ≤ 40” for men & ≤ 35” for women
  - Blood pressure: systolic ≤ 140 AND diastolic ≤ 90
  - Cholesterol/HDL ratio ≤ 4.0
  - Fasting glucose ≤ 100 OR non-fasting glucose ≤ 140
  - 6 months tobacco free – self-report

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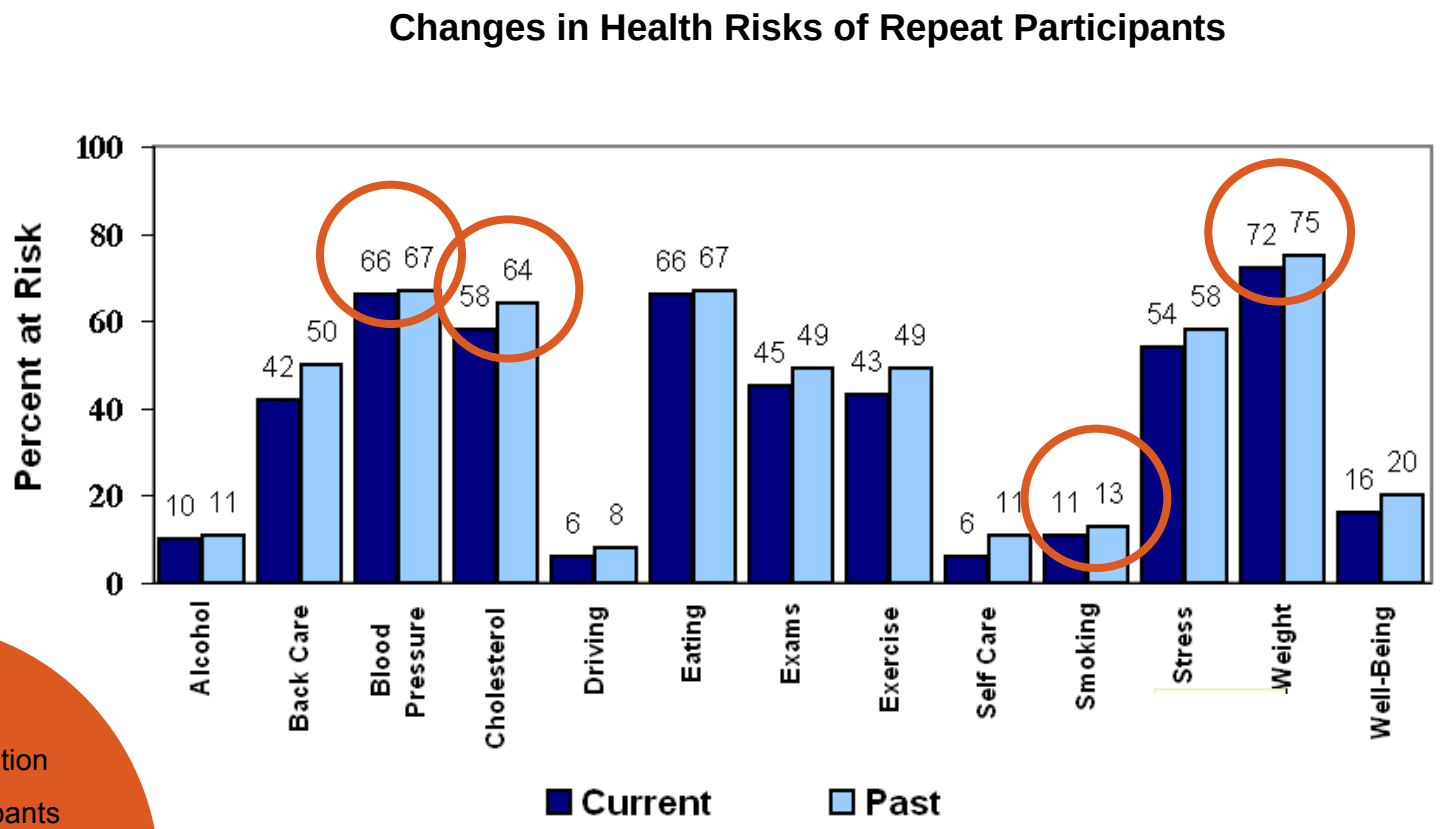
Three Levels of Cash Incentives: Year 1 vs. Year 2 Outcome Trends



66% HA participation

82% of HA participants were repeaters

8% decrease in average number of health risks from 3.4 to 3.1

Benefits Integrated Incentive Strategy

Requirements to Earn Wellness Credits

- Premium discount first half of year:
  - Complete screening either at worksite for doctor's office
- Premium discount second half of year:
  - Meet biometric health standard, or
  - Complete coaching program (3+ calls)

Benefits Integrated Incentive

- Single: $40 PEPM – $480 per year
- Employee+1: $60 PEPM – $720 per year
- Family: $80 PEPM – $960 per year

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Benefits Integrated Model: Program Results

		% In range based on Client Criteria			
	n	Criteria	2008	2010	% Change
BMI	2,580	≤ 30	71.2%	71.9%	1.0%
Systolic BP	2,580	≤ 140	89.9%	92.9%	3.3%
Diastolic BP	2,580	≤ 90	92.9%	95.8%	3.1%
Total cholesterol	2,580	≤ 200	60.0%	69.2%	15.3%
Tobacco*	2,174	Nonusers	82.3%	82.9%	0.7%

2008 and 2010 Participation

*Tobacco status- self -report