Economic Incentives for Health Behavior Change

The National Occupational Research Agenda (NORA):
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Nico Pronk, Ph.D.
Vice President and Research Investigator
Center for Health Promotion and HealthPartners Research Foundation
HealthPartners

Good Morning. I’m very pleased to be here this morning and talk to you about what we’re doing in this area at Health Partners, and really also look at the background in terms of the context in which these programs are shaping up.

So the topic is Economic Incentives for Health Behavior Change.
As an outline, where I thought I’d start was to give you the backdrop – the background – of some of these programs, and what drives the need for behavior change in the context, particularly of employers and their interests…

But then also, very quickly, turning to – well, if there IS a need for behavior change, and if there is a role of economic incentives, what should be the design principles that sort of sit behind the programs themselves?

How do incentives affect all stakeholders?

Health assessments, as it is one of the few tools that is available right now that captures behavioral information systematically, and use it as an entry point into behavior change programs….

The whole notion of outreach and engagement of people, as by design of the program itself….
The ability to report on the back end….

And then, how do you improve as you go along?

A little bit about information technology, and then a case study of our Health Investment Program at Health Partners.
In terms of the background and the context, we’ve seen over the past five years or so a steady and dramatic increase in health care costs. In fact, when you look from 1999 to 2003, there is double-digit increase on an annual basis, and the total average health insurance cost per employee has gone up from roughly $3,600-$3,700 to $6,300 in 2003. And that has implications for employees in terms for out-of-pocket costs, co-pays, deductibles, and benefits. Most of us have seen this, probably most of us have experienced it, and we’ve all started thinking about it.
A couple of interesting data points have emerged, though, and it includes the employer cost changes, recognizing that they have increased roughly 13 percent per year. But when you look at, for example, the average premium increase for employers in 2003 at about $6,700-$6,800 and 2004 at roughly $7,200 or $7,300, that’s an increase of about 7.4 percent. That reflects the changing in plan designs. The 13 percent increase is not sustainable. The 7 percent is. So, the implication is that there are changes happening that do affect participant spending and that certainly reflect an evolution in terms of how employers look at this issue.
At the same time, consumers or employees are making their own moves, as you see more changes shifting -- cost changes shifting towards the employee. The employee actually does make a move on their own. When you look at the graphic here, the impact of contribution changes on enrollment – meaning, the plans that have contribution changes that are decreases (so starting at the green bar) all the way down to plans that are increasing their contribution changes, you see actually concomitant enrollment towards those plans that have a decrease.

So, in other words, as the costs shift, enrollees immediately shift over to those plans that actually decrease their contribution. Makes sense. And of course, those plans with the largest increases see the biggest drop in enrollment.

So in other words, employees are changing their way of thinking about ‘what do I do now?’
At the same time, they respond to the change in terms of their own planning and saving strategies. There is an increased enrollment from 2003 to 2004 in terms of Flexible Spending Accounts, so in response to changes in plan design – employee contributions – enrollment in those FSAs has increased by 25%. At the same time, people put more money into it, in that they defer an increased amount of 7 percent just over the course of one year.
So, the implications, or the observations here, are that employers maintain a sustainable increase in health care costs through plan design changes as well as increases or shifts over to their employees, so employee contributions increase. The employees, in turn, respond to this relatively quickly by changing to plans that have the lowest contributions, they increase their 401K contributions, and they enroll more often in the FSA type of options that become available in new products.
In addition to that, as employees are faced with the increasing financial accountability or liability for healthcare expense, they take action. In response to that, the need for health improvement – or health, if you will – to lower their own financial liability, becomes more and more apparent. In other words, if you want to start managing your financial liability in the context of health care cost, access to health promotion, disease prevention, disease self-management tools becomes very much a needed, integral part of a new plan design, or a covered benefit.
To sum up these observations and implications, at the macroeconomic level, wealth creates health and health creates wealth. Now with some of these changes, we see more and more that at the individual level, health management starts to allow for wealth management. Strong driver, when you look at that at the individual level.
Background and Context
Summing-up Observations and Implications

“The future ain’t what it used to be!”
--Yogi Berra

In Yogi Berra’s words, “The future ain’t what it used to be.”
Health Promotion Program Integration into Insurance Products

- Focus on
  - Program design
  - Key components
  - Incentives for all stakeholders
  - Reporting

With that kind of a context, let’s start taking a look at – you know – what do these programs, then, need to look like, in terms of their design if we want to integrate it into an insurance product? So we’ll look at program design principles, we’ll look at some key components, and then start talking about those economic incentives that really need to be aligned across all of the stakeholders involved, and then some of the reporting challenges.
In terms of incentives, there is a whole variety of incentives that you could build into programs – anything from merchandise award programs that really – you know, sort of the “Well-Bucks” idea. You may use those points to purchase merchandise. “Well Days,” which is really additional PTO or vacation time. Benefits design modifications, where the degree of participation in programs that meets a certain criteria is associated with an enhanced benefit sets. The MSA, or the Medical Spending Account, where you create basically a lump sum of money that is made available for a defined health care benefit. Cash payments that provide an immediate financial reward or benefit. And then premium differentials – lowering the premium based on a defined wellness related criteria and/or participation in a program. So there’s a whole variety of these incentives available.
In terms of key stakeholders for – in the context of these incentives – the employer, or maybe the purchaser, the employee and the health plan are clearly three key stakeholders. They may not be all the stakeholders, but certainly, they’re the key ones.

And in terms of incentives, and the way they look at this – what is the key incentive for employers? What’s the key incentive for an employee or for a health plan? Turns out, they all respond to money. An economic incentive is a strong driver.
So then the next question would be, how do those incentives then show up in a meaningful way for all of these stakeholders? For employers – and certainly over the past five to ten years, we’ve seen an increasing dialogue around the need for a return on the investment on particular programs. But as those return on investment data starts to come out and is used more and more often, the next step is really to start talking about reduced trend, which is really the ultimate objective, is to reduce overall trend. And there is a difference between the two. ROIs are much more in the context of a particular program, whereas trend is your overall experience.

Employees – how do these incentives show up for employees? Well, clearly a reduced premium is a major way of showing that, but also cash bonuses or payouts, you know, different ways of reaching the employee.

And for the health plan, the reduced total cost of care is a major incentive, as well as increased membership, which is on the revenue side.
Program Design
Incentives

- How do the monetary/economic incentives show-up?
  - For employers
    - Increased ROI
    - Reduced trend
  - For employees
    - Reduced premium
    - Cash bonus/payout
  - For health plan
    - Reduced total cost of care
    - Increased membership

So if you look at these two examples – there are more, but just picking two of the major ones – these would be sort of aligned across three stakeholders, and I think that’s where these incentives need to end up. They need to be in alignment with one another, so that you really create, in this kind of a case, a win-win-win.
Other program design components – first of all, the change or the behavioral health assessment – we need to figure out a way to capture that data on behavioral risk, what to take action on. The health assessments represent such a tool, and they’re being increasingly used across the industry. They’re fairly accurate. They describe the population health risk quite well. They also describe individual health risks. So it does give you an opportunity to identify out of the total group of employees that subset of individuals that is at high risk. That’s the subset that you want to immediately engage in programs.

It is also an opportunity for predictive modeling. It doesn’t get done very often today, but particularly in the context of using this self-report type of data, alongside claims data, it would give a great opportunity for predictive modeling – but in its own right, it can also be used to identify individuals at high risk but still pre-disease in a short time frame, to really impact on reduction of incidents of new disease.
It’s also an ideal access point for interventions. We can ask people, “How ready are you to make changes in these different areas where you do have risk? At the same time, how willing are you to participate, were you given an opportunity to do so?” If people indicate ‘yes, call me, let me know what’s available to me’ it’s a great opportunity to engage people proactively before that risk turns into a high cost case.

We’ve done some studies in this area, where we also showed that willingness to communicate with a health plan or a clinical care provider around taking action to lower risk is actually associated with that sub-group of the population that is already at a higher level of cost. So it gives you an opportunity to immediate get the right people in terms of their cost levels engaged to lower their costs. It also provides, then, a mechanism for proactive outreach. Unfortunately, the optimal use of this tool is limited by completion rates. So we know that, by and large, most employee groups of companies that implement health risk assessment or health risk appraisal or health assessments tend to have low completion rates. This is, again, where incentives come in.
Outreach and Engagement

- Predictive modeling critical for effective outreach to high-risk and active disease individuals and maintenance of low-risk
- Engagement into programs linked to incentives
- Without participation there is no impact
- Hand-offs to other parts of the health system optimizes impact on key outcomes in the areas of cost and quality (health)

The outreach and engagement component – the predictive modeling, again, is critical for effectively doing so, particularly when you want to reach that high-risk, high-cost sub group. Engagement into programs is also linked to the incentives, again. Not only – the incentive will drive people to complete this health assessment in the first place, but then take an action to take the next step can also be linked to incentives again, because at the end of the day, if you don’t get anybody to participate, you don’t have any impact. So then health assessments would just be a great tool to document decline in health status.

And then, if it’s possible to create hand-offs to other parts of the health system, it also optimizes, again, your chances on key outcomes in these areas of cost and quality. So if somebody indicates they are at a high likelihood for repeated admission into the hospital, just to document that is one thing, but to immediately link it to a proactive, outbound kind of action step and increasing the chances that you keep that person out of the hospital, that creates real impact on the employee (obviously), but at the same time the employer, as well as the health plan.
On the reporting end, health assessment group aggregate reports is clearly one area that needs to be done, giving feedback to those areas, those stake holders that can then use that. But at the same time, these follow-up participation reports can be blended with other employer reporting, particularly if health assessment response rates are high enough to be representative of that group so you can link it to claims or employer reporting kinds of reports.

In our setting, we’ve created sort of an approach to this using a funnel report – I’ll go over that here in a second – as well as the integration of reporting and improvement activities. What do you do with the data? And particularly in an applied setting, it’s very difficult to continuously create highly complex data driven kind of reports that need a level of expertise that you don’t find in the front line. So how do you create something – a metric, if you will – that is simple enough so that the front-line implementers and practitioners can use it and know that, on a daily basis, their program is working and is heading in the right direction? And that’s what we created – we created what we call the “Pipe Impact Metric,” and I’ll go over that as well.
First, the funnel report – basically what this is – it’s an report that starts combining claims reviews with health assessments. The claims review is where we start, and these individuals here – which is a total of 628 as an example – we start populating this as a unique individual, first on this end through claims, and then you add to it whoever did a health assessment that is left over, it is not captured in this area. So in this case, we end up with 628 people.

Out of those, 292 – 61 of those ended up in pre-disease management programs. Others went into condition specific or complex case management; then out of these 61, 20 of them when to a pre-diabetes program, 6 of them went to a pre-heart-disease program, and 35 were enrolled in programs that had ongoing either disease or risk management. In this case, it’s risk management.
When you add all this up, it allows us to report back to an employer, or at least a stakeholder of a particular population – how did we identify, where did people come from, how many of them did we engage, and what was the program that they ended up in? You’re starting to be able to track people through a system over time. So that’s one way to start combining these.

At the same time, at the total funnel, we would do the same coming out of claims review – where did these 154 go to? Which program do they end up in? And so at the end of the day, you can start accounting for the number of people that you’re actively intervening with and linking that on the back end to other reports, including claims and cost reports.
Continuous Improvement

- Adding CQI and rapid cycle improvement methods (e.g., PDSA) to program design and the impact monitoring approaches allows for improvement in real-time, as opposed to waiting until opportunities for program success have passed.
- Building the data elements needed for tracking and monitoring into the program design is critical.

Having said that, once you start tracking people through programs and you start using the data in a way that becomes actionable in terms of creating ongoing improvements, you do need to add to this, so that this whole notion of CQI – of Continued Quality Improvement – but particularly in a rapid cycle improvement method. You don’t want to wait six months to find that it didn’t work – or a year, as you do a repeat health assessment and say, “Oops, that was a good idea last year, but it didn’t work, so now we’ve got to do something different.” It would be much better if you found out on either a weekly or even a daily basis – what’s the progress? How well are we doing? What kind of a feedback mechanism do we have?

So, plan-do-study-act cycles – for programs – need to be built into program designs and impact monitoring approaches in real time. And building these data elements for tracking and monitoring into the program as it’s implemented is absolutely critical.
So the way that we looked at this is to start with the program design phase. We called it “The Four S’s of Design” – size, scope, scalability, and sustainability.

The first question of size has to do with – well, if we have a program – let’s say it’s a physical activity improvement program – what’s the effect size that we really need to end up with in order to have a significant impact at the end of the day of this program? What does the content, if you will, look like of a program that looks at physical activity or (health) promotion or improvement. What kind of physical activity? What kind of people? What type of physical activity are we talking about? Is it walking, is it swimming? Is it everything? What’s the frequency per day? What’s the intensity at which the physical activity is conducted? And at the end of the day, do enough people enroll so that you can get an impact of not only physical activity increases per individual in the group, but also, does it relate to a health benefit? So size relates to effect size, if you will.
Scope – how broadly defined is this program? Does it in fact include sky diving versus walking, or is the program limited to a walking only message? How broadly is it defined?

Is it scalable? If we look across an entire defined population – let’s say it’s 10,000 people and we want to reach 7,000 with this walking program. Is the program able to reach 7,000 people? Is it scalable enough to get that done? If it isn’t, we’ve got to change the design of it.

And sustainability – if the grant runs out after one year of intervention, what are you going to do then? Or if the pilot project funding runs out, what are you going to do then? Is it sustainable the way it’s designed?

Then once we answer these questions in the design phase, to the degree where everybody is comfortable, then we implement, and we monitor the approach to this with this Pipe Impact Metric, which is penetration in to the total group that you want to reach. Are we implementing – and particularly across multiple stakeholders – if a health plan works with an employer – and then into reaching an employee a member. You’ve got, really, three different stakeholders connected.
If the health plan does 80 percent of the work, the employer does 80 percent of the work, how much of the total work is actually reaching the individual? By the time everything is said and done, it’s not 100 percent any more. Implementation sort of reflects – you’ve got to do the work in order to get the outcomes -- and how much of this work, and how well do you do it? So you use detailed work plans to monitor that.

Participation reflects out of the total number of people that we’re trying to reach, how many actually do enroll in this program? And then finally, how many cases do we have that meet the criteria of success and effectiveness level? This effectiveness level is set at the level of the individual, not at the level of the group. So at the total group, you just monitor – you count, literally – the number of cases that meet a success criteria, and that then gives you a percentage.
So the Impact Metric, then, becomes useful in terms of monitoring – are we doing okay? Then you link this all the way back on a – let’s say it could be a weekly or a monthly basis, where you get informational penetration – so if we roll out a program and after Week 1 we get 4 percent of the population reached, maybe it’s time to go back up to scalability and say ‘our marketing approach doesn’t work, we need to do something different.’ That’s a feedback loop that you can build in as you go along, and particularly that plan-do-study-act cycle can sort of be fed through that. But in order to do that, you need access to this data on a rolling, real-time basis.
Connecting the Dots
Information Technology

- Information technology is critical in connecting all program elements
  - Enrollment data
  - Assessment data
  - Participation data
  - Integrative reporting
  - Tracking of individuals
  - Reporting process and outcomes

Connecting the dots is critical and to do it by hand is very difficult, so information technology becomes a critical component in this. Enrollment data, assessment data, participation data, integrative reporting, tracking of individuals over time, and then reporting processes and outcomes – all of those have information technology behind it, and in my mind, it’s the only way to get at some of these programs.

Reporting of process and outcomes directly, and the tracking of individuals, directly reflects this notion of, “How and when do you pay out when you put incentives into the program?” You need to know up front how that’s going to get done, so you need to be able to track it.
Do Economic Incentives Increase Participation?

The first question, then, if these programs are being rolled out and you link economic incentives in it – do they actually work? Do people respond to economic incentives? Well, there is very little data in the literature available.
A review on the impact was recently published by Serksner and others. Basically, what they find in the literature is – you see a couple of examples that are sort of on the low end of financial or economic incentives… less than $25, about $20 to $25; $50; and then all the way up to $500.

In this area, you see a pretty steep increase over a fairly low amount of money, such that by a $50 incentive, you see about a 70 percent response rate.

To get from 70 to 95 percent, you go from $50 to $500 – but there’s a big gap in between, and we don’t know what that curve looks like. You may already be there by $100, I’m not sure – but we have a little bit of data to show you on that. There is only one company out here that reports this, so there are very few data points here.

But clearly, there is a response, at the beginning, here, of this curve.
The effect of intensity of recruitment effort on response disposition

- Harvard Medical School, Department of Health Care Policy
- HealthPartners, Center for Health Promotion and Research Foundation
- Group Health Cooperative, Center for Health Studies
- Kaiser Permanente, Denver
- American Airlines, Dallas

We’ve done a little bit of work in this area, and I think it actually supports what that curve looks like. We did a project – with Harvard and a group health cooperative, Kaiser in Denver, and American Airlines – that looked at this issue of intensity of recruitment, if you will, on response disposition to health assessments.
Methods

- Sample
  - Subject sample of 2,539 employed adults
  - Four sampling frames
    - 3 frames from corporate lists of primary subscribers from 3 health plans
    - 1 frame from current employees from a large self-insured corporation
  - Site-specific sub-samples included
    - random sample
    - heavy utilizers of primary care (10 or more visits per year)
    - chronic disease patients (CHF, diabetes)
    - current treatment for emotional problems (chronic fatigue, irritable bowel)
    - prior history of depression-related disorder treatment


We looked at a sample of roughly 2,500 employed adults. They came out of three frames from corporate lists and one frame from a current employer, which was American Airlines. Site-specific samples included – there was a random sample – sub-samples, rather – a random sample – we looked at heavy utilizers of primary care, chronic disease patients, current treatment for emotional problems, and prior history of depression.
The procedures that we went through – health risk appraisal was implemented, but it was expanded with measures of productivity, of work performance; we used IVR technology, using the telephone and a touch pad on the phone to collect the data – we mailed the invitations to call into this 800 number – but because of this previous slide that sort of shows that at zero incentive, you get low response, we were very worried about bias if you’re going get, in fact, this 20 percent response or so.

So, we integrated the sensitivity analysis, where we took – after the mailing to all of the subjects, which was 2,539, we did a reminder post card at two weeks. Then we created two random sub-sets of non-responders up to that point – 400 and 200 people. All those 600 folks received a telephone call for completion of the survey. Three attempts were made. Then the 400 sub-group was offered no incentive, but 200 of those people were offered $20 to complete.
These were some of the measures. The HRA did demographics, medical history, all the way down to work performance.
What happens to response rate? Well, the first group – about 20 percent response rate, so it kind of fits into that earlier slide that shows you the literature review, if you will. The second group, that got one or two mailings – 26 percent response rate. The third group which got the telephone call outreach jumps up to 51 or 52 percent. Then you add $20, and you get an additional 18 or 16 percent, close to 70 percent here – which fairly close resembles what that earlier slide looked like.
The effect of intensity of recruitment effort on prevalence of chronic conditions

No statistical differences for condition rates across recruitment sub-samples ($\chi^2$, p>0.05)


Because of that sensitivity analysis, we also were able to show that, in fact, the group was not differentially affected when you looked, for example, at chronic conditions. So all of these four groups – these bars look at each – colored bar, colored section, if you will – similar response rates for people with no chronic conditions, one or two, three or four, or five or more. So there are no differences between each of these sub-samples.
Results-Response Rate and Prevalence

The effect of intensity of recruitment effort on prevalence of work impairments (productivity decrements)

No statistical differences for condition rates across recruitment sub-samples ($F_{3,4}$, $p>0.05$)


And same in terms of their productivity or work performance outcomes, in terms of absenteeism, the quantity of work performed, the quality of work performed, interpersonal relationships with co-workers, or overall job performance – no significant differences.

So that’s an important lesson that at least economic incentives don’t differentially affect the bias – or don’t bias – the responses across these indicators.
“Look Before You Leap…”
Economic Incentives and Legal and Regulatory Issues

- HIPAA
  - Applies to only “bona fide wellness programs” that meet 4 criteria:
    - Limit the reward to a specified amount
    - Be reasonably designed to promote health and prevent disease
    - Be available to all similarly situated individuals
    - Inform employees that individual accommodations and alternatives are available
  - All wellness programs that are based on participation rather than outcomes are permitted
  - Allows plan designs that establish discounts, rebates, modified co-payments and deductibles for individuals who meet criteria for specific health promotion programs


Now having said all that – sort of look before you leap – as soon as you start integrating economic incentives into programs, you want to probably run rather than walk to your legal counsel. You want to make sure you stay out of deep weeds. So now, with HIPAA and the privacy rules – HIPAA applies only to what’s called bona fide wellness programs. The four criteria that are linked to that is that the reward is limited to a specified amount, that it is reasonably – that the program itself is reasonably designed to promote health and prevent disease, that it’s available to all similarly situated individuals, and that it informs employees that individual accommodations and alternatives are available. So you need to meet those criteria right away.

At the same time, you’re much better off incenting based on participation, which allow an individual a choice, rather than outcomes, which may not be under the individual’s control. Some people just can’t lower their cholesterol, and who are we to say that they can? Participation keeps you, again, focusing on the side of safety.

At the same time HIPAA allows plan designs that establish discounts, rebates, modified co-payments or deductibles for individuals who meet criteria for specific health promotion programs.
“Look Before You Leap…”
Economic Incentives and Legal and Regulatory Issues

- ADA
  - Incentive programs must be designed to all “qualifying individuals with a disability” to be able to meet the eligibility criteria for payouts

- Tax Issues
  - Cash awards and fair-market value of non-cash awards are subject to Federal withholding and potential State withholding taxes

- Recommendation:
  - Seek legal council during program design phase and prior to implementation


In addition to HIPAA, there’s ADA – and incentive programs must be designed in a way that all qualifying individuals with disability can participate.

But in addition to that, you have tax issues. Depending on state tax laws, cash awards may be applicable to that, so you want to check that out beforehand. Again, my recommendation is to seek legal counsel BEFORE you implement, rather than after you implement.
Integration of Economic Incentives for Behavior Change with Benefits Design

Case Study

- HealthPartners’ Health Investment Program (HIP)
- 2003 design
- 2003 3rd and 4th quarter experience

To go through a case study, it seemed like a good idea to say, “Well, if all these are good ideas, how do you actually, then, put something like this together and make it part of an integrated package, if you will, that does link economic incentives to behavior change as well as insurance products?” So, the Health Investment Program was something that was designed in 2002. In 2003, we had quite a few groups take the early steps to implement this, so this particular data is reflective of our third to fourth quarter experience in 2003 – and I’ll give you some data on that.
The basis design of the program sort of looks like this; in the first step, the employer needs to establish what they perceive to be an incentive approach that makes sense for their company to complete both a health assessment as well as participate in those health improvement programs that are really that follow-up step – that next step.

Then there is an online health assessment that gets completed, and immediately, the health plan takes action – proactive, systematic follow-up – for those people that are identified as being at high risk but still pre-disease for diabetes and heart disease, those people that have an eight- to ten-fold higher increase in risk, or likelihood, to have a diagnosis of diabetes or heart disease over the next two-and-a-half years. So that’s relatively short-term, and it’s a group of people with multiple risk factors, because the risk of those diseases is linked to a cluster of risk factors.

There are also automatic referrals to case management. For example, people that are at high likelihood for repeated admissions into the hospital, alcohol abuse links to behavioral health outreach, poly-pharmacy is linked to pharmacy outreach, and of course, each individual gets a tailored report with a personalized health improvement action plan.
On the end of the employee, as soon as the online health assessment is completed, that employee immediately becomes eligible for a health investment account. That account is linked to incentives if they participate in programs. The programs that are made available are linked to the health assessment and the risk factors that are identified. So there is something for everybody. It doesn’t mean that you have to be at high risk to participate; if you want to participate to stay at low risk – even better.

There are walking programs, healthy nutrition programs for everybody, available. There’s something for everyone. Then the participant completes that activity, earns points toward year-end rewards – we would track participation shares, reporting progress to the employer, particularly at year-end when it comes time to provide the rewards. So those points could be something like for every ten points you get $10, so that at the end of the year 10 points is linked to one program, if you complete the program and you meet the criteria for payout, you get $100 at the end of the year. It may be $100, it may be PTO time, it may be a continued reduction in premium – it’s whatever works in the setting for the employer. Then you repeat in the subsequent year the whole cycle again.
For the employer, the incentive is a guaranteed reduction in trend in the following year, but it only applies if the health assessment response rate is over 80 percent. So if you want to get something, you’ve got to do something, and it applies on all sides – both the health plan, the employer, as well as the individual employee. The individual employee, for example, gets that incentive only if they complete the health assessment, and they can do that, again linking back to the employer, if the employer decides to make it part of their eligibility for medical plan coverage, or it could be linked to financial incentives, such as a lower premium.
And so, what do we see? Well, based on incentives as well as marketing communications, this data reflects individual companies that have implemented this approach, but at different levels of incentives and how well they communicated the program. So what we’ve done is, we’ve characterized companies by being either a low, medium, or a strong incentive company and the same low, medium, or strong on marketing – how well do you communicate?

There are 78 companies in this analysis, for a total of close to 23,000 invited health assessment completers. Basically, what happens then, is you get these companies that are organized in categories – strong incentives, strong marketing and communications, all the way down to low incentives and low communications. The strong incentives, for example, is if you lower a premium for $150. Low incentives is nothing going on.
HIP
Impact of Incentives and Marketing
on HA Completion

- Data reflects:
  - Incentives/Marketing and communication
  - 78 companies in 3rd/4th Q 2003
  - Total of 22,838 HA invitees
  - 77.1% of the variance in HA completion is explained by type of incentive and marketing and communication
- Incentives
  - Low = e.g., merchandise awards, drawing, small gift, etc.
  - Strong = e.g., mandatory, premium reduction, co-pay reduction, etc.
- Marketing and communication
  - Low = e.g., very limited messaging, short timeline
  - Strong = e.g., appropriate messaging, communication plan and timeline

Basically, the trend line explains about 77 percent of the variance in completion of the health assessment. Going back, then, we can start placing new companies on this trend line and, up to this point, it’s working pretty good. Companies that come in with medium and strong sit somewhere between the 60 and 40 percents, and it fits pretty nicely. So now this at least becomes a tool to support the companies and the employers in terms of designing their rollout of these kinds of programs.
Then when I looked at a couple of companies more like on a case study basis – here are four companies presented, in terms of – first of all, the first step is the health assessment completion, the first employer has no incentives, medium incentives for the rest.

Then the next step is the follow-up step. Out of this group of employees of 30, 80, 50, and 75 percent, some of them, a percentage of them, is at high risk. So we follow-up proactively with that group. (And what’s the response that we get over here in terms of outreach?) And out of this group, what’s the percentage that actually engages and does something?

Basically, what we start seeing is that the employers that start high on the health assessment data itself – Employer 2 and 4 – end up with the highest percentage of rank performance, if you will, in terms of engaging, which is not a surprise when you go back to that Pipe Impact Metric, which basically says, “If you don’t penetrate well, you know, you start going downhill from there.”
So if you don’t penetrate well, you’re not going to have high participation, and that shows up right in here, where Employer 1 starts low and ends up with only 3 percent of all completers engaged, whereas Employer 2 and 4 start high and end up with 28 and 15 percent. In other words, if you start high, you’re going to end up okay. If you start low, you end low.
In conclusion, it looks like economic incentives for behavior change programs are feasible. The incentives appear to increase participation for individuals. And we also need to make sure that they’re combined with good communications and marketing messaging. People need to know what’s coming at them. Successful implementation also is strongly related to efficient use of information technologies, and efficiency is a big factor there.
Parting Thought

“The obscure we see eventually.
The completely obvious, it seems, takes longer.”

--Edward Murrow

So that’s where I would stop. I’ll leave you with this thought – that the obscure we see eventually; the completely obvious it seems takes a little longer.

Thank you.