Applying Behavioral Economics to Corporate Wellness

New Thinking About What Motivates Employees to Change

Spring 2013

DR. WAYNE WINEGARDEN
Managing Director and Senior Economist
Arduin, Laffer & Moore

Dr. Winegarden is responsible for analyzing and writing the firm's industry-based policy studies. Prior thereto, he worked as an economist for Altria Companies Inc., in Hong Kong and New York City. In these roles, Dr. Winegarden analyzed the impact of the economic environment in East and Southeast Asia on the company's operations, and integrated these insights into Altria's strategic planning process. Additionally, Dr. Winegarden examined the impact of tax and regulatory policies on the company's operations and supported its government affairs objectives. Dr. Winegarden also has experience analyzing federal and state budget, regulatory and financial sectors for policy and trade associations in Washington, D.C.

Having further served on the economics faculty at Marymount University, Dr. Winegarden is a columnist for Townhall.com, and has been interviewed and quoted by Bloomberg and CNN. He is frequently invited to deliver research findings at policy conferences and meetings. Dr. Winegarden received his B.A., M.A., and Ph.D. in Economics from George Mason University.

CHRISTIAN MORENO
Lockton Dunning Benefits
Vice President, Producer
cmoreno@lockton.com

Christian Moreno is Vice President and Producer at Lockton Dunning Benefits. With more than 14 years of experience, he specializes in designing health plans that are fully integrated with wellness solutions and helping employers manage the demand side of healthcare.

He gained global experience in South Africa and Southeast Asia, where he helped implement consumer-driven health plans and wellness solutions to employers in large- and mid-sized markets before similar insurance models began launching in the U.S. He then brought this expertise to the U.S. and sold some of the earliest consumer-driven health plans in the country.

Christian speaks frequently to professional organizations about managing healthcare costs with both insurance plan designs and wellness programs. He has been featured several times in the *Dallas Business Journal* for his innovative plan designs and wellness solutions.

ABSTRACT/SUMMARY

- Incentives are a common tactic among employers to boost participation in corporate wellness programs.
- A continuous rise in chronic conditions and simultaneous increase in healthcare costs despite lucrative incentives suggests more dramatic tactics are necessary.
- The healthcare "wedge" that separates consumers from the direct cost of their care is a major factor that limits their motivation to participate in wellness programs, as well as their ability to understand and manage their own healthcare costs.
- Economic theory suggests that disincentives, or penalties, are more effective when it comes to eliciting behavior change and will also help put the consumer closer to the costs of care, thus reducing the healthcare wedge.
- New allowances in the Patient Protection and Affordable Care Act (health reform) present significant opportunities for employers to design wellness programs that are more penalty/outcomes-focused.

LOCKTON

INTRODUCTION

Behavioral economic theory has been applied throughout history to help "steer" consumer behavior in certain directions. Retirement savings, shopping patterns, and approaches to risk are all common examples where these theories have come into play to get people to take steps to have a positive impact on them over the long term.[1]

These same theories of behavioral economics are applied to the nation's healthcare system, specifically employer-subsidized insurance policies and the corporate wellness programs that are paired with these policies in an effort to contain costs. Conventional wisdom about what motivates people to choose one behavior over another has led employers to offer incentives like cash and other rewards in exchange for completing designated wellness activities. An examination of both health and cost data shows that incentives have not led to the progress that was anticipated.

The following is a brief overview of the evolution of the private healthcare system in the United States and the resulting "wedge" between the system and the employees it serves. We'll also examine the growing corporate wellness industry that in some cases exacerbates the problem of the healthcare wedge. Finally, we'll use economic theory to explore incentives and penalties to determine what method is most effective at getting employees more engaged.

EMPLOYER-SPONSORED HEALTH INSURANCE: A BRIEF OVERVIEW

A look at the origins of group health insurance helps tell the story of how the industry got where it is today; specifically how employees have become increasingly removed from the cost of their healthcare.

"An examination of both health and cost data shows that incentives have not led to the progress that was anticipated."

The earliest forms of health insurance were implemented in the early 1900s, but it wasn't until the 1940s that the United States saw the proliferation of comprehensive employee benefit plans, as strong unions negotiated for additional benefits.

During World War II, companies competing for labor had limited ability to use wages to attract employees due to wartime wage controls, so they began to compete through health insurance packages. The companies' healthcare expenses were exempted from income tax, and the resulting trend is largely responsible for the workplace's present role as the main supplier of health insurance.

The government was not involved in health insurance until 1954, when Social Security coverage included disability benefits for the first time. In 1965, Medicare and Medicaid programs were introduced. In the 1970s and 1980s, costs began to rise significantly for health insurance companies, in part because of major advancements in medical treatment methods and new technologies.

Group Health Insurance History

1940s
Start of employee benefit plans

Unions negotiated for benefits

WWII
Companies used health insurance as a part of compensation to attract employees

1956
Federal government entered health insurance

Social Security began to include disability benefits

1965
Medicare and Medicaid programs began

1970-80s
Health insurance costs skyrocketed due to medical technologies/ advances

1990s
PPO Model was widely used

2012
Consumer-Driven Health Plan (CDHP) is most common plan implemented today

Responding to higher costs, employee benefit plans changed into managed care plans, and Health Maintenance Organizations (HMOs) emerged. HMOs were unique in that they involved a particular network of healthcare providers who had been verified for quality and who agreed to charge a set price for services. Employees using these plans were limited in which providers they could see. Unfortunately, HMOs only succeeded in temporarily slowing the growth of healthcare costs.[2]

> "162 million Americans have employer-sponsored insurance."

Lack of expected cost containment, coupled with consumers who were disappointed with the lack of choice in providers, led to the Preferred Provider Organization (PPO) model that was prevalent throughout the 1990s. It remains in limited use today.

One of the most popular plans being implemented today is the consumer-driven health plan (CDHP), with nearly two-thirds of employers offering these plans in 2012.[3] These plans combine the positive aspects of PPOs (choice of providers, bigger networks, no referrals) with a financial model that helps consumers understand more about the cost of their care. The name "consumer-driven" speaks to this goal of employees becoming more engaged in managing their healthcare spending by exposing them to actual costs. CDHPs typically feature a high annual deductible underneath which the employee is responsible for all out-of-pocket costs.

Today, 162 million nonelderly Americans have employer-sponsored insurance either in their own name or as a dependent. As of 2006, the tax subsidy from federal and state employer-sponsored insurance tax exemptions was estimated to be $208.6 billion.[4]

> Disconnecting consumers blinds them from the costs of their actions.

The Problem of the Healthcare "Wedge"

Despite attempts to educate employees about the cost of care and increase their involvement—particularly with today's consumer-driven plan designs—there continues to be a "wedge" in healthcare that has existed since the early days of employer-sponsored insurance plans.

For years, consumers have been shielded from actual costs, in most cases simply paying a low co-pay amount of $20-$30 for a doctor's visit with no perspective on the actual costs of services performed. In reality, the cost of a simple visit can extend into the hundreds or thousands of dollars.

The healthcare wedge creates a distortion in healthcare decisions across the entire healthcare market. Disconnecting consumers blinds them from the costs of their actions and actually creates disincentives for people to participate in corporate wellness programs. A quick economic digression illustrates how:

> Healthcare prices should reflect the underlying costs of providing healthcare services. If unfettered, prices and price changes reveal to consumers the underlying costs and trade-offs for the goods or services they need (or want) to purchase. When consumers are blinded to market prices, inefficiencies arise. Economist Friedrich Hayek summarized the key role that prices play in behavior in a classic 1945 article using the example of tin.[5] In his study, he explained that if consumers around the world suddenly had new opportunities to use tin in various forms of building, those that were using tin before would need to economize their use of the material as it became scarce and, thus, more expensive. Hayek goes on to explain that consumers do not need to know why tin prices have risen in order to do the right thing—consume less tin. Simply exposing consumers to the higher cost of tin is enough for people to adjust their actions appropriately.

Relating this concept to healthcare and corporate wellness programs, one could argue that people do not need to know the clinical or epidemiological reasons why participating in a corporate wellness program is beneficial. However, consumers do need to see the costs that their unhealthy actions are creating, in order to make the right decisions.

Today, American employers face two major challenges that may be attributed to poor employee health: rising healthcare costs and declining worker productivity. Attempts to address both of these challenges have been complicated by the healthcare wedge because employees have long been disconnected from their health behaviors and the resulting impact on costs and productivity. The corporate wellness program—if structured correctly—provides a real opportunity to address both issues.

The Wellness Program Explosion

Chronic diseases such as heart disease and diabetes are the major cause of death and medical expenditures in the United States. According to the Centers for Disease Control and Prevention, chronic diseases are responsible for seven out of 10 deaths and more than 75 percent of healthcare expenditures.[6] Lifestyle choices, such as not exercising or being overweight, are important risk factors for chronic diseases—especially for younger people.

> “Roughly $2 billion is spent on wellness by employers each year.”

The growing medical and financial costs associated with chronic diseases, coupled with the legacy of the United States employer-based health insurance system, creates a powerful incentive for corporations to help their employees more effectively manage the risks from chronic diseases. The need to manage these risks has led to an increased focus on corporate wellness programs, and the industry has exploded throughout the last decade.

Goals for Corporate Wellness

In an ideal scenario, businesses operating a high-quality corporate wellness program would lower their medical costs; improve worker productivity; create happier, healthier, and more loyal employees; and lower rates of disease prevalence and employee absenteeism.

Whether this is actually occurring is up for debate. Chronic diseases are on the rise in the United States, with rates of obesity and diabetes skyrocketing in recent years. In this same time period, the wellness industry has grown substantially, with more than 7,500 wellness vendors operating in the U.S. today, and roughly $2 billion spent on wellness by employers each year.[7]

An examination of wellness programs—with a close look at the incentives used in these programs—offers key insights into what may not be working as well as corporations had planned.

Although corporate wellness programs vary widely in scope, as a class of programs, they differ from corporate healthcare programs that typically focus on employee assistance and health insurance. Corporate wellness programs focus on promoting healthy behaviors and lifestyles. Work-site wellness programs can include a broad spectrum of activities including proper diet counseling, smoking cessation programs, and physical fitness centers.[8]

History of Employer Assistance

1950s

Employers began aiding employees with health-related issues such as alcoholism and mental health

1980s

Companies offered disease management that assisted employees once they were diagnosed with a condition

Today

Corporate wellness plans are widely used to try to intervene before employees get sick, with a goal to change behaviors

Corporations first began aiding employees with health-related issues by addressing problems such as alcoholism and mental health in the 1950s.[9] These programs, which were often peer-led, were the earliest forms of the Employee Assistance Programs (EAPs) that exist today. In the 1980s, employers offered "disease management" programs that attempted to intervene early when employees were diagnosed with a condition. Outbound phone calls to employees or educational materials provided an overview of the condition, answers to common questions, advice about complying with treatment plans and medications and more. These attempts to manage disease after diagnosis were replaced by programs that aimed to intervene before employees got sick, with a goal to change behavior, improve their lifestyles and as a result, lower healthcare costs.

Modern corporate wellness programs are designed to leverage the central social role of today's workplace for the majority of working adults. Due to this central role, the hope has been that workplace culture can profoundly influence the behavior of individual employees and, thus, can be leveraged to promote healthy lifestyle habits through a corporate wellness program.

Ultimately, the corporate value of a wellness program depends upon a demonstrated short- and long-term return as measured by lower overall corporate health expenditures, increased worker efficiency, or a combination of both. For this to happen, employers have to motivate employees to engage with the program, which has led to the addition of lucrative incentives in recent years.

Carrots vs. Sticks: What Behavioral Economics Tells Us About What Works

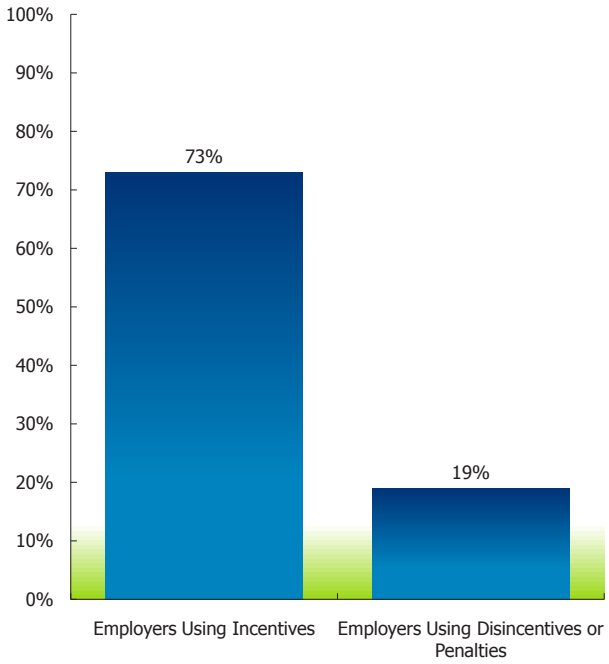
Incentives to participate in corporate wellness programs are typically positioned as either positive incentives (carrots) or, less frequently, as negative incentives (sticks).

In 2007, the Integrated Benefits Institute, along with Harris Interactive (authors of the Harris Poll) surveyed more than 500 employers representing roughly 5 million employees on the incentives and the disincentives they offer to promote healthy and productive workforces. Their findings showed that the cost from health-related lost productivity was large enough to justify significant investments into wellness programs; and, that employers understand this.

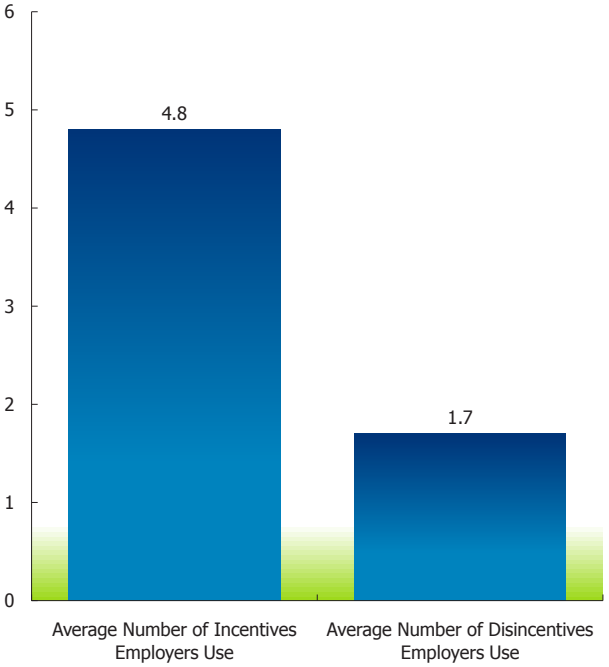
Fully 73 percent of employers were investing in incentives for employees. Disincentives were used less frequently—19 percent of respondents include such an approach, which is likely attributed to the more negative perception of a disincentive, or penalty-based approach to improving health.

On average, employers have 4.8 incentives and 1.7 disincentives in their programs. Employers use cash-based and benefits-related strategies for incentives and disincentives most frequently; prizes and gifts are less common, while salary and job disincentives are used by just a few.[10]

PERCENTAGE OF EMPLOYERS USING INCENTIVES OR DISINCENTIVES



AVERAGE NUMBER OF INCENTIVES/DISINCENTIVES EMPLOYERS USE



Making the Most of Program Performance

A look at how people currently behave with incentives inside a wellness program offers insight into what steps employers might take in the future to optimize program performance.

Some individuals are motivated to engage in healthy behaviors because they enjoy exercise or enjoy eating healthy foods. These people do not need positive nor negative incentives to engage in healthy behaviors.

Other individuals will not engage in healthy behaviors but will also not be responsive to financial incentives or penalties. For these individuals, the pleasure from engaging in unhealthy behaviors is so large, or the displeasure from engaging in healthy behaviors is so great, that regardless of the potential financial benefit (incentive) or the potential financial cost (disincentive/penalty), they will not be dissuaded from engaging in unhealthy behaviors. For these individuals, financial incentives or penalties are not the appropriate method for changing their behavior.

> "There are those individuals who are responsive to financial incentives and, because the healthcare wedge is blinding them from the true costs of their actions, they are engaging in unhealthy behaviors."

However, there are those individuals who are responsive to financial incentives and, because the healthcare wedge is blinding them from the true costs of their actions, they are engaging in unhealthy behaviors. These are the people who could be incentivized to engage in healthy behaviors (i.e., to participate in the corporate wellness program) through financial incentives or penalties. In other words, these individuals are currently engaging in unhealthy behaviors but would not be if they could see the true costs of their actions.

The fundamental problem with incentives within corporate wellness is that they add costs to a program that is already an additional cost for an employer. A corporate wellness program that provides positive incentives has to pay both the individuals who would participate in the corporate wellness program without financial incentives as well as the target group of individuals in order to achieve its goals. This costs employers money, in addition to their existing healthcare costs that are rising each year.

Another problem with incentives for wellness is that the healthcare system itself creates adverse incentives that encourage employees to remain unhealthy, while employers are trying to combat these with positive incentives for employees to get healthy. For example, individuals do not face higher costs today when they

engage in unhealthy behaviors that, statistically speaking, create higher healthcare costs tomorrow. Because there is no cost today for engaging in unhealthy behaviors (e.g., eating unhealthy foods, avoiding undesired activities), but there is a benefit today as individuals are engaging in activities they deem pleasurable, the current healthcare system is actually incentivizing less healthy behaviors. Effectively, the healthcare wedge is currently providing a positive incentive to engage in less healthy behaviors.

When these broader healthcare incentives are taken into consideration, it is evident that the right incentive structure for a corporate wellness program reduces the overall healthcare wedge and connects the plan participants to the choices they make—effectively eliminating the wrong incentives created by the overall healthcare system. It also solves the problem of time consistency by ensuring that the costs of people's actions are visible in a timely manner. The goal of corporate wellness programs should be to directly address the source of the problem by maximizing the connection rate between employees, their personal health decisions, and the consequences of those decisions. In other words, effective wellness programs ensure incentives such that the member's economic incentives and health incentives are aligned.

Another limitation of incentives is that the perceived value of them can vary widely depending on the employee. What constitutes a powerful incentive for one employee may not be interesting to another at all.[11]

Finally—and perhaps most importantly—while incentives are something most people say they want, years of behavioral studies indicate that people sometimes behave in a manner that is both inconsistent with their stated preferences and not in their long-term best interests.

STUDY ONE

Study One: Incentives That Produce a Less-Than-Optimal Outcome

People's savings choices are an oft-cited example of how a suboptimal outcome is possible without the right incentive and choice structures.

In the case of saving, people are being asked to defer pleasure, by contributing money to a 401(k) or other retirement vehicle. For many of these people, a "match" contribution is offered by the employer, which is essentially "free" money for the employee, but it can't be used until a much later date. The problem is that by spending money now rather than saving it, people are actively doing something today that is pleasurable. While consumers often agree that the optimal activity in this scenario is to put that money aside today to enjoy a much greater gain from it in the future, they don't always follow through.

This common scenario demonstrates that people generally do not value the future consumption high enough and overemphasize the benefits from consuming today. Consequently, people are naturally incented to insufficiently save. While the majority of people would agree that it's better in theory to save their money, many don't do it. This is an example of a problem known as time-inconsistency because people tend to give less weight to the pleasure they will receive in future (having ample savings) over the pleasure they could receive today (spending their paycheck on things they want to buy now).

> "The right incentive structure for a corporate wellness program reduces the overall healthcare wedge and connects the plan participants to the choices they make."

STUDY TWO

Study Two: Disincentives and a More Optimal Outcome

In a seminal study, Tversky and Kahneman created an experiment that examined how people react in a situation where something may be taken away from them compared to a situation where they stand to gain.[12] In Tversky and Kahneman's study, more than 150 college students at Stanford University and the University of British Columbia were asked to imagine that they faced the following pair of concurrent decisions. Students first examined both decisions, then indicated their preferred options.

For decision number one, students were asked to choose between:

- A sure gain of $240
- A 25 percent chance to gain $1,000 and a 75 percent chance to gain nothing

For this decision, 84 percent of students chose option A, the sure gain of $240. Only 16 percent of students opted for the more lucrative, but also more risky option of either a 25 percent chance to gain $1,000 and 75 percent chance to gain nothing.

For decision number two, students were asked to choose between:

- A sure loss of $750
- A 75 percent chance to lose $1,000 and a 25 percent chance to lose nothing

For this decision, only 13 percent of students chose the sure loss of $750. The majority of students (87 percent) instead opted for the 75 percent chance to lose $1,000 and a 25 percent chance to lose nothing.

What this experiment showed is that the framing of a decision matters. The majority choice in decision number one is risk averse, while the majority choice in decision number two is risk seeking. This is a common pattern: choices involving gains are usually risk averse, and choices involving losses are often risk seeking—except when the probability of winning or losing is small.

This tendency for individuals to seemingly act irrationally can often be traced to the specific incentives (or disincentives) they face and the specific manner in which the choices are presented to them. Consequently, it is imperative to establish the correct incentives or disincentives and present the choices a person faces in the optimal manner. The following studies provide a closer look at this phenomenon.

The two key findings from these analyses for corporate wellness programs are:

1. **Changing the way a choice is presented changes people's choice preference.**

2. **People tend to act in a more risk-adverse manner when there is a chance of loss rather than a chance of gain.**

The second finding is particularly important for designing the optimal participation incentives for corporate wellness programs. People respond to the chance of a gain (in the case of wellness programs, a positive incentive) differently than a chance of a loss (in the case of wellness programs, a penalty or disincentive). Specifically, people tend to act in a manner that minimizes the chances for a potential loss and are more willing to forgo a potential gain. These findings support the use of disincentives (a potential loss) to encourage people to participate in a corporate wellness program rather than an incentive (a potential gain). The desire to avoid the potential loss will be a greater motivating factor rather than the desire to obtain a potential gain.

Here are examples of two corporate wellness programs in action. One uses an incentive structure and the other focuses on disincentives.

Case Study One: Incentive, Participation-Based Program

A self-funded energy company with 600 employees introduced a wellness program that offered a premium differential of $360 per covered employee per year or $1,200 per covered family per year. In order for employees to avoid paying these higher premiums, they had to complete a health risk assessment, get their biometric screening, and get their annual physical during the plan year. Failure to complete all elements of the program also resulted in employees being placed on a different health plan with lesser benefits.

This strategy resulted in 90 percent of employees participating and completing all three requirements in the first year of the program. The company sustained this level of participation over multiple years.

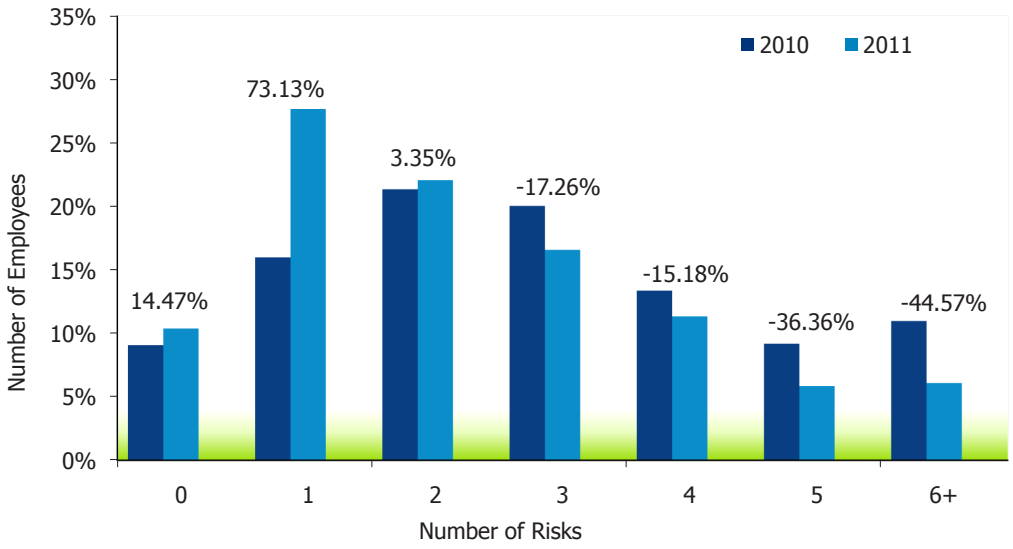
A cohort analysis was completed to compare biometric results for the same enrolled population in 2009 and 2010, and the analysis revealed that the group's total risks actually increased over this time period. Of the six risk factors tested for in 2009, the total group had an average risk of 4.42, and that increased to 4.54 in 2010. It should be noted that this group has three classes of employees—two field classes and one corporate class—and the risk factors increased in every class of employee from 2009 to 2010.

Based on these results, the group used 2011 as a transitional year to move to an outcomes-based program, which now holds the employees accountable to actually reducing any risk factors identified during the screening process. The rewards for employees who achieve specific outcomes are lower plan premiums as well as access to a richer benefit plan. After moving to the outcomes program in 2012, the group saw a reduction of at least one risk factor in 33 percent of participants. More importantly, 50 percent of the population with five or more risk factors reduced at least one risk factor, which lowered the probability of that population experiencing additional large claims.

Case Study Two: Disincentive, Outcomes-Focused Program

A 2,500-employee, multisite hospital group introduced its first employee wellness program in 2010. The program provided a $200 annual employee contribution incentive for participation, and 34 percent of employees participated that year. In 2011, the company offered a larger disincentive ($500) for participation in the current program, and introduced the idea of an outcomes-based/disincentive program that would take effect in 2012. Approximately 50 percent of employees participated that year. In 2012, the company implemented the outcomes-based wellness program with a 20 percent disincentive ($1,440 per year) and program measurements that included body mass index (BMI), tobacco use, blood pressure, and cholesterol. All of these were valued at $30 per metric met.

2010-2011 COHORT POPULATION RISK FACTOR DISTRIBUTION WITH PERCENT CHANGE



Source: Lockton InfoLock® 2012

- 68.9 percent of population participated in program
- 60 percent of the population with three or more risk factors reduced at least one risk
- 39 percent of the population remained constant with two or fewer risk factors
- 17 percent of the population remained unhealthy with three or more risk factors
- 8 percent of the population increased risk factors

In terms of dollars received from disincentives, this number increased from just more than $500,000 in 2011 to $1.8 million in 2012 on a program that cost $250,000. The company "reinvested" the disincentive dollars received into the program for employees. The company plans to continue the momentum behind its program with the introduction of a health savings plan in 2013, followed by full-replacement HSA in 2014, an increase of the disincentive to 30 percent, plus the introduction of spouses to the outcomes/disincentive wellness model.

> Corporate wellness programs, if designed well, still have great potential to address the growing problem of chronic diseases in the U.S.

How Can Disincentives (Penalties) Better Help Employers Remove the Healthcare Wedge?

As introduced earlier, many of the problems with our current healthcare system either stem from, or are aggravated by, the adverse incentives created by the healthcare wedge between consumers and suppliers—including the problems wellness programs are designed to address.

On the consumer side of the market, the healthcare wedge diminishes consumers' incentive to monitor and appropriately respond to costs, because these consumers bear only a fraction of the costs from any additional healthcare service.

On the supplier side, doctors and other medical providers are not given incentives to provide higher-quality services for less cost—there are not any positive benefits for doctors who do so. But, there are costs. One of the most important disincentives for doctors to monitor costs is the tort liability threat. According to the American Medical Association, defensive medicine in response to rising tort liability costs added $99 billion to $179 billion in additional costs in 2005 alone.

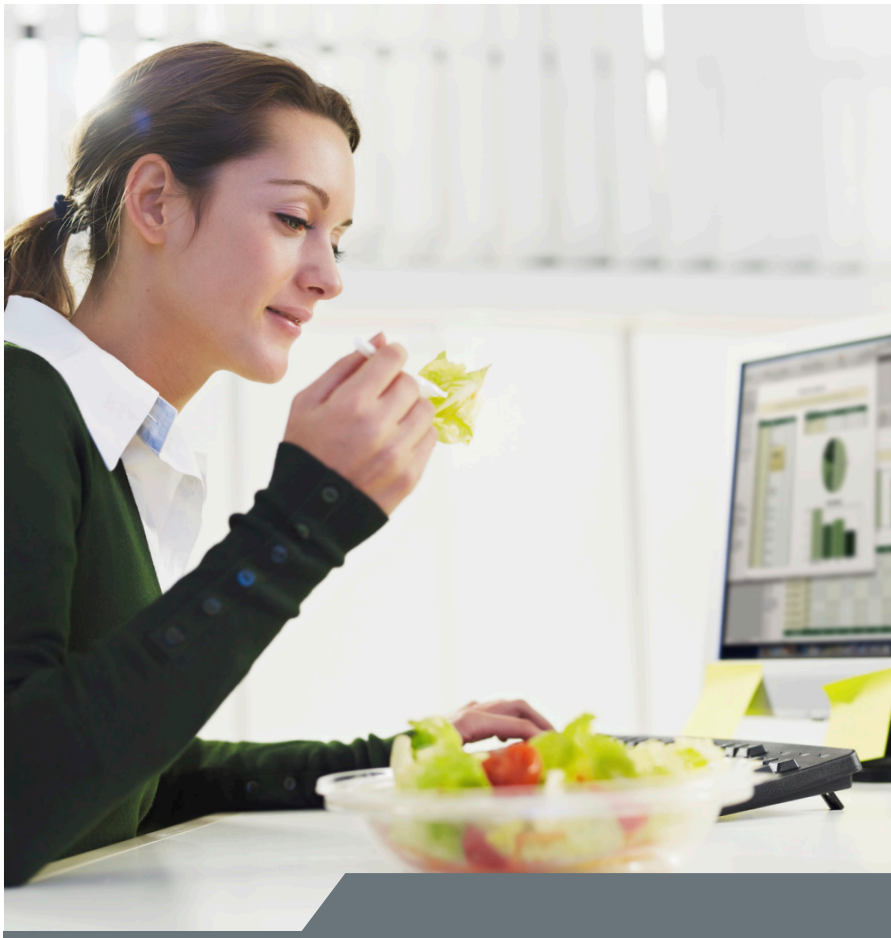
As a result, Medicare, Medicaid, and tax-favored, employer-based coverage blind both patient and doctor to the cost of care, while litigation risks incentivize doctors to run additional tests to limit their liability exposure.

President Obama's Council of Economic Advisors has cited the incentive problem as one of the key drivers of excessive healthcare inflation:

> *"While health insurance provides valuable financial protection against high costs associated with medical treatment, current benefit designs often blunt consumer sensitivity with respect to prices, quality, and choice of care setting. There is well documented evidence that individuals respond to lower cost-sharing by using more care, as well as more expensive care, when they do not face the full price of their decisions at the point of utilization. Additionally, most insurance benefit designs do not include direct financial incentives to enrollees for choosing physicians, hospitals, and diagnostic testing facilities that are higher quality and lower cost."*[13]

It's no surprise, then, that the rise of unhealthy behaviors over the past few decades has corresponded with a decline in out-of-pocket expenditures. The percentage of Americans who are obese (with a BMI of 30 or higher) has tripled since 1960, to 34 percent, while the incidence of extreme or "morbid" obesity (BMI above 40) has risen sixfold, to 6 percent.[14] There are obviously many variables at play that have caused Americans to gain weight (poor food choices, more sedentary careers, etc.), but it can be argued that consumers have been sheltered for years from the one thing that may actually have the greatest chance to force health improvements: a direct hit to their bottom line in the form of higher insurance premiums.

In recognition of the impact that obesity has on overall health costs, the Affordable Care Act directly confronts this crisis in a number of ways—beginning with empowering employers to charge obese employees up to 30 percent more in what they contribute toward their health insurance benefit should an employee refuse to participate in a qualified wellness program designed to help them lose weight.[15]



> "A penalty-based system that counteracts the healthcare wedge should be playing a greater role in employer programs if the true goal is behavior change and cost control."

This allowance in the Affordable Care Act represents the biggest opportunity for employers to remove the healthcare wedge, but it requires a fundamental cultural shift in how we think about a wellness program and the purpose it serves within a company. By connecting an employee's actions directly to the cost of his or her premiums, employers have a chance to control their costs and in the process move employees toward improved health. The 30 percent differential means employers can move beyond participation-focused programs and implement programs that have actual outcomes built in to them, and employees making positive strides in the outcomes they present will lead to more manageable healthcare costs for employers (and themselves) in the long term.

Conclusion

Corporate wellness programs, if designed well, still have great potential to address the growing problem of chronic diseases in the United States.

However, because the U.S. healthcare system hides much of the cost of unhealthy behaviors from individuals, a penalty approach to wellness will be more effective than one that uses incentives to change behavior. Positive incentives, while sound in theory, are compounding the problem of the healthcare wedge because employees must truly be exposed to the costs of their care, and held accountable to those costs if they choose to remain unhealthy, in order for progress to be made. Additionally, employers are unnecessarily paying positive incentives to all employees, when there are some who would participate in corporate wellness programs without the lucrative incentives, thus biasing the program toward unnecessarily higher costs.

A penalty-based system that counteracts the healthcare wedge should be playing a greater role in employer programs if the true goal is behavior change and cost control.

The result of a well-designed penalty program should be greater overall participation in the program, employees who are more educated about the cost of healthcare (and thus able to understand the cost of their own poor health), and—in the long term—employees who show health improvements that result in more sustainable healthcare costs for both themselves and the company.

Sources

1 Daniel Kahneman and Vernon Smith both received the Nobel Prize in Economics for their work that helped integrate psychology and behavioral experiments into economics. See: http://www.econlib.org/library/Enc/bios/Kahneman.html; and http://www.econlib.org/library/Enc/bios/SmithV.html.

2 Zhou, Katherine (Nov. 1, 2009) "The History of Health Insurance in the United States". Yale Journal of Medicine and Law: Vol. VI, Issue 1.

3 The 16th Annual Towers Watson /National Business Group on Health Employer Survey on Purchasing Value in Healthcare.

4 Buchmueller, Thomas C. and Monheit, Alan C. (2009) "Employer-sponsored Health Insurance and the Promise of Health Insurance Reform" NBER Working Paper 14839, April; http://www.nber.org/papers/w14839.

5 Hayek, Friedrich (1945) "The Use of Knowledge in Society" American Economic Review XXXV, No. 4; pp. 519-30.

6 (2009) "Chronic Diseases: The Power to Prevent, The Call to Control: At A Glance 2009" Centers for Disease Control and Prevention; http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm.

7 IBIS World Industry Report OD4621: Corporate Wellness Services in the U.S., December 2011.

8 Society for Human Resources Management. (2008). 2008 Employee Benefits Survey: Wells Publishing.

9 Owens, D. (2006). EAPs for a diverse world: employers that provide culturally competent employee assistance programs show employees they care. HR Magazine.

10 Jinnett, Kimberly, Thomas Parry, and William Molmen. Employer Incentives for Workforce Health and Productivity. Publication. Integrated Benefits Institute, Oct. 2008. Web. 15 July 2012[http://www.acoem.org/uploadedFiles/Career_Development/Tools_for_Occ_Health_Professional/Health_and_Productivity/Employer%20Incentives%20for%20Workforce%20Health%20and%20Productivity.pdf.

11 Tversky, Amos and Kahneman, Daniel (1986) "Rational Choice and the Framing of Decisions" The Journal of Business, Vol. 59, No. 4, October, pp. S251-S278.

12 Tversky, Amos and Kahneman, Daniel (1986) "Rational Choice and the Framing of Decisions" The Journal of Business, Vol. 59, No. 4, October, pp. S251-S278.

13 Executive Office of The President, Council of Economic Advisors (2009) The Economic Case for Healthcare Reform, June.

14 (2012) "Study: Obesity adds $190 billion in health costs" Reuters, April 30; http://www.msnbc.msn.com/id/47211549/ns/health-diet_and_nutrition/t/study-obesity-adds-billion-health-costs/.

15 Ungar, Rick (2012) "Obesity Now Costs Americans More In HealthCare Spending Than Smoking" Forbes.com, April 30; http://www.forbes.com/sites/rickungar/2012/04/30/obesity-now-costs-americans-more-in-healthcare-costs-than-smoking/.

Our Mission

To be the worldwide value and service leader in
insurance brokerage, employee benefits, and risk management

Our Goal

To be the best place to do business and to work

www.lockton.com

g\whitepaper\winegarden\2013\winegarden_behavior economics and wellness_March13.indd\blg