



CARROTS & STICKS

Employers prod workers to adopt behaviors that improve health

A Massachusetts man lost his job at a Scotts Miracle-Gro lawn and garden center in 2006 when a routine drug test came back positive. The finding: nicotine. Company leaders were cracking down on smoking and other unhealthy behaviors they saw as bad for the bottom line.

That same program saved another Scotts employee's life. In this case, the worker—following the advice of a company-paid health coach—had some medical tests done and discovered that he was likely just days away from a massive heart attack. Two stents inserted into his coronary arteries saved him from a life-threatening blockage.

These are just two examples of how U.S. employers are dangling “carrots” and swinging “sticks” to prod workers to change their behavior and better their health. Companies have long had an interest in keeping workers healthy, productive, and satisfied while cutting health-care and insurance costs. Increasingly, though, they are

Peter Horvath



using incentives—and disincentives—to rein in these costs' runaway growth.

So far, tobacco use and obesity are getting the most attention. To prompt workers to stop smoking and lose weight, employers are, among other things:

- adopting no-tobacco policies on and off the job
- offering cash-incentive payments and gift cards
- reimbursing workers for gym memberships
- providing free health coaching
- offering insurance-premium discounts to those who meet health standards—and surcharges to those who don't

According to a 2008 national survey by Harris Interactive, 91 percent of employers “believed they could reduce their health care costs by influencing employees to adopt healthier lifestyles,” wrote two Harvard School of Public Health (HSPH) experts in the July 10, 2008 issue of the *New England Journal of Medicine*. Michelle Mello, a professor of

law and public health in the Department of Health Policy and Management, and colleague Meredith Rosenthal, an HSPH associate professor of health economics and health policy, spelled out the legal parameters of employer-sponsored wellness programs as they stand today.

According to surveys cited by Mello and Rosenthal, 19 percent of employers with 500 or more employees offered wellness programs as of 2006. Almost 40 percent said they planned to offer monetary rewards for healthy behaviors within two years.

BY THE RULES

Employee wellness programs have been around for decades. But one likely impetus for these programs to offer a new round of health incentives was the issuing, in December of 2006, of final rules on group health plans under the Health Insurance Portability and Accountability Act (HIPAA).

These rules reduced the uncertainty about what was legally

continued

IBM: Carrots Only

IBM offers employees up to two \$150 payments a year if they complete Internet-based assessments organized around healthy eating, exercise, overall health, and children's health. To earn payments, employees must meet specific requirements such as weight loss, diet change, or attainment of physical fitness goals, with each option.

CARROTS

- Healthy Eating Option: food tracking, meal planning, goal setting
- Physical Activity Option: walking, running, swimming, aerobics
- Preventive Care Option: preventive care recommendations and maintenance of personal health records
- Children's Health Rebate: educational resources for employees to establish healthy eating and exercise routines for their children
- New Hire Rebate: new employees complete an online health assessment and visit Web-based health resources

permissible, which was probably holding some insurers back from moving in this direction, Mello says.

"It's rare for courts to find that obesity constitutes a disability under the Americans with Disabilities Act."

—Michelle Mello, HSPH professor of law and public health

Among other things, HIPAA limits the value of incentives that group health plans can offer to less than 20 percent of the total cost of health insurance (meaning premiums paid by both employer and employee). This rule allows for up to \$2,420 for a family insurance policy costing \$12,100 a year. HIPAA rules also distinguish between incentives based on participation in a program and incentives based on achieving certain health standards, such as quitting smoking or attaining a healthier weight as reflected by the body mass index (BMI).*

There are caveats, however. "If the reward is tied to achieving a health standard but there's no alternative standard available to people who can't reasonably be expected to meet that standard, it would violate HIPAA," Mello notes.

Assume, then, by way of example, that "Company X" requires its employees to be nonsmokers and have a BMI under 30. The company's rationale, backed by the medical literature, would be that (a) people who smoke are more likely to develop heart disease, lung cancer, and other costly and debilitating diseases and (b) those with a higher BMI are likely to develop these as well as other problems, such as diabetes, all of which could erode their productivity and ratchet up their and the company's health care costs. HIPAA might allow the incentive to help slightly obese workers reach a BMI under 30; however, the law would also require that morbidly obese workers receive the same incentive to meet a less drastic and more realistic target BMI.

All of this is perfectly legal, as long as group health plans abide by HIPAA and insurers and employers abide by the Americans with Disabilities Act, plus other applicable federal and state laws. "It's rare for courts to find that obesity constitutes a disability under the Americans with Disabilities Act," Mello says. "Courts have also consistently found that nicotine or tobacco use does not constitute a 'disability.'" She and Rosenthal point out, however, some courts have ruled "morbid obesity" to be an "impairment" if it can be linked to a "physiological cause."

Still other federal laws governing health incentive plans include civil rights laws, pay and age discrimination laws, the

Employee Retirement Income Security Act (ERISA), and the tax code. State laws may also limit a company's ability to impose health standards. Several states have statutes that explicitly disallow hiring or firing workers based on their tobacco use.

STEP ONE: HEALTH SCREENING

To screen employees for unhealthy behaviors, many wellness programs use a health risk appraisal as a first step. "Health risk appraisals tend to be broad instruments that collect information about clinical conditions, health-related behaviors, and medical history," says HSPH's Rosenthal. "Most include questions related to tobacco and alcohol use, even to things like seat-belt use. Some are more tailored than others."

* To calculate your BMI, divide your weight by your height in inches squared. Multiply that by 703. A BMI of 25 to 29.9 is overweight, while 30+ is obese. A BMI calculator is available at www.findmybmi.org.

Alabama: Targeting Highest-Risk Workers

Starting in January 2010, the state of Alabama will charge current employees a \$50-a-month health insurance premium (no premium is charged now, except for tobacco users). Incentives will kick in for employees who choose to participate.

CARROTS

- \$25 premium discount to employees who don't use tobacco
- \$25 "wellness premium discount" for employees who meet standards for blood pressure, cholesterol, glucose, and BMI
- Anyone whose results fall outside certain boundaries receives a voucher that covers the co-payment for a doctor's visit.
- Beginning in 2011, employees can receive the discount if they have shown that they are within set boundaries, or are taking steps to get healthier.

STICKS

- \$25 monthly premium for tobacco users rises to \$50 in 2011
- No wellness premium discount for employees who don't take health risk assessments and/or steps to reduce their health risks

Such tools also reflect medical standards for health indicators such as blood pressure and cholesterol, established by clinical experts based on evidence from patient studies. Disease-specific organizations, such as the American Heart Association (AHA) and American Diabetes Association (ADA), post benchmarks on their Web sites.

For example, the AHA puts the high end of normal blood pressure at 120/80. ADA describes blood glucose levels of 70 to 130 mg/dl before meals as normal. Some doctors urge people to take action if their total cholesterol level is above 200, for example, or when their BMI reaches the overweight and obese range.

In August of 2008, the state of Alabama—which already charges tobacco users \$25 per month in insurance premiums—announced that as of 2010 it would charge additional monthly premiums for employees who choose not to participate in the state's wellness program. The state employs more than 37,500 people. (See "Alabama: Targeting Highest-Risk Workers," left).

Alabama's chief goal is to identify the people most at risk first, because their levels for BMI, cholesterol, and blood pressure are far above what is considered healthy. "We try to identify people who are at highest risk so they can get the care they need," explains William Ashmore, chief executive officer of the State Employees Insurance Board (SEIB). Contrary to early news accounts, he says,

continued



Scotts Miracle-Gro Gets Down to Details

Scotts uses both incentives and disincentives. They include:

CARROTS

- \$10 monthly fitness center membership fee, reimbursable after 120 uses of the center
- Free health coaching
- Free medical services for employees and covered dependents
- Free prescriptions for generic drugs

STICKS

- Scotts offers a voluntary health-risk appraisal called Health Quotient. Employees who choose not to participate pay a \$40-per-month insurance premium surcharge.
- If an employee takes the appraisal and is in the mid- to high-tier range of risk levels, he or she can opt to consult a health coach and take steps to lower risks. However, if that employee chooses to do nothing, he or she will pay a \$67 insurance premium surcharge per month.

SEIB is not imposing a “fat tax.” Employee representatives have endorsed the program, he says.

Ashmore says “high-risk” standards that trigger incentives are:

- BMI: 35 or higher
- Cholesterol: 240 total and higher

- Blood pressure: 140/90 and higher
- Blood glucose: Greater than 180 mg/dl

“Alabama is probably barking up the right tree,” says Rosenthal. “Some experts say setting very tight standards and encouraging people to get to them may be missing the point. Getting people below this very high level is much more important in terms of mortality and morbidity than getting people to look like [fitness experts] Jack LaLanne or Kathy Smith. Getting people from a seriously high risk situation to a somewhat less but still risky situation may be the most cost-effective approach.”

APPROACHES VARY WIDELY

Some companies are using carrots only. IBM, for instance, offers cash payments for completing certain assessments. Says IBM Well-Being Director Joyce Young, MPH '81, “We have programs aimed at every risk” (see “IBM: Carrots Only” on page 6). The programs include some on-site fitness centers and, due to the widely dispersed work force, Internet-based assessments. IBM has spent \$130 million on wellness since 2004. That figure includes more than 100,000 payouts last year.

A “Smoke-Free Rebate” that IBM offered for three years was recently discontinued, Young says, because the percentage of workers who smoked had plummeted to less than 10 percent. The company still offers a smoking cessation program through an interactive Web site and telephone counseling. IBM’s newest incentive, a “Children’s Health Rebate,” aims to tackle childhood obesity.

One company’s wellness efforts were featured in a cover story in *Business Week* in February 2007. Scotts Miracle-

Spending on Health Care in 2007

TOTAL U.S. HEALTH CARE SPENDING: \$2.3 TRILLION (\$7,600 PER PERSON)¹

Average annual employer health insurance (family): \$12,100²
(individual): \$4,400

- Employer health insurance premiums doubled since 2000.
- Workers paid \$1,400 more for premiums than in 2000.

U.S. government and private health care spending is predicted to increase by about 6.7 percent a year through 2017 to \$4.3 trillion, or 19.5 percent of gross domestic product.³

For four straight years, in the Business Roundtable’s annual CEO Economic Outlook Survey, executives cited health care expenditures as the top fiscal pressure on their companies. (In 2007, energy costs were tied with health care costs as the most weighty concern.)⁴

1. National Coalition on Health Care, www.nchc.org/facts/cost.shtml

2. The Henry J. Kaiser Family Foundation, www.kff.org/insurance/7672/index.cfm

3. Centers for Medicare and Medicaid Services, www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf

4. Business Roundtable, www.businessroundtable.org

Gro, headquartered in Marysville, Ohio, built a \$5 million “Wellness Center” in 2005 near its headquarters and maintains a medical clinic, a pharmacy, and a fitness center. (See “Scotts Miracle-Gro Gets Down to Details,” page 8.) Scotts adopted a controversial tobacco-free policy in 2006. It no longer hires tobacco users in certain states. Meanwhile, its wellness program aims to encourage smokers to quit.

But trouble emerged when, in September of that year, a man named Scott Rodrigues, who had been working at Scotts on Cape Cod, Massachusetts, for about two weeks (of a 60-day probation), took a required drug test that turned up nicotine. Scotts, whose no-tobacco policy was slated to take effect the next month, let him go. Rodrigues sued. As *Business Week* noted, the outcome of the case—pending in federal court



cost benefit to show up. Even in the best-case scenarios, companies would likely see slower growth in health care costs rather than cost reductions.

“It is difficult to tease out which activity is responsible for what behavior,” explains HSPH alumna and IBM wellness program head Joyce Young. Any change in benefits prompts a cost change, and “You have to control all the changes to be able to see the effect of a health-improvement change,” she

says. “It takes years before you see trends.”

As for IBM’s physical activity program, Young and her collaborators at the University of Michigan Health Management Research Center have determined that it does deliver. From 2003 to 2005, participants—53.8 percent of eligible employees—saw their health care costs rise by \$291 a year,

“Getting people from a seriously high-risk situation to a somewhat less but still risky situation may be the most cost-effective approach.”

—Meredith Rosenthal, HSPH associate professor of health economics and health policy

as of November 1—is difficult to predict because there is so little case law on this narrow topic.

Attorney Lewis Maltby, founder and president of the National Workrights Institute in Princeton, New Jersey, says employers should be cautious in implementing wellness programs that may infringe on privacy and personal interests. But he says he knows of no other cases like the one in Massachusetts. That includes Michigan, where Weyco Inc., now part of health-benefits manager Meritain Health, had not only a no-smoking policy that included mandatory tobacco testing of workers, but a no-smoking policy for spouses as well. No Michigan statute prohibits that kind of action, Maltby says.

DO INCENTIVES REALLY WORK?

According to several studies, the cost-effectiveness of health promotion programs varies widely. The Wellness Councils of America maintains that the “return on investment,” or ROI, of such programs is \$3 or more for every \$1 spent. However, little has been published so far on the ROI of incentives alone. Many experts agree that it takes two to three years for any

compared to \$360 for nonparticipants. At Scotts, spokesperson Keri Butler says 80 percent of employees take advantage of the company’s Wellness Center. The payoff? Costs are rising, but at a rate “lower than the national average,” she reports.

For her part, HSPH’s Rosenthal says she recently explored whether people who take health risk assessments actually do make behavioral changes to improve their health. “The results don’t suggest any dramatic effects,” she says. “It’s not clear whether assessment alone will be very effective.” On the other hand, there is reason to believe penalties will be. According to a body of research, Rosenthal says, “People are much more averse to losing something than they are excited about the possibility of a gain.”

Experts agree: More research is needed to learn just how effective workplace incentives and disincentives really are. When it comes to the daunting challenge of changing people’s health-related behavior, “carrots” and “sticks” may be the best tools available.

Larry Hand is associate editor of the Review.