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Agency of Human Services

M E M O R A N D U M

TO: Representative Janet Ancel, Co-Chair, Health Reform Oversight Committee
Senator Tim Ashe, Co-Chair, Health Reform Oversight Committee
Senator Claire Ayer, Chair, Senate Committee on Health and Welfare
Representative William Lippert, Chair, House Committee on Health Care

CC: Hal Cohen, Secretary, Agency of Human Services

FROM: Steven M. Costantino, Commissioner, Department of Vermont Health Access

DATE: January 15, 2016

RE: Request for Extension – Blueprint for Health Wellness Incentives Report

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Pursuant to Act 54 of 2015, Sec. 26, the one-time report on wellness incentives from the Blueprint for Health is due to the General Assembly by January 15, 2016. The 2016 annual report for the Blueprint for Health is due to the House Committee on Health Care, the Senate Committee on Health and Welfare, and the Health Reform Oversight Committee on January 31, 2016. In an effort to ensure that this report provides a comprehensive overview of wellness incentives properly placed in the broader context of the Blueprint for Health Program, the Department of Vermont Health Access is requesting an extension to allow this report to be submitted with the annual report for the Blueprint for Health on January 31, 2016.

Thank you for your consideration.

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2015 Blueprint Wellness Incentive Report

VERMONT Blueprint for Health

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2.1 Purpose and Scope of Report

Vermont Act 54 Section 26.b tasks the Blueprint with exploring potential wellness incentives. These incentives encourage people to improve health-related behaviors and their health outcomes through either benefits or penalties. Studies on such incentive programs have shown mixed results, with some demonstrating improvement in health and reduction in medical costs, with others showing no change. While this report does not answer the question of whether such approaches would be a beneficial component of health reform in the State of Vermont, it does review the different approaches to wellness incentives, the results of numerous evaluations, and the legal and regulatory considerations. This report also identifies potential opportunities for testing expanded wellness incentives in Vermont.

2.2 Defining Wellness Incentives

Wellness incentives encompass a broad scope of programs aimed at improving an individual's health and thus reducing that person's health care costs. Incentives come in three broad forms:[1]

- **Penalties**: This approach aims to discourage harmful habits, such as smoking, or non-participation in wellness programs. Penalties may include higher health insurance premiums or higher percentage of cost sharing (deductibles, co-payments, or co-insurance).
- **Rewards**: This approach gives compensation for practicing healthy behaviors, such as exercising, or for participation in wellness programs. Rewards may include cash incentives, gift cards, prize drawings, or reduced premiums or cost-sharing.
- **Benefits**: These include discounted or free services and recreational activities, such as gym memberships or ski passes.

2.3 Goals/Types of Wellness Incentives

The wellness incentive strategy an organization employs will depend on the organization's wellness goals. These strategies typically fall into one of the following three categories:

- *Participation-based* incentives offer rewards to individuals for participating in a wellness program or activity. Examples include completing a health risk assessment, participating in sponsored fitness activities, or engaging in a session with a health coach or nurse.
- *Outcomes-based* incentives reward participants for achieving specific health outcomes, usually measured through biometric results. For example, individuals may be rewarded for lowering their cholesterol or blood pressure or for losing weight.
- *Progress-based* incentives reward individuals for progress towards customized personal health goals, essentially recognizing smaller achievements than outcomes-based incentives.[2]

2.4 Who Traditionally Offers Wellness Incentives?

While employers most frequently offer wellness incentive programs, health insurance companies (payers) and government entities frequently provide programs that also meet the criteria for wellness

incentives. Currently, Vermont has a number of wellness incentive programs available through employers, payers, and government programs. The following list provides examples of wellness programs offered in Vermont and is not meant as a complete list.

2.4.1 Sample of Employer Incentives in Vermont

The State of Vermont offers a wellness incentives program for permanent State employees who elect health insurance coverage under Blue Cross & Blue Shield of Vermont (BCBSVT). In 2016, up to $175 in cash incentives are awarded to employees who receive an annual medical exam, complete a health assessment, attend a certain number of health-related educational workshops, and participate in wellness challenges. Employees not eligible for this program can alternately earn points toward wellness drawings through participation in alternatives.

The University of Vermont Medical Center (UVMMC) provides employees with financial incentives for completing a biometric screening and a health assessment, seeing a primary care physician, and participating in sponsored wellness programs. For weight management, employees have access to Weight Watchers at Work and a wellness health coach.

Dealer.com at its facility on Pine Street in Burlington hosts an on-site café serving meals prepared with organic ingredients, a full gym, a CrossFit/yoga studio, tennis courts, miniature golf, and a sun deck. Employees receive discounts on ski passes and for golf courses.

Lake Champlain Chocolates rewards employees with paid days off for health and wellness in addition to discounted ski passes.

GE Healthcare asks employees during annual open enrollment to attest to being tobacco-free before enrolling in health insurance benefits. Employees who are not tobacco-free pay higher premiums for coverage.

MyWebGrocer encourages employees to participate in wellness activities with their co-workers, such as:

- Fitness classes offered on-site;
- Ski and snowboard groups;
- Weekly sunrise hikes up local mountains;
- Walking the Winooski River Walk on breaks; and
- Road races.

King Arthur Flour, a 100% employee-owned company, has included a section on wellness incentives in its 2014 Benefit Corporation Report and has adopted a culture "of wellness and healthy lifestyles throughout the organization". [3] Components of the wellness program that launched in 2014 included:

Exercise	Healthy Eating	Education and Prevention
More onsite fitness classes	Healthy Cooking & Nutrition Classes	Monthly TED Talk showings on wellness topics
Mind, Body, Spirit Wellness Classes	Onsite Vegetable Garden	Healthy Living Newsletter
Company organized exercise initiatives	60 Subsidized CSA Shares to Employees	Onsite Flu Shot Clinic
Treadmill walking stations	Free fresh fruit, yogurt, and granola for all onsite employees	Smoke Free Campus
Health Club membership reimbursements	Wellness Wagon with healthy treats and wellness tips	
"Flour Power" Teams participating in local rides/runs for charity	Onsite Weight Watchers program	
Ping Pong table with impromptu coworker challenges		
"Active Wellness Commute" reimbursements		
More stand up desks		

Setting goals and tracking metrics for the employee wellness program, *King Arthur Flour* incorporated progress reports into monthly employee meetings. Metrics tracked included dollars spent on employee wellness ($72,000 vs a $60,000 goal), wellness class spots filled (68% for an 85% goal), fitness class spots filled (36% for a 35% goal), and available financial wellness incentives per employee ($650).

King Arthur Flour's program represents one of the most comprehensive approaches in the State.

2.4.2 Sample of Payer Incentives

Blue Cross & Blue Shield of Vermont (BCBSVT) sponsors "Blue Health Solutions", a collection of health and wellness programs available to enrolled members.[4] These programs include:

Program Name	Members Eligible	Description of Benefits

Better Beginnings®	Pregnant mothers (free, registration includes a health risk assessment	• $125 in reimbursement for educational classes (childbirth, parenting, breastfeeding, CPR)
		• Choice of a book on parenting topics
		• DVD on infant care
		• 3 post-delivery visits from a visiting nurse or lactation consultant
		• Nurse case manager
		• For enrollment prior to 34 weeks, one of the following enhanced benefits:
		  ○ $150 in reimbursement for fitness classes
		  ○ $150 reimbursement for a car seat
		  ○ $225 in reimbursement for up to 9 hours of house cleaning services
		  ○ Voucher for purchase of a personal breast pump

24-Hour Nurse Line	All	Toll-free number available 24/7 to ask questions of an "experienced, licensed nurse"
Specialty Care Management	Members with chronic illness, catastrophic health events, high-risk pregnancies (free and voluntary participation)	Toll-free number available for inquiries about eligibility. Individualized support offered through: • Coordination of Services • Education • Strategy • Problem Solving
Chronic Condition Management	Members with certain diagnoses, including asthma, diabetes, COPD, CHF, and CAD	Outreach performed proactively by a nurse, though participation in the program is voluntary and kept confidential. Educational materials are provided, as well as access to nursing staff for guidance on lifestyle changes to improve overall health.
Worksite Health & Wellness	Employers	Consulting services available to employers, including initial assessment and planning, for the design and implementation of a workplace wellness program. It also includes a pre-packaged "toolkit", including posters, emails, articles, and quizzes, that can be used to promote wellness to employees.
Blue Extras	All	Discounts provided at participating Vermont and New Hampshire business that promote healthy lifestyles, such as yoga studios, golf courses, ski resorts, bowling alleys, day spas, martial arts academies, and acupuncturists.

Additionally, BCBSVT offers its members Health & Wellness Research databases from its Web site and Seasonal Health Tips for members to learn more about condition management and health maintenance. It also offers support and resources to businesses to assist them in improving worksite health and wellness.[5]

Cigna offers an outcomes-based incentive program that rewards members and covered spouses for improvements in biometric screening results, including blood pressure, total cholesterol, and height/weight or body mass index (BMI).[6]

After determining that 50% of medical expenses resulted from unhealthy weight, high blood pressure, high cholesterol, and diabetes, Cigna studied 200,000 individuals between 2012 and 2014 to assess the "impact of incentives on health engagement, health outcomes, and medical cost". [7] Cigna set the following biometric goals for members and offered financial incentives for achieving these goals:

- Body mass index less than 30.
- Cholesterol less than 240.
- Blood pressure less than 140/90.
- Fasting blood sugar less than 100.

Findings for the study period indicated that the outcomes-based financial incentives more than doubled biometric screening rates among members, increased engagement with health coaching programs by 24%, and reduced total healthcare costs by 10% for those 50 and older or those with chronic conditions.

Remaining tobacco-free, filling out an online health assessment, attending an appointment with a physician, and having a health care professional submit biometric screening results allow Cigna members to meet the prerequisites for collecting up to $1,026 in financial incentives annually. Covered spouses can earn an additional $500 in rewards if they also complete a personal plan.[8]

MVP Health Care's Wellness & Rewards (MVP) programs are tailored for each health plan and include a "personalized scorecard of your current health status" to support patient engagement in self-monitoring and tracking progress online.[9] MVP's Wellness Rewards program includes the following cash incentives:

- Up to $300 for completing a personal health assessment, participating in a lifestyle coaching session by phone, completing self-guided, online education courses, and meeting recommended health guidelines.
- $200 per calendar year for completing health-related activities.
- $125 reimbursement per calendar year for kids' sports, weight management, and gym membership.

MVP members also enjoy discounts at ChooseHealthy.com, including vitamins, herbal and natural products, and wireless health products.

2.4.3 Sample of Government-Sponsored Wellness Incentives

The *Vermont Department of Health (VDH*) offers the "802 Quits" program for tobacco cessation. This program offers tools for quitting tobacco use such as free nicotine replacement therapy (gum, patches, and lozenges) and free support (via phone, in-person, and online) to those who want to quit smoking. It also provides valuable information on the effects of second-hand smoke and smoking while pregnant, and on strategies for quitting.

VDH also administers the Women, Infants, and Children (WIC) program, which assists new mothers, pregnant women, and young children up to age 5 with eating well, learning about nutrition, and staying healthy. Benefits include a purchasing card for eligible, healthy foods at participating grocery stores,

nutrition and health education services, breastfeeding support, and referrals to health care services and community programs.

As part of Healthy Vermonters 2020, *VDH* provides consulting services for employers looking to implement worksite wellness programs, similar to the services offered by BCBSVT through their Worksite Health & Wellness program.

VDH's Venture Vermont program awards points for visiting Vermont's forests, parks, and other outdoor recreational facilities, including participation in activities like canoeing or kayaking, playing Frisbee, or attending nature programs. Earning 250 points results in being awarded a Gold VIP Pass to all Vermont State Parks, providing free day entry for the remainder of the year in which it was earned and the following year.

The *Blueprint for Health* sponsors free statewide self-management support programs to individuals for health promotion, weight loss, chronic condition management, tobacco cessation, and emotional well-being.

Led by Regional Coordinators, each of the 14 Health Service Areas (HSAs) recruit local workshop leaders. Leaders attend free training to become certified to lead specific types of workshops. Based on the needs and interests of the population in their communities, Regional Coordinators determine the mix and frequency of workshops offered within each HSA.

Healthier Living Workshops (HLW) for chronic disease, diabetes, and chronic pain, which use evidence-based curriculum developed at Stanford University, provide individuals with support and group sessions to promote better management of these chronic illnesses and a healthier lifestyle.

In collaboration with VDH, the *Blueprint* offers group tobacco cessation workshops in each HSA, which provide in-person peer support for those who want to quit smoking.

Partnering with the YMCA, the *Blueprint* hosts local Diabetes Prevention Program (DPP) workshops. While there is no cure for diabetes, those diagnosed with pre-diabetes can prevent onset of the disease through lifestyle changes, including weight loss, healthier eating, and increased physical activity. Individuals must meet the following criteria to quality for referral to DPP workshops:

- Over 18 years of age.
- Not pregnant.
- Not diagnosed with diabetes.
- Have a body mass index (BMI) greater than 25.
- Have one of the following:
    - HbA1c between 5.7 – 6.4%.
    - Fasting plasma glucose between 100 and 125 mg/dl.
    - Health care provider diagnosis of prediabetes.
    - 2-hour plasma glucose between 140 and 199 mg/dl.
    - Meet at least two (2) of the following risk criteria:
        - Blood pressure 140/90 or higher.
        - Elevated cholesterol levels.
        - Participates in physical activity less than two (2) times per week.
        - Has or had a parent or sibling with diabetes.

Over the course of 12 months, participants attend 16 one-hour weekly workshops focused on healthy eating, increasing physical activity, reducing stress, and problem solving, followed by monthly sessions with a trained lifestyle coach. Programs goals for each participant are simple: losing 7% of body weight and gradually increasing physical activity to 150 minutes per week.

Regional Wellness Recovery Action Plan (WRAP) workshops are also offered through the *Blueprint*. These group sessions help individuals struggling with mental health issues to make and follow a plan for achieving emotional well-being and achieving their life goals.

One *Blueprint* HSA had a self-management program completely lapse (with 0 workshops hosted and 0 program completers) for the 2014 grant fiscal year due to a vacancy in the Regional Coordinator position. In fiscal year 2015, the new Regional Coordinator revitalized the program by providing free meals, gas cards, and running shoes, which were donated by local vendors, to encourage individuals to participate in and complete self-management workshops. As a result of her recruitment efforts and creative incentives, five workshops were hosted in the area with a total of 34 individuals completing the programs.

3 Effectiveness of Wellness Incentive Programs

3.1 Impact of Wellness Incentives on Behavior and Health Outcomes

A number of studies have evaluated the impact of incentives on a person's behavior and health. These studies cover effects of incentives offered through a variety of strategies on behavior, health outcomes, and cost. Below are examples of some of the research in the area of wellness incentives.

3.1.1 Studies on Behavioral and Health Outcome from Wellness Incentive Programs

Higgins et al. studied the impact of financial incentives, in the form of vouchers for retail items, on cessation rates among pregnant women who smoke cigarettes.[10] One group of women only received the vouchers upon confirmation by a biochemical test that they were tobacco-free. The other group of women received the same vouchers without the contingency. The results showed that women whose incentives were based on remaining tobacco-free had a much higher abstinence rate at the end of pregnancy (37% v. 9%; p-value = 0.025) and at 12-weeks postpartum (33% v. 0%; p-value = 0.003), when the vouchers ended. The higher rates of abstinence remained among the contingent group even after another 12-weeks without the financial incentives (27% v 0%; p-value = 0.007).

In a follow up study, Higgins et al. assessed whether differences in how contingent vouchers were distributed had different effects on smoking abstinence and fetal development.[11] The study found that the two methods of distributing contingent vouchers (contingent vouchers (CV) and revised contingent vouchers (RCV)) both had positive impacts on cessation rates at early and late stages of pregnancy relative to those receiving non-contingent vouchers (NCV), but had no significant difference between the two. In early pregnancy the cessation rates were 46% for the CV group, 40% for the RCV group, and 13% for the NCV group (p-value = 0.07). In late pregnancy, the cessation rates were 36% for the CV group, 45% for the RCV group, and 18% for the NCV group (p-value 0.04).

In a randomized control trial, Volpp et al. assessed whether financial incentives in work settings improved tobacco smoking cessation rates.[12] Both the incentive and control groups received information on community-based, smoking cessation resources within 20 miles of their worksite. While the control group received only this information, the incentive group received $100 for completing a smoking cessation program, $250 for quitting smoking within six months of enrolling in a program, and another $400 if they had continued to abstain for another six months. The incentive group had higher levels of enrollment in cessation programs (15.4% v 5.4%; p-value < 0.01) and higher levels of program completion (10.8% v. 2.5%; p-value < 0.01). Cessation rates were also higher for the incentive group at the six-month follow-up (14.7% v. 5.0%; p-value < 0.01) and at the twelve-month follow-up (9.4% v. 3.6%; p-value < 0.01).

Focusing on the impact of incentives on weight loss, Volpp et al. grouped participants into two intervention groups and a control group in a randomized trial. All participants participated in a 16-week weight monitoring program with monthly weigh-ins and a 16 pound weight loss goal. The two intervention groups received different incentive schemes: 1) a lottery system where participants were eligible for a daily lottery prize if they had met their weight goal; and 2) a deposit contract in which participants could deposit a daily matched amount and receive the full balance back at the end of the month if they met or exceeded their weight goal. The lottery group achieved a mean weight loss of 13.1 pounds, the contract group lost a mean of 14.0 pounds and the control group lost a mean of 3.9 pounds.

The differences between each of the intervention groups and the control group were statistically significant (p-values = 0.02 and 0.006 respectively). Approximately, half of each of the intervention groups achieved the 16 pound weight-loss goal, whereas only 10.5% of the control group met this goal. However, weight-loss differences after seven months beyond the initial 16 week study were not significant.

Merrill et al. reviewed the effectiveness of the company Syngenta's wellness program, which offered monetary incentives to employees who participated.[13] Participants could earn points for a number of health related activities such as a health risk appraisal, biometric screening, documentation of regular cardiovascular exercise, consistent use of a seatbelt, smoking cessation, etc. Participants could then exchange these points for up to $250. Looking at the mean change in biometric characteristics over the study period, Merrill et al. saw significant improvements in blood pressure, cholesterol, triglycerides, and blood glucose. They also looked at changes in behavior and emotional and physical well-being. Of all these variables, employees reported significant improvements in feeling calm and peaceful, feeling happy, feeling more energetic, fruit and vegetable consumption, and the number of alcoholic drinks per week.

The company Johnson & Johnson has one of the more mature wellness programs – the first iteration of its program was introduced in 1979. The current iteration, the Johnson & Johnson *Health & Wellness Program* was introduced in 1995. This program offers a number of intervention services for before, during, and after major health-related events. These services range from education to care coordination to counseling. The company also offers the program *Pathways to Change* to employees identified as high-risk based on health risk assessments. To encourage participation, employees are offered a $500 medical benefit plan credit upon completing the health risk assessment. If an employee was referred to the *Pathways to Change* program based on the assessment and refused participation, they could lose their benefit credit. Goetzel et al. in their 2002 paper reviewed these programs to assess their impact on employee health risks.[14] They found that in the *Health & Wellness Program* employees who participated in two health risk assessment at least a year apart saw a reduction in risks in eight of thirteen risk categories. High-risk employees, who opted to participate in the *Pathways to Change*, saw better outcomes in six categories than high risk employees who did not participate. However, they saw worse outcomes in five categories and no difference in two.

Not all studies showed promising outcomes. In a recent study on premium-based financial incentives and their impact on workplace weight loss, Patel et al. did not find significant changes in weight.[15] Participants included individuals with BMIs 30 or over and were assigned to either a control group or one of three groups receiving financial incentives. They were given the goal of reducing their weight by five percent and had two required weigh-ins at six and twelve months. The first incentive group was offered a delayed premium adjustment meaning that if they met their five percent goal, they would receive $550 in premium discounts over 26 bi-weekly installments in the following year. The second group was offered immediate premium adjustments – once they met their target, they would immediately receive the $550 beginning immediately. The third group received a daily lottery incentive. If they met their daily weight goal and won the daily lottery, they could collect the reward, up to $550 over the course of the study period. At the twelve-month weigh-in, there were no significant differences in the mean weight loss across all four groups.

3.2 Potential of Return on Investment for Wellness Incentives

While the above studies looked at health and behavior outcomes of wellness incentive programs, other studies have looked at the potential savings associated with such programs. The below are examples of such studies.

3.2.1 Return on Investment Outcomes from Wellness Incentive Programs

Four early studies looked at cost savings resulting from wellness incentive programs for Johnson & Johnson employees (1986)[16], Bank of America retirees (1992)[17], the California Public Employees Retirement System (PERS; 1994)[18], and Citibank employees (1999)[19]. All four found greater reductions in expenditures for persons participating in incentive programs. The authors in the Johnson & Johnson study[16] found that participants in the wellness program had a mean increase of $43 dollars for inpatient costs compared to $76 increase for the non-participants. No difference was found in outpatient and other health care costs. The Bank of America study[17] found that total direct and indirect costs as ascertained by claims reduced by 11% for the experimental group and increased by 6.5% for the control group. In the PERS study[18], claims data showed a decrease in cost growth relative to controls. Annual costs were $3.2 to $8.0 million dollars less than would be expected if the costs for the experimental group grew at the same rate as the control group's costs. Finally, in the Citibank study[19], the return on investment based on cost for the health, demand, and disease management program and the estimated savings in medical expenditures ranged from $4.56 to $4.73.

Baiker et al. in 2010, conducted a meta-analysis of the literature on the costs and savings associated with wellness incentive programs.[20] Reviewing 32 publications, the authors analyzed cost outcomes (22 studies) and employee absenteeism (22 studies; eight studied both) across all studies. They found that the average annual savings in health care costs per employee was $358 and the annual savings due to reduced absenteeism per employee was $294. When compared to the average cost invested, the programs saved companies $3.27 in health care costs and $2.73 in absenteeism for every dollar spent.

In the seventh of a series of reviews, Pelletier reviewed 16 peer-reviewed studies published between 2004 and 2008 on the clinical and cost-effectiveness of comprehensive health promotion and disease management worksite programs.[21] Each of these studies, in addition to the majority of the 153 studies included in the previous six reviews, indicate that wellness programs have a positive impact on both clinical and cost outcomes. Only seven of the 16 specifically reported positive return on investments.

Reporting in the third installment of another series of meta-evaluations, Chapman reviewed an additional ten studies along with the 56 peer-reviewed studies previously analyzed.[22] In spite of wide variation in the methodology of the studies reviewed, the results showed reductions across all studies for average sick leave absenteeism, health costs, and workers compensation and disability claims. Those studies that looked at return on investment found positive results.

Berry et al. analyzed results of wellness programs in 10 large employers spanning multiple industries with similarly-run wellness incentive programs.[23] The results indicated that these companies saw returns on investment as high as $6 for every $1 spent on wellness incentives. Beyond looking at cost-savings, the study also evaluated the essential elements to a successful program. In addition to being viewed as a "strategic imperative" for the company, wellness programs also included the following.

1. *Multilevel leadership:* Four levels of leadership are cited as making a difference. Executives visibly had to make time for exercise to decrease employees concerns about taking time to work

out while working. Managers had to unify their team around a shared personal health goal. A dedicated employee was needed as the wellness program manager to promote, advise, coordinate, and measure the organization's wellness program. Finally, employee volunteers acted as wellness champions to encourage, educate, and mentor their peers on wellness activities and health events.

2. *Alignment of incentive goals with corporate goals:* The program "should be a natural extension of a firm's identity and aspirations". It should also foster trust and good will between employees and employer.
3. *Broad Scope:* The program must be inclusive of physical, mental and emotional well-being since all of these factors can affect productivity. Individualization of programs to employees' health needs also boosts success rates.
4. *Accessibility:* Availability and convenience of recreational and exercise facilities, clinics, counseling services, healthy food offerings, and other wellness incentives all contribute to successful wellness programs.
5. *Partnerships:* coordinating internal expertise about the program and costs with external vendors to take advantage of community infrastructure already in place lends credibility and quality to the programs.
6. *Communications:* A well-crafted, pervasive communications plan that tailors messages to intended audiences is key for ongoing employee engagement in company-sponsored wellness incentive programs.
7. *Measurement and Evaluation:* Given that measurement and reporting are the only concrete ways to determine the effectiveness and ROI of wellness incentive programs, the authors recommended programs track utilization of activities, percent of employees participating, percent of participants categorized as heavy or light users, number of employees that continue to engage in risky behavior, the percent of employees categorized as having high, moderate, or low health risks as determined by a health risk assessment, and health care costs. The authors also recommend evaluating employee safety, productivity, view of company's culture, and workplace satisfaction.

Critics of wellness incentives offered to individuals for practicing healthy behaviors question the effectiveness against implied goals. With health care costs skyrocketing, those offering wellness incentives assume rewards or penalties will entice individuals to practice healthier behaviors, thus lowering their health care costs. However, Horwitz et al. reviewed a number of studies on workplace wellness incentives through the lens for potential discrimination.[24] Their findings question the effectiveness and the return on investment of wellness programs, especially health-contingent ones that target individuals for smoking, hypertension, high cholesterol, and obesity. Overall, financial incentives did not appear to be the primary motivator in changing behavior, as demonstrated in a study where individuals with hypertension saw success from counseling alone as from wellness incentives for long-term control of blood pressure.[25] In conclusion, the authors express concern that wellness incentives shift greater health costs to those with higher health risks even as this population tends to be of lower socioeconomic status.

3.2.2 Limitations of Wellness Incentive Studies

While many studies show promise, they are not without their limitations. Many look at a wellness program offered at a single corporation, which can limit the sample to specific geographical regions, age

groups, ethnicity, and education levels.[12] Furthermore, many studies look at programs implemented by large corporations who have the resources and economy of scale that allow for higher positive return on investment.[20] These limitations reduce the generalizability of the findings.

Finally, studies that do not show significant differences or gains in such program are often not published. This potential trend could introduce a publication bias in any assessment of whether wellness incentives are effective.[20,21]

3.2.3 Rewards ("Carrots") or Penalties ("Sticks")?

In a joint consensus statement entitled "Guidance for a Reasonably Designed, Employer-Sponsored Wellness Program Using Outcomes-Based Incentives", 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 highlight the pros and cons of using rewards ("carrots") versus penalties ("sticks"). The paper argues that while behavioral economic research indicates people avoid penalties or loss more than they seek equivalent gains, wellness incentives seen as too punitive risk employee good will. Rewards on the other hand are seen as supporting a long-term culture based on partnerships.

In a study conducted by Rand study entitled "Workplace Wellness Programs: Services Offered, Participation, and Incentives" sponsored by the United State Department of Labor, wellness incentives in the form of penalties, or "sticks", proved most effective in motivating employee participation in employer-sponsored wellness programs during the study year, 2012.[26]

4 LEGAL AND REGULATORY CONSIDERATIONS

The questions brought up in the last section and by Horwitz et al. hint at the legal and regulatory concerns that surround wellness incentive programs. Do these programs unfairly target or sufficiently accommodate people with disabilities? Do they discriminate against certain groups of people? When does an incentive shift from voluntary to de facto obligatory? The following explores these questions more completely.

4.1 LEGAL CONCERNS

The potential for discrimination against individuals based on health status is the biggest legal concern related to offering wellness incentives to individuals. Different program structures can have different potential for discrimination. Federal regulations distinguish between *participatory wellness programs* and *health-contingent wellness programs*.[1,27]

Participatory wellness programs have the least risk for violating an individual's federal health protections. These programs offer discounts for health-related activities, such as ski passes or fitness club memberships, or rewards for participation in a wellness activity without requiring further action from the individual to improve his or her health status.

Health-contingent wellness programs require individuals to take direct action to improve their health status in order to earn an incentive. Activities for eligibility may include smoking cessation, achieving specific targets for biometric results (like lowering BMI below 30), or proof of participation in an exercise program. These programs, which are often aligned with insurance premium benefits, must comply with requirements of the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act (ACA), and the Americans with Disabilities Act (ADA).

4.2 FEDERAL REGULATIONS (HIPAA, ACA, AND ADA)

Under the rules for non-discriminatory wellness programs under HIPAA as modified by ACA[28], five requirements must be met by group health insurance coverage employers offering health-contingent wellness programs:

1. Opportunity to qualify for the incentive at least once per year
2. For wellness programs that require achievement of a health standard, such as BMI below 30, the total wellness incentive for the year must not exceed 30% of the cost of employee-only or employee-plus-dependents coverage. (For tobacco cessation programs or requirements, the threshold is elevated to 50%.)
3. Program design must reasonably promote health and prevent disease.
4. For "similarly situated individuals", the full reward must be made available, meaning the program must allow for a "reasonable alternative standards or a waiver of an otherwise applicable standard". For example, pregnant women should not participate in an outcomes-based weight loss program, so a reasonable alternative must be made available to them.
5. The reasonable alternative standard or waiver must be clearly communicated in all plan materials.

Compliance with ADA regulations, which apply to employers with 15 or more employees, imposes additional restrictions on wellness incentive programs. Under the ADA, employers are prohibited from asking disability-related questions or medical examinations. In the context of wellness programs, "voluntary" medical examinations are permissible. The definition of "voluntary" then becomes important, as does the question of when and if wellness incentives or penalties render non-participation involuntary.[29]

A proposed rule by the Equal Employment Opportunity Commission (EEOC), 29 CFR Part 1630, would amend the ADA regulations pertinent to employer wellness programs by clarifying the definition of "voluntary" and including the following requirements of wellness programs: [30]

- "Reasonably designed to promote health or prevent disease."
- "Not simply shift costs from employers to targeted employees based on their health."
- Employees are not required to participate, meaning:
    - Health insurance coverage is not denied as a result of non-participation;
    - No adverse action is taken against employees who refuse to participate or achieve certain outcomes; and
    - No retaliation can be made against employees for non-participation.
- Incentives do not exceed the 30% of coverage maximums dictated by ACA/HIPAA rules.
- Employees must have a clear explanation of:
    - The medical information that will be obtained;
    - How the medical information will be used;
    - How medical information will be shared and who has access;
    - How medical information disclosure will be restricted; and
    - Steps the employer will take to prevent improper disclosure of the medical information.

Furthermore, the EEOC also requires non-disclosure of individual personally identifiable medical information collected through a wellness program to the employer, although aggregate, de-identified data is acceptable. Those who manage medical information gathered through wellness programs should also not be responsible for making employment decisions (hiring, firing, or disciplinary actions).

Finally, the wellness programs themselves may not discriminate on the basis of disability, meaning, for example, that access to health information provided must be available to those with hearing or vision impairments.

5 NEXT STEPS FOR EXPANDING WELLNESS INCENTIVES IN VERMONT

In the process of developing this report, the Blueprint has identified three preliminary areas of opportunity. Based on the limitations identified in the literature, access to wellness incentives appear to be most available to those with commercial health insurance and those employed by large companies, leaving those insured by Medicaid and uninsured and those employed by small business with less access. These latter groups are not a comprehensive list of those who do not benefit from wellness incentives, but they may be starting points for exploring ways to expand access.

For example, through establishing coalitions, small businesses might be able to achieve economy of scale that would allow a wellness incentive program to be cost effective. Likewise, the *Blueprint's* self-management programs may be appropriate places to pilot an incentive program to increase participation and increase the effectiveness, such as increasing smoking cessation or weight loss. The role of ACOs in promoting wellness among their attributed lives should also be explored.

Should the Legislature request a formal report on the cost effectiveness of increasing access to wellness incentives, the Blueprint, along with community and medical partners across the state could engage legislators, administration staff, and state health and human services leaders to identify objectives and funding potential.

Next, the group would expand the report presented here, further exploring:

- National best practices and innovations in wellness incentives.
- Recent academic literature on most effective incentive models.
- Consultation with experts in wellness incentives (benefits designers/administrators, behavioral economists, social marketers and others).

This expanded report would be the key input for a collaborative design process, led by the Blueprint and engaging a broad group of stakeholders and content experts (likely via a short series of intensive workshops) in developing a recommendation for the behaviors to target, the incentives to offer, and the structure and process by which to implement them.

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