GUIDELINES & RECOMMENDATIONS FOR IMPLEMENTING OUTCOMES-BASED INCENTIVES

A RedBrick Health Whitepaper

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EXECUTIVE SUMMARY

As part of their efforts to improve the health of employee populations, employers are increasingly exploring the integration of outcome-based incentives into existing incentive program designs. Outcome-based incentives differ from activity-based incentives in that they reward individuals based on actual results realized from healthy activities—such as reducing blood pressure levels—rather than incenting based solely on healthy activities completed, such as participating in a coaching program, that may or may not lead to a measurable difference in key health factors.

Outcomes-based incentives can be more complex to implement than activity-based incentives. However, being familiar with a few guidelines and best practices can help employers successfully leverage the benefits of outcomes-based incentives as part of a total incentive design package.

The following recommendations address the unique legal considerations of implementing outcomes-based incentives. A summary of recommendations follows to provide guidance on which Healthy Factors to measure and incent, and what appropriate expectations are for each Healthy Factor.

With an informed set of expectations set around Healthy Factors, as well as an awareness of the taxation, non-discrimination and privacy laws governing outcomes-based incentives, employers can successfully incorporate outcomes-based incentives into their overall incentive program designs. A combination of rewards for healthy outcomes along with incentives for participation in healthy activities can increase employees’ engagement in health and wellness programs—and reward employees whose efforts pay off in the form of improved Healthy Factor outcomes.
Many employers are turning to health activity-oriented financial incentives as a way to increase engagement in programs and to align the interests of employers and employees around better health. Some employers are beginning to explore outcome (or results)-based incentives in order to increase accountability. At RedBrick Health, we support clients in successfully implementing both activity and outcomes-based health incentives. To maximize engagement and minimize employee dissatisfaction, we recommend an outcomes-based incentive design that balances rewards for healthy outcomes with incentives for participation in health improvement activities. This type of design aligns with emerging industry best practices, and helps organizations implement accountability-oriented incentive designs while recognizing that an individual's health measure can be influenced by a complex set of factors.

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The outcomes that are typically measured and incented – Body Mass Index (BMI), cholesterol and blood pressure – correlate to a population's future risk for illness and disease. Our approach to determining the target healthy factors for outcomes-based incentives is supported by the latest clinical research and guidelines for population-based risk levels and measurements. These measures are representative for a wide population, but each individual's elevated risk metrics need to be considered in the context of their entire range of risks, including personal and family history. For example, a blood pressure of 130/90 will not materially shorten the lifespan of every individual at this level. An individual's elevated risks identified through a health screening are best evaluated in consultation with their personal physician.

The clinical guidelines and research regarding biometric risk factors continues to evolve over time. RedBrick Health is constantly monitoring the latest research and providing updates to our clients on current best practices. The guidelines are set by the U.S. Preventive Services Task Force (USPSTF), which reviews a broad range of clinical preventive health care services and develops recommendations for health care organizations. Their recommendations are published in the form of “Recommendation Statements” and are utilized by RedBrick Health. For more information about the USPSTF, visit www.USPreventiveServicesTaskForce.org.

In order to make it scalable and practical for employers to implement an outcomes-based incentive model, we balance the strictest interpretation of the current research with what can be achieved practically, efficiently and cost-effectively. RedBrick Health recommends annual health screenings for simplicity of understanding and implementing. Customizing the timing of each screening based on age, gender, personal history and additional risks adds a high level of complexity to the screening process that quickly becomes unmanageable and unsustainable. The annual health screening model is a practical compromise of evidence-based recommendations and developing a program that can be more easily executed and understood.
As employers pursue health and wellness program designs that produce a measurable impact, a growing number are shifting from incentive designs focused on activity to those focused on outcomes, or results. There are many models for incenting healthy outcomes with varying degrees of risk relative to the current regulatory guidance. While RedBrick Health will provide an overview of the current regulations governing outcomes-based incentives, along with our recommendation for how to implement such a model, we strongly advise each company to consult with its legal counsel before implementing an outcomes-based incentive design.

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Health and wellness programs, particularly those with outcomes-based incentives, represent a rapidly developing area of law. Program designs continue to outpace regulators in their efforts to provide clear guidelines. The following laws govern health and wellness programs and cover everything from discrimination to privacy, taxation and more.

**HIPAA NON-DISCRIMINATION RULES**

These rules stipulate that plans may not vary premiums or contributions, or provide different discounts or rebates, to similarly situated individuals as a result of a health factor. Even if a wellness program is not a group health plan, linking it to a health plan through a premium reduction invokes these rules. Key considerations include:

- The total rewards for all wellness programs within the health plan must not exceed 20% of the cost of coverage (PPACA increases the percentage to 30% in 2014).
- The program must be designed to promote good health or prevent disease.
- All individuals eligible for the program must have an opportunity to qualify for the incentives at least once a year.
- Program rewards must be available to all similarly situated individuals, and a reasonable alternative standard must be available to achieve the reward to anyone who could not otherwise obtain the reward because of a health condition.
  - The health plan must disclose the alternative minimum standard in all materials describing the terms of the wellness program.
  - One way to meet the alternative minimum standard requirement is to offer a waiver option to individuals who obtain validation from their physician that it is unreasonably difficult or medically inadvisable to achieve or attempt to achieve the outcomes-based incentives.

To accommodate the alternative minimum standard, RedBrick Health recommends using healthy activity participation as an alternative to earning the healthy factor incentives.
AMERICANS WITH DISABILITIES ACT (ADA)

The ADA requires employers to provide reasonable accommodations to qualified individuals with disabilities. Employees who have difficulty attaining an incentive because of a disability may need to be provided with reasonable accommodations to allow them to earn the incentive. Even if a program is not subject to the “reasonable alternative” rules under the HIPAA non-discrimination rules, it may be subject to the ADA “reasonable accommodation” rules.

Additionally, the wellness program must also comply with the ADA Privacy Rules. These rules limit the ability of employers to conduct medical examinations or make disability-related inquiries, which applies to health assessments and health screenings. Accordingly, employers may not require participation or penalize employees who do not participate. An exception to this rule exists for “voluntary” medical examinations.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

Title I of GINA prohibits a group health plan from collecting genetic information prior to enrollment and using genetic information, which is defined to include family medical history, for underwriting purposes. It states that a request to complete a health assessment that includes questions on family medical history is a request for genetic information, and if premium reductions are offered, this is treated as using genetic information for underwriting purposes and may violate the prohibition on collecting genetic information prior to enrollment. Title II of GINA provides that an employer may collect genetic information as part of a wellness program subject to various requirements, including:

- Offering a waiver option
- Only seeing genetic information in aggregate terms

ADDITIONAL LEGAL CONSIDERATIONS AFFECTING WELLNESS PROGRAMS

- Incentives tied to group health plan premiums, deductibles, copays or coinsurance are subject to the rules governing taxation of group health plans. Cash or gift cards are taxable, regardless of amount. Taxable incentives must be included on the employee’s Form W-2 and are also subject to withholding of employment taxes.

- The Civil Rights Act of 1964 (Title VII) prohibits disparate treatment of members of a protected class (some diseases may be more prevalent in protected classes, and programs that offer cash rewards based on health factors could be in violation).

- The Age Discrimination in Employment Act (ADEA) is not likely to be an issue in most wellness programs unless rewards are tied to athletic performance standards that have a disparate impact on older employees.

- When not preempted by ERISA, state laws may have broader definitions of prohibited discrimination (for example, Michigan prohibits discrimination based on height or weight).

- Many states protect the rights of employees to engage in lawful activities away from the workplace (for example, smoking).

The Department of Labor provides a Wellness Program Checklist that is a helpful resource for employers. The checklist is available at http://www.dol.gov/ebsa/pdf/fab2008-2.pdf.
Our recommendations use evidence-based measures that correlate with improvements in health status and corresponding cost savings. While there are other measures that are effective for some individuals, the recommended healthy factors have been thoroughly studied and are proven to be applicable to a wide population. RedBrick Health recommends measuring and rewarding healthy factors using the following guidelines.

**TOBACCO**

**Recommended Measurement:** Non-user, identified through enrollment or the Health Assessment

**Healthy Factors:** Not currently using tobacco products

Tobacco use is the worst lifestyle habit in terms of reducing lifespan and leading to cancer, heart attacks, stroke and COPD. Tobacco cessation has improved the lifespan of Americans much more than any other health care change over the past 50 years. Reduction in tobacco use, from more than 50% of adults in the 1950s to just over 20% of adults now, has added an average of three years to the life expectancy along with better control of blood pressure, cholesterol and many other medical factors within a year of cessation (NEJM, 2007).

Many companies now offer wellness incentives to non-smokers, or have different medical plan premiums for those who smoke. When not smoking is incented, it is believed that as many as one-third to two-thirds of smokers falsely state that they do not smoke.

**ALTERNATIVE APPROACHES TO MEASUREMENT**

Most companies rely on an “honor code” to capture tobacco use. Some additional practices are sometimes used, including:

- Non-tobacco user pledges or attestations during open enrollment to encourage more honesty in stating tobacco status.
- Cotinine testing with a mouth swab to confirm that the individual has not recently used a product containing nicotine. If individuals report that they are using nicotine replacement products, an alternative measurement could be ordered, or an exception could be granted.

**RECOMMENDED APPROACH TO EXCEPTIONS**

Incentives and restrictions on tobacco use tend to be very political. The regulations vary from state-to-state; in fact, more than half of the states have laws protecting smokers’ rights. Because of the complexity of the regulations surrounding this issue and the risks involved, we strongly advise each company to consult with its legal counsel before implementing a tobacco-related incentive. Regarding the tobacco-related incentive structure, we recommend incenting those who are not currently using tobacco, and offering those who are using tobacco the alternative of completing a tobacco cessation program to earn the incentives.

“Our recommendations use evidence-based measures that correlate with improvements in health status and corresponding cost savings.”
III. RECOMMENDED HEALTHY FACTORS

References
• Minnesota Smoker Employment Statute: https://www.revisor.mn.gov/statutes/?id=181.938
• American Lung Association (ALA) listing of Smoker Protection States:
  http://www.lungusa2.org/slati/appendixf.php
• ALA State Compilation of all Tobacco Regulation: http://www.lungusa2.org/slati/states.php

WEIGHT
Recommended Measurement: Body Mass Index (BMI)

Healthy Factors:
• Underweight: <18.5
• Healthy: 18.5-24.9
• Overweight: 25-29.9
• Obese: 30+

BMI is derived from a formula that uses weight and height to estimate body fat and gauge health risks caused by carrying too much weight. The purpose of the BMI measure is to identify individuals that are likely to be at high-risk for illness or disease. While no measurement is perfect for every individual, BMI provides a reliable indicator of an individual’s body fat percentage for a majority of people and is the most researched and practical measurement of being overweight or obese.

Multiple studies have shown that being overweight or obese, as defined above, are associated with increased mortality. For example, each one point increase in BMI is associated with a 12% increase in hypertension, even in the 20 to 25 BMI range (Source: Huang, et al, Annals Internal Medicine, 1998; 128:81-88). As shown on the following page, all-cause mortality is generally the lowest with a BMI of 20 to 24.9.


ALTERNATIVE APPROACHES TO MEASUREMENT
There are two additional methods that are sometimes used to measure whether an individual’s weight is healthy for them. Those include:

• Waist circumference –The intent of waist circumference is to identify individuals in the overweight BMI range of 25 to 29.9 that are at an even higher risk than those with a smaller waist circumference. It is not helpful in identifying individuals with a high BMI but with low clinical risk. This measurement is sometimes used to grant an exception for those with a BMI in the 25 to 29.9 range who may not be at higher risk; however, this is an unproven association, as shown below.

**III. RECOMMENDED HEALTHY FACTORS**

- **Body composition** — This measurement divides the composition of an individual’s body into a fat component and a non-fat component. Health risk is closely associated with the fat component and distribution. The search for valid methods of measuring body composition that are both practical and inexpensive is an ongoing process. Most practical methods have a relatively high error factor that can be increased dramatically due to the skill level of the technician taking the measurement. While body composition can be a valid measurement on an individual basis, most related research has validated BMI as the measure most closely associated with health status change. For this reason, we do not recommend using body composition as an alternative measurement for those with a BMI over 25.

**ALL-CAUSE MORTALITY RELATIVE TO BMI**

Furthermore, the USPSTF states the following regarding alternative measurements of weight:

“A number of techniques, such as bioelectrical impedance, dual-energy X-ray absorptiometry, and total body water can measure body fat, but it is impractical to use them routinely. Body Mass Index (BMI), which is simply weight adjusted for height, is a more practical and widely-used method to screen for obesity. Increased BMI is associated with an increase in adverse health effects. Central adiposity increases the risk for cardiovascular and other diseases independent of obesity. Clinicians may use the waist circumference as a measure of central adiposity.”

*The Diabetes Prevention Project showed that people at risk for developing diabetes can prevent or delay the onset of diabetes by losing a modest amount of weight (at least 5%) through diet and exercise.*
We recommend incenting those with a BMI in the healthy range and those who have decreased their BMI by a pre-determined percentage since their last health screening.

Suggested levels for incenting a BMI decrease are:
- 5% for a more conservative approach
- 10% for a more aggressive approach

These levels are evidence-based and correlate with risk reduction. The Diabetes Prevention Project showed that people at risk for developing diabetes can prevent or delay the onset of diabetes by losing a modest amount of weight (at least 5%) through diet and exercise. More information is available at ndep.nih.gov.

To avoid many exceptions to the BMI measurement, some companies will incent the healthy level of BMI at 27.5. The research suggests that all-cause death rates start to climb with a BMI over 25, but much more so with a BMI over 27.5.

### RECOMMENDED APPROACH TO EXCEPTIONS

There is no exception for BMI that is valid in every case. Individuals with a BMI that is not considered healthy should be evaluated by their physician, who can assess all related risk factors and determine if that individual is not at high risk. Based on the physician’s evaluation, an exception to the standard can be granted if that individual is determined to be healthy.

Reference: http://www.uspreventiveservicestaskforce.org/3rduspsf/obesity/obesr.htm

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### RECOMMENDATION FOR INCENTING

<table>
<thead>
<tr>
<th>Class</th>
<th>Disease Risk* Relative to Normal Weight and Waist Circumference</th>
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<tbody>
<tr>
<td>Underweight</td>
<td>Men &lt; 102 cm (40 in) and Women &lt; 88 cm (35 in) Men &gt; 102 cm (40 in) and Women &gt; 88 cm (35 in)</td>
</tr>
<tr>
<td>Normal</td>
<td>Men &lt; 102 cm (40 in) and Women &lt; 88 cm (35 in)</td>
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<tr>
<td>Overweight</td>
<td>Increased</td>
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<tr>
<td>Obesity</td>
<td>High</td>
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<tr>
<td>Extreme Obesity</td>
<td>Extremely High</td>
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* Disease risk for type 2 diabetes, hypertension, and CVD.
† Increased waist circumference also can be a marker for increased risk, even in persons of normal weight.

CHOLESTEROL

**Recommended Measurement:** Total cholesterol

**Healthy Factors:**
- Healthy: <200
- Moderate Risk: 200-239
- High Risk: >240

Cholesterol is a soft, waxy substance in blood and cells that the body makes and that is found in some foods. There are two types of cholesterol:
- **Low-density lipoprotein (LDL)** – LDL is the “bad” cholesterol. Over time, it builds up in the vessels that carry blood through the body. This build-up can block the flow of blood to the body.
- **High-density lipoprotein (HDL)** – HDL is the “good” cholesterol. It clears “bad” cholesterol from the arteries.

If there is too much LDL cholesterol in the blood, it can stick to the walls of arteries and develop a plaque. Plaque can narrow the arteries, reducing blood flow, or the plaque can break off and form a blood clot that travels to the heart or brain causing a heart attack or stroke.

**ALTERNATIVE APPROACHES TO MEASUREMENT**

There are two additional methods that are sometimes used to measure whether an individual’s cholesterol is healthy for them. Those include:
- **Cholesterol ratio** – The cholesterol ratio is found by dividing HDL by total cholesterol. This measure is no longer used because it is not specific enough to predict future risk.
- **LDL** – The LDL is the single best measure for cholesterol risk, but it is difficult to measure directly with a finger stick. The most common and cost effective method to measure LDL is to calculate the LDL, which requires a measurement of triglycerides. Triglycerides measurements vary widely and fluctuate with recent diet intake and therefore are only accurate when fasting. Additionally, inaccuracies in the calculation can occur if the triglycerides or the total cholesterol is very low.

**RECOMMENDATION FOR INCENTING**

We recommend incenting those with total cholesterol in the healthy range and those who have moved into a better risk tier since their last health screening.

**RECOMMENDED APPROACH TO EXCEPTIONS**

The purpose of the cholesterol screen is to identify those who may be at risk due to high cholesterol. For those outside of the healthy cholesterol range, we recommend considering the following exceptions:
- Those with LDL less than 130
- Those with a total cholesterol minus HDL of less than 160

The measurement of total cholesterol includes the LDL, HDL and a small amount of other cholesterol subtypes. The total cholesterol may be high due to a high LDL, a high HDL or both. There is no specific HDL cut off above which an individual would automatically be considered at low risk. Risk increases at all cholesterol levels if there are additional risks present, such
as obesity (BMI >30), hypertension, tobacco use, family history of cardiovascular disease, personal history of cardiovascular disease and diabetes.

We recommend that anyone with total cholesterol outside of the healthy range, with the exceptions noted above, be evaluated by a physician who can then request an exception to the standard if that individual is determined to be healthy.

Reference: http://www.uspreventiveservicestaskforce.org/uspstf/uspschol.htm

**BLOOD PRESSURE**

**Measure:** Blood pressure (systolic over diastolic)

**Healthy Factors:**
- Healthy: <120/80 mm Hg
- Moderate Risk: 120-139/80-89 mm Hg
- High Risk: >140/90 mm Hg

Blood pressure measures the force of blood pushed through the vessels that carry blood throughout the body. It is measured as two numbers:

- **Systolic pressure** – This is the first number in a blood pressure reading. It shows the pressure when the heart contracts and pumps blood into the body.

- **Diastolic pressure** – This is the second number in a blood pressure reading. It shows the pressure when the heart rests in between heart beats.

High blood pressure, also called hypertension, makes the heart work harder. Over time, it damages the blood vessels that carry blood through the body. If uncontrolled, it can cause a heart attack or stroke. High blood pressure can also lead to heart failure, kidney disease, blindness and other health issues.

*Note: If systolic and diastolic measures fall into different risk categories, then blood pressure as a whole is considered to be in the higher of the two risk thresholds (for example, a blood pressure of 130 / 95 is considered a high risk measure).*

**ALTERNATIVE APPROACHES TO MEASUREMENT**

There are no alternative approaches used to measure blood pressure.

**RECOMMENDATION FOR INCENTING**

We recommend incenting those with a blood pressure in the healthy range and those who have moved into a better risk tier since their last health screening.

**RECOMMENDED APPROACH TO EXCEPTIONS**

The purpose of the blood pressure screen is to identify those who may be at risk due to high blood pressure. There are no standard exceptions for the blood pressure measurement. For those who have an initial reading of high blood pressure at the health screening, we recommend that the screener re-tests the reading three times.

For those outside of the healthy blood pressure range, we recommend that they be evaluated by a physician who can then request an exception to the standard if the individual is determined to be healthy.

Reference: http://www.uspreventiveservicestaskforce.org/uspstf07/hbp/hbprs.htm
For more information, contact RedBrick Health at 612.659.3065