

The Law, Policy & Ethics of Employers' Use of Financial Incentives to
Improve Health

Kristin M. Madison, Kevin G. Volpp & Scott D. Halpern
Draft Version: June 2011

*A revised version of this article was published in volume 39 of the
JOURNAL OF LAW, MEDICINE & ETHICS, and is available at
<http://onlinelibrary.wiley.com/doi/10.1111/j.1748-720X.2011.00614.x/pdf>.*

Abstract. The Patient Protection and Affordable Care Act (ACA) turns to a nontraditional mechanism to improve public health: employer-provided financial incentives for healthy behaviors. Critics raise questions about incentive programs' effectiveness, employer involvement, and potential discrimination. We support incentive program development despite these concerns. The ACA sets the stage for a broad-based research and implementation agenda through which we can learn to structure incentive programs to not only promote public health but also address prevalent concerns.

The Law, Policy & Ethics of Employers' Use of Financial Incentives to
Improve Health

Introduction.....	1
The Expanding Use of Health Incentives	2
The ACA's Support for Employer-Sponsored Health Incentives.....	4
Three Controversies	5
I. Do Incentive Programs Work?.....	6
Incentive programs in theory	6
Incentive programs in practice.....	7
The challenges of incentive program design	9
II. Employers' Roles in Incentive Programs	11
Concerns about employer-sponsored incentive programs	11
Reasons to support employer involvement	12
III. Ethical Considerations in Incentive Program Design	14
Incentive programs' potential for discrimination	14
Addressing incentive program barriers.....	16
Incentive program design: Carrots and sticks.....	19
The ethics of sticks.....	21
The ethics of carrots.....	26
IV. The ACA's Limits on Program Design	28
V. The Need for Further Research and Evaluation.....	32
Conclusion	34

INTRODUCTION

Individuals can often take steps to preserve or improve their own health. They can eat appropriate quantities of healthy foods, exercise, and refrain from smoking. They can obtain preventive care and adhere to their physicians' advice about how best to manage their health. But they often fail to take these steps.

A widespread failure to adopt healthy behaviors can significantly erode public health while increasing health care costs. Obesity, for example, increases the risk of heart disease, stroke, liver disease, and

certain cancers.¹ By one estimate, it is responsible for almost 10 percent of medical spending in the United States, or about \$147 billion per year.² Smoking increases the risk of heart disease, stroke, lung disease, and cancer; it accounts for nearly twenty percent of deaths each year in the United States and about \$96 billion in health care expenditures.³

Public health officials, health care providers, health insurers, and others have historically used many techniques to encourage individuals to improve their own health. In recent years, however, one particular mechanism for health improvement has attracted increasing attention: financial incentives.

The Expanding Use of Health Incentives

Financial incentive programs designed to promote healthy behaviors take many forms. They vary in the identity of their sponsors, the structure of their incentives, and the nature of the activities or outcomes they incentivize. Governments, for example, have been active in developing financial incentive programs. Mexico has given cash transfers to millions of families fulfilling conditions related to education, nutrition, and health, such as obtaining childhood immunizations and getting physical checkups.⁴ In a privately funded demonstration modeled after Mexico's program, New York City paid cash rewards to participating families receiving medical checkups.⁵ Australia pays families a "maternity immunization allowance" totaling more than \$250 for children who meet immunization requirements at designated ages.⁶ A few state

¹ Centers for Disease Control and Prevention, *The Health Effects of Overweight and Obesity*, available at <http://www.cdc.gov/healthyweight/effects/index.html>.

² E.A. Finkelstein, J.G. Trogon, J.W. Cohen and W. Dietz, "Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates," *Health Affairs* 28 (2009): w822-w831, at w822.

³ Centers for Disease Control and Prevention, *Smoking and Tobacco Use*, available at http://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/

⁴ See P. Gertler, "Do Conditional Cash Transfers Improve Child Health? Evidence from PROGRESA's Control Randomized Experiment," *American Economic Review* 94 (2004): 336-341. The program is now called Oportunidades. See *Oportunidades, A Human Development Program*,

http://www.oportunidades.gob.mx/Portal/wb/Web/oportunidades_a_human_development_program; Peter Bate, *The Story Behind Oportunidades*, available at <http://www.iadb.org/idbamerica/index.cfm?thisid=3049>.

⁵ See NYC Center for Economic Opportunity, Opportunity NYC, http://www.nyc.gov/html/ceo/html/programs/opportunity_nyc.shtml; J. Riccio, N. Dechausay, D. Greenberg, C. Miller, Z. Rucks and N. Verma, "Toward Reduced Poverty Across Generations: Early Findings from New York City's Conditional Cash Transfer Program," (March 2010): ES-4, available at <http://www.mdrc.org/publications/549/execsum.pdf>.

⁶ Australian Government, Payment Rates, http://www.centrelink.gov.au/internet/internet.nsf/payments/mat_rates.htm.

Medicaid programs have used financial incentives to encourage healthy behaviors, such as taking prescribed medications, obtaining checkups and immunizations, and participating in smoking cessation programs.⁷

Individuals can create their own incentive programs, too. The website StickK.com allows users to create commitment contracts in which they define their own goals, such as losing weight, eating better, or going to the gym.⁸ Users can also choose to put some of their own money at stake as an incentive. If the user fails to achieve his or her goal, the money is then redirected to the recipient previously designated by the user.

Perhaps the most rapidly growing type of health incentive program, however, is the employer-sponsored program. Employers have long taken an interest in employee health, but financial incentive programs are relatively new. By the early 1990s, a few employers had begun to tie financial incentives to health-related characteristics and activities. Some offered cash rewards or health insurance premium adjustments based on participation in health risk assessments or screenings; others adjusted insurance premiums based on smoking status, weight, cholesterol levels, blood pressure levels, or exercise habits.⁹ By the end of the 1990s, incentive use had increased significantly. While a 1990 survey of 1,000 employers found that only four offered financial incentives for wellness, by 1999, a national survey of worksites with fifty or more employees found that about ten percent offered health incentives.¹⁰

Today, employer use of financial incentives is even more widespread. A recent national survey of nearly 600 employers with more than 1,000 employees found that about 25% tied incentives to enrollment in healthy lifestyle activities, 22% to tobacco use, and 6% to biometric measures such as weight or cholesterol levels.¹¹ The same survey suggests

⁷ J. Greene, *Medicaid Efforts to Incentivize Healthy Behaviors*, Center for Health Care Strategies, Inc., Pub. 299 (July 2007), available at http://www.chcs.org/usr_doc/Medicaid_Efforts_to_Incentivize_Healthy_Behaviors.pdf.

⁸ StickK, *The Smartest Way to Set and Achieve Your Goals*, <http://www.stickk.com>.

⁹ S. Caudron, "Are Health Incentives Disincentives?", *Personnel Journal* (Aug. 1992): 35-40.

¹⁰ R. Priester, "Are Financial Incentives for Wellness Fair?", *Employee Benefits Journal* (March 1992), 38-40, at 38 (noting results of 1990 survey); R. Christensen, "Employment-Based Health Promotion and Wellness Programs," *EBRI Notes* 22 No. 7 (July 2001): 1-6, at 2 (describing results from the 1999 National Worksite Health Promotion Survey, conducted by the Association for Worksite Health Promotion, William M. Mercer, Inc., and the U.S. Department of Health and Human Services' Office of Disease Prevention and Health Promotion).

¹¹ National Business Group on Health and Towers Watson, *The Road Ahead: Shaping Health Care Strategy in a Post-Reform Environment*, 15 (2011), available at <http://www.towerswatson.com/assets/pdf/3946/TowersWatson-NBGH-2011-NA-2010-18560.pdf>.

that prevalence of these programs will increase rapidly; for example, about 40% of employers report an intention to implement biometric outcome incentives in 2011 or later.¹² These large employers may not be representative of all employers, but their actions do demonstrate increasing levels of employer interest in health incentives.

The Affordable Care Act's Support for Employer-Sponsored Health Incentives

The Patient Protection and Affordable Care Act (ACA) both reflects and promotes growing interest in employer incentive programs. Encouraged by the reported experiences of large employers such as Safeway, legislators included several wellness program-related provisions in the ACA.¹³ One provision, sometimes referred to as the “Safeway Amendment,” increases the magnitude of financial incentives that may be used as part of employer wellness programs.¹⁴ While under previous regulations, employers were permitted to tie up to twenty percent of the cost of insurance coverage to achieving standards related to health factors, the ACA lifts this ceiling to thirty percent, and gives the Secretaries of the Departments of Labor, Health and Human Services (HHS), and Treasury the discretion to further raise the ceiling to fifty percent.¹⁵

The ACA also offer grants for small employer wellness programs that include initiatives to change unhealthy behaviors, and requires HHS to provide employers with technical assistance to evaluate wellness

¹² Id.

¹³ See The White House, Fact Sheet: Innovative Workplace Practices: A Discussion with President Obama (May 12, 2009) (describing employer wellness initiatives and stating that the “president hopes that by encouraging more employers to adopt similar programs, we can improve the productivity of our workforce, delay or avoid many of the complications of chronic diseases, and slow medical cost growth”), available at http://www.whitehouse.gov/the_press_office/Fact-Sheet-Innovative-Workplace-Practices-A-Discussion-With-President-Obama/; Steven A. Burd, “How Safeway Is Cutting Health-Care Costs,” Wall Street Journal, June 12, 2009 (describing Safeway wellness program initiatives and calling for increasing the legal limits on the use of financial incentives). David S. Hilzenrath, “Misleading Claims about Safeway Wellness Incentives Shape Health-Care Bill,” WASHINGTON POST, January 17, 2010 (describing how Safeway shaped legislative debate but suggesting that Safeway’s experiences do not demonstrate that incentives prevent health care cost increases).

¹⁴ Patient Protection and Affordable Care Act § 1201, to be codified at 42 U.S.C. § 300gg-4. See also D.S. Hilzenrath, “Misleading Claims about Safeway Wellness Incentives Shape Health-Care Bill,” WASHINGTON POST, January 17, 2010 (referring to the “Safeway Amendment”).

¹⁵ See 26 C.F.R. 54.9802-1(f)(2)(i), 29 C.F.R. 2590.702(f)(2)(i), 45 C.F.R. 146.121(f)(2)(i) (regulations imposing twenty percent ceiling); ACA § 1201, to be codified at 42 U.S.C. § 300gg-4(j)(3)(A).

programs.¹⁶ Although the ACA promotes health incentive programs in a variety of contexts, including Medicaid programs and individual insurance markets, it clearly contemplates a central role for employers in offering incentives to promote healthy behaviors.¹⁷

Three Controversies

The ACA's support for employer incentive programs is controversial in a number of respects. First, many people question the effectiveness of incentive programs in improving health, regardless of the identity of their sponsor. Second, some people argue that it is not appropriate for employers to take such a significant role in influencing their employees' health. Third, many critics view financial incentive programs as coercive or as potential tools for discrimination.

This Article will consider each of these arguments in turn. In Part I, we discuss how incentive programs might improve health in theory and briefly review empirical evidence on their effects in practice. This evidence is decidedly mixed, showing that financial incentives do have the potential to improve health-related behaviors, but that their success is far from universal. We suggest that recent work in behavioral psychology and economics may provide guidance on how to improve program effectiveness but that more research on program design is needed.

In Part II, we argue that employers may be key partners in improving public health by addressing health behaviors. In addition to having both the incentive and administrative capabilities necessary to operate incentive programs, employers may be able to take advantage of their physical and social settings to support individuals seeking to improve their own health. While not all employers will be equally well positioned to provide such support, these considerations imply that society should look to employers in addition to individuals, health care providers, and governmental entities, in our collective efforts to improve public health.

In Part III, we consider the ethical implications of incentive program design, including the potential for discrimination. We highlight the many factors that will affect employees' ability to respond to incentives, and suggest that programs should be designed so as to

¹⁶ ACA § 4303, to be codified at 42 U.S.C. § 280I (technical assistance); ACA § 10408, to be codified at 42 U.S.C. 280I note (grants for small businesses).

¹⁷ ACA § 4108 (allocating \$100 million for grants to states to test incentive programs for Medicaid beneficiaries), to be codified at 42 U.S.C. 1396a note; ACA § 1201, to be codified at 42 U.S.C. 300gg-4(l) (mandating creation of a 10-state demonstration project involving wellness programs by insurance issuers that offer health insurance in individual markets).

minimize *ex ante* differences in employees' abilities to reap the benefits of incentives. We also examine concerns related to coercion and undue inducement, identifying the limited circumstances under which such concerns might arise.

In Part IV, we briefly review the ACA's constraints on incentive programs, explaining where they do, and do not, address the concerns identified in Part III. We point out, for example, that the aggregate limit on incentives may fall short in protecting individuals against discrimination and undue inducement.

Finally, in Part V, we emphasize the need for further research on both programs' effectiveness and their unintended consequences. We suggest that regulators condition any increase in the incentive ceiling on evaluation and reporting of programs' effects. We also propose greater regulatory flexibility to permit incentive experiments. Ultimately, it is only with more research and evaluation that we will be able to assess the societal impact of incentive programs.

I. DO INCENTIVES PROGRAMS WORK?

Incentive programs in theory

Incentive programs change the relative costs and benefits of behavior, potentially leading individuals to make different choices. A busy employee might historically have been unwilling to participate in a weight loss program, but the promise of a bonus might increase the program's value just enough that the employee would decide to join. This sudden change of heart raises a question: If individuals act rationally, then does it make sense to try to alter their behavior in this way? After all, by not participating, the rational employee has revealed his belief that the program's costs exceed its benefits. Adding an incentive may change the employee's decision, but does not affect the program's intrinsic costs and benefits.

There are several responses to this concern. One is that individuals may value their health, but lack full information about the relationship between their health and the choices they make. Perhaps the employee's previous assessment of costs and benefits was erroneous because he or she did not recognize the longer-term consequences of obesity. Incentive programs might address this problem by increasing the salience of health-related issues, prompting employees to seek out more information. Alternatively, incentive programs could be designed to generate the same decisions that would be made in the presence of full information. So, for example, if people systematically underestimate the long-term benefits of

weight loss, an incentive program could offer a reward that offsets the underestimate.

A second response is that incentive programs may address factors that prevent fully informed, generally rational employees from reaching their health goals. Employees may want to lose weight and understand how to do so but nevertheless fail to do so. They may make short-term decisions inconsistent with their own long-term preferences, a phenomenon that has captured the attention of social scientists.¹⁸ Individuals also may lack the self-control necessary to achieve their goals. Financial incentives may provide the extra push affected individuals need – and want – to achieve their self-defined goals. In some cases, financial incentives could remove financial barriers to pursuing healthier behaviors.¹⁹

Some might offer a third response, arguing that an individual's weighing of costs and benefits is irrelevant, because the goal of incentive programs should be to shift costs to those who are most responsible for them. Under this view, for example, smokers could be required to pay higher premiums than non-smokers. Our primary interest, however, is in the use of incentives to improve health, not merely to redistribute costs.²⁰

Incentive programs in practice

Do these programs work? Many employers believe that wellness programs produce positive economic returns. They might point to a recent study finding that Johnson & Johnson's wellness program generated a return on investment in a range of \$1.88 to \$3.92 for every dollar spent on the program,²¹ or a recent meta-analysis showing a \$3.27 decrease in medical costs and a \$2.73 decrease in absenteeism costs for every dollar spent.²² Even if statistics like these are accurate, however, they may be misleading. Successful programs are probably more likely to be evaluated, and evaluations revealing positive impacts are probably more

¹⁸ D. Laibson, "Golden Eggs and Hyperbolic Discounting," *Quarterly Journal of Economics* 62 (1997): 443-477.

¹⁹ While this mechanism is more likely to be at work for rewards directed at very low income individuals, such as conditional cash transfer programs, it is possible that a financial reward for something like blood pressure control could help offset the costs associated with achieving it.

²⁰ Furthermore, in Part III, we raise questions about the extent to which incentive programs redistribute resources.

²¹ R.M. Henke, R.Z. Goetzel, J. McHugh and F. Isaac, "Recent Experience in Health Promotion at Johnson & Johnson: Lower Health Spending, Strong Return on Investment," *Health Affairs*, 30 (2011): 490-99, at 490.

²² K. Baicker, D. Cutler and Z. Song, "Workplace Wellness Programs Can Generate Savings," *Health Affairs*, 29 no. 2 (2010): 1-8.

likely to be publicly reported. Further, when an economic impact assessment is based on the experience of voluntary program participants, it can be difficult to disentangle the effects of the wellness program from the effects of participant characteristics. If healthier people are more likely to choose to participate, their experience may not be representative of that of broader populations. Finally, most published statistics measure the impact of wellness programs as a whole rather than the incremental impact of financial incentives.

Evidence on incentive programs' health effects is also limited, but growing. Several studies have shown short-term benefits from weight-loss incentives. A 2007 pilot study, for example, found that tying small financial rewards to weight loss resulted in higher weight loss at three months, and that larger incentives (fourteen dollars versus seven dollars per one percent of weight lost) were associated with higher weight loss.²³ A 2008 study found that individuals faced with incentives in the form of deposit contracts or daily lotteries lost more weight over sixteen weeks than individuals in a control group.²⁴ Incentives were then terminated, and participants' weights were re-measured at seven months; while those who had received financial incentives still weighed significantly less than their starting weights, their difference in weight loss relative to the control group was no longer statistically significant.²⁵ This result is consistent with literature reviews that conclude that consumer health incentives have a short-term impact, but find less evidence of long-term effects.²⁶

Similarly, a recent Cochrane review of studies involving incentives for smoking cessation found that "[t]here is some evidence that . . .

²³ E.A. Finkelstein, L.A. Linnan, D.F. Tate and B.E. Birken, "A Pilot Study Testing the Effect of Different Levels of Financial Incentives on Weight Loss Among Overweight Employees," *Journal of Occupational and Environmental Medicine* 49 (2007): 981-89.

²⁴ K.G. Volpp, L.K. John, A.B. Troxel, L. Norton, J. Fassbender and G. Lowenstein, "Financial incentive-Based Approach for Weight Loss: A Randomized Trial," *JAMA* 300 (2008): 2631-2637.

²⁵ Id.

²⁶ Authors of a review of 47 articles published between 1966 and 2002 concerning consumer health incentives concluded that "consumer incentives are effective for simple preventive care and distinct behavioral goals that are well defined" but that there was not "sufficient evidence at this time to say that economic incentives are effective for promoting the long-term lifestyle changes required for health promotion." R.L. Kane, P.E. Johnson, R.J. Town and M. Butler, *Economic Incentives for Preventive Care: AHRQ Publication No. 04-E024-2* (August 2004), Agency for Healthcare Research and Quality, Evidence Report/Technology Assessment No. 101, at vi. A more recent review of the financial incentive literature concluded that "research evidence suggests that incentives can increase adoption of healthy behaviors but that positive effects may diminish over time." K. Sutherland, J.B. Christianson and S. Leatherman, "Impact of Targeted Financial Incentives on Personal Health Behavior: A Review of the Literature," *Medical Care Research and Review* 65 (2008): 36S-78S.

recruitment rates can be improved by rewarding participation” in cessation programs but that “[i]ncentives and competitions have not been shown to enhance long-term cessation rates, with early success tending to dissipate when the rewards are no longer offered.”²⁷ This conclusion does not necessarily imply, however, that incentive programs are ineffective. In many past studies, small sample sizes hindered researchers’ ability to detect even large differences in long-term cessation rates, and small incentive magnitudes may have further limited program effects.²⁸ In a 2009 study of an employer-sponsored smoking cessation program, Volpp and colleagues found that a financial incentive of up to \$750 for quitting smoking for one year induced near-tripling of long-term smoking cessation rates.²⁹

This brief discussion of incentive program results hints at the challenges involved in assessing the overall impact of employer-sponsored health incentive programs. The number of studies of incentive programs is limited, and few have tracked long-term effects. Many questions remained unanswered. For example, if incentives for weight loss were to continue indefinitely, would program participants maintain or add to their initial weight loss? If incentives are terminated after a long period of time, do individuals quickly return to their original weights, or is there a point at which individuals have been sufficiently successful in changing their lifestyles that incentives are no longer needed? Or might incentives eventually undermine individuals’ inherent commitment to healthy behaviors, such that they find themselves unable to adopt or maintain healthier behaviors in the absence of incentives? More research is needed to address all of these questions.

The challenges of incentive program design

“Do these programs work?” is likely too simplistic a question to have a meaningful answer. Incentives’ size, structure, schedule, and setting may all affect how well incentive programs work. The growing literature on behavioral psychology and economics suggests that program design is likely to make a difference. That scholarship highlights decision biases and errors that help to explain both why individuals may fall into

²⁷ K. Cahill and R. Perera, “Competitions and Incentives for Smoking Cessation,” *Cochrane Database of Systematic Reviews* 2008, Issue 3.

²⁸ K.G. Volpp, A.B. Troxel, M.V. Pauly, G.A. Glick, A. Puig, D.A. Asch, R. Galvin, J. Zhu, F. Wan, J. DeGuzman, E. Corbett, J. Weiner and J. Audrain-McGovern, “A Randomized, Controlled Trial of Financial Incentives for Smoking Cessation,” *N. Engl. J. Med.* 360 (2009): 699-709 at 707 (discussing limits of 2005 Cochrane Collaboration review).

²⁹ *Id.*

unhealthy behaviors, and why some programs might be more effective than others in altering these behaviors.³⁰

One potential contributor to obesity, for example, is present-biased preferences; individuals often focus disproportionately on present costs and benefits relative to future ones. They might consider the benefits of eating now but fail to fully account for future costs associated with obesity, even if they know they would prefer a lower weight in the long term.³¹ In addition, individuals tend to be motivated more by the measurable and tangible than by the intangible, which means that “losing weight is difficult because any single indulgence has no discernible effect on weight,” or, more generally, on health.³²

These same biases and others suggest that there may be room for appropriately designed programs to help individuals achieve their health-related goals. For example, research suggests that immediate, small rewards are often more effective than larger payments in the distant future. This implies that regular cash awards may be more effective motivators than discounts on future health insurance premiums.³³ Because people often discount small magnitudes and overweight small probabilities, offering a reward in the form of entry into a lottery may be more effective in changing behavior than a smaller, guaranteed payment.³⁴ Finally, people may be loss averse, in that they “feel pain of loss more strongly than joy of gain.”³⁵ If so, incentives structured as losses, such as a deposit contract under which a participant voluntarily agrees to forfeit money if he or she fails to meet a health-related objective, may be more effective than a program that offers participants gains.³⁶ Individuals might volunteer to participate in such a program if they believe that it will help them obtain their objectives.

Ultimately, rather than ask, “Do these programs work?,” we should ask, “Which program designs are most effective in improving health?” The only way to answer this question is to study the effects of these programs in the real world.

³⁰ G. Loewenstein, T. Brennan and K.G. Volpp, “Asymmetric Paternalism to Improve Health Behaviors,” *JAMA* 28 (2007): 2415-2417.

³¹ *Id.* at 2415.

³² *Id.* at 2416.

³³ K.G. Volpp, M.V. Pauly, G. Loewenstein and D. Bangsberg, “P4P4P: An Agenda for Research on Pay-for-Performance for Patients,” *Health Affairs* 28, no. 1 (2009): 206-214, at 210-11.

³⁴ *Id.* at 211.

³⁵ *Id.* at 211.

³⁶ *Id.* at 211.

II. EMPLOYERS' ROLES IN INCENTIVE PROGRAMS

Concerns about employer-sponsored incentive programs

Employers could be valuable partners in studying incentive programs. Some have been leaders in developing these programs and are eager to evaluate their results. Employer-sponsored incentive programs have been controversial, however. Some controversy stems from the incentives themselves. For example, a national poll found that more people think it is unfair (42%) than fair (37%) “to ask people with unhealthy lifestyles to pay higher insurance premiums than people with healthy lifestyles.”³⁷

Another controversy surrounding employer incentive programs is more directly related to employer involvement. While there is support for employer involvement in wellness programs generally – eighty percent of employees in a recent national survey agreed that “programs related to weight management or healthy lifestyles belong in the workplace” – some employees may want to separate their personal and professional lives. Newspaper articles on incentive programs often comment on employer incentive programs’ potential for intrusion.³⁸ A number of states have enacted statutes that prohibit employers from discriminating against employees based on smoking outside the workplace, perhaps reflecting in part concerns about employers’ interference in employees’ personal lives.³⁹ More generally, health is often viewed as a personal matter, a realm in which privacy and confidentiality is valued; some employees may be reluctant to disclose personal health information in the context of an employer-sponsored health plan.⁴⁰ And, as discussed in Part III below,

³⁷ Press Release, “WSJ.com/Harris Interactive Survey Finds Drop in Public Support of Higher Healthcare Costs for Smokers or the Obese” (October 31, 2007). A small survey of patients in Philadelphia primary care clinics found a similarly mixed opinion about paying smokers to quit smoking or paying obese individuals to lose weight, although respondents were more supportive of incentive arrangements operated through insurance. J.A. Long, M. Helweg-Larsen and K.G. Volpp, “Patient Opinions Regarding ‘Pay for Performance for Patients,’” *Journal of General Internal Medicine* 23 (2008): 1647-1652 at 1649.

³⁸ See, e.g., B. Rose, “Employers Experiment with Tough Get-Healthy Regimes,” *Chicago Tribune* (February 10, 2008) (“Few would argue it’s OK for employers to dictate workers’ lifestyles outside work . . .”)

³⁹ L. Jesson, “Weighing the Wellness Programs: The Legal Implications of Imposing Personal Responsibility Obligations,” *Virginia Journal of Social Policy and the Law* 15 (2008): 217-298, at 266-268.

⁴⁰ The Americans with Disabilities Act offers some protections for employees’ health information. Under 29 C.F.R. § 1630.14, information “regarding the medical condition or history of any employee shall be collected and maintained on separate forms and in separate medical files and be treated as a confidential medical record . . .”

there is a concern that employers could use incentive programs to discriminate against unhealthy employees.

Reasons to support employer involvement

Given these concerns, is there reason to support employer involvement in health incentive programs? We know that individuals fail to engage in healthy behaviors for many reasons, including some of the previously discussed cognitive biases. To rectify these failures, individuals may turn to family members and friends for help. They may pay health care professionals or commercial weight-loss programs for assistance. They may rely on governmental efforts to promote healthy behaviors through direct provision of services (such as smoking cessation programs), regulation (such as menu labeling requirements), and financial incentives (such as tobacco taxes, Medicaid incentives, or conditional cash transfer programs). Although each of these strategies could certainly help individuals improve their own health, employers may still have an important role to play.

First, employers have a financial incentive to take an interest in employee health because of its implications for productivity and health care costs. A 1999 government report found that adult smokers cost \$1,760 each year in lost productivity and \$1,623 in additional medical spending.⁴¹ A 2005 study suggested that obesity-related medical and absenteeism costs range from \$400 to more than \$2,000 per obese employee per year.⁴² Another study found that obese working-age individuals have medical costs more than 35% higher than those of normal weight individuals.⁴³ If firms bear these costs directly, they have an incentive to reduce them. If they instead pass along these costs to employees in the form of higher health premiums or lower pay, then employees have a collective incentive to support firms in their efforts to improve employee health.

Second, employers may have the administrative capacity to operate financial incentive programs; large employers can take advantage of economies of scale in doing so. Human resources departments that have an understanding of employee needs, concerns, and motivators can help design wellness programs in light of these characteristics, alone or in

⁴¹ “Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs – United States, 1995-1999,” *Morbidity and Mortality Weekly Report* 51, no. 14 (2002): 300-303.

⁴² E. Finkelstein, I. Fiebelkorn and G. Wang, “The Costs of Obesity Among Full-Time Employees,” *American Journal of Health Promotion* 20 (2005): 45-51.

⁴³ K.E. Thorpe, C.S. Florence, D.H. Howard and P. Joski, “Trends: The Impact of Obesity on Rising Medical Spending,” *Health Affairs* (2004): w4-480-w4-486 at w4-483.

collaboration with outside vendors. Employers can build on the mechanisms they use to pay for wages or benefits to process financial rewards. Because they are in regular contact with their employees, employers can easily convey information about program content. While it is certainly not impossible to develop these functions outside of the employer context, other types of entities, including governments, health care providers, nonprofit organizations, and for profit companies, are likely to face considerable challenges in performing one or more of these functions.

Third, employers will often be able to support employees' wellness efforts, helping to ensure that employees have the opportunity as well as the incentive to adopt healthier lifestyles. Employers might change the offerings or prices or layouts in corporate cafeterias to increase the consumption of healthier food.⁴⁴ They might offer an on-site gym or provide access to on-site health care providers.⁴⁵ They might build open stairwells or walking paths.⁴⁶ When employees spend many hours in workplace-controlled settings, these efforts to make healthier choices more visible, less costly, and more convenient can provide employees with the tools they need to make the changes encouraged by financial incentives. Similarly, employers can create a culture that promotes healthy lifestyles by offering leadership support, encouraging team competitions, or undertaking other wellness initiatives.⁴⁷ Few non-employer entities would have an equivalent opportunity to integrate incentives into broader wellness programs that could influence individuals' decision making on a daily basis. While employers can surely make these changes in the absence of incentive programs, incentive programs may enhance their impact.

Admittedly, not all employers share these advantages. Smaller employers in particular may find it too difficult or expensive to operate or support wellness programs, although outside vendors could help address some of the challenges involved. Moreover, employers may not have employees' long-term interests at heart. If employees turn over quickly, employers have little reason to focus on lifestyle changes with long-term payoffs, except perhaps as a recruitment tool for employees who value

⁴⁴ See, e.g., S. Okie, "The Employer as Health Coach," *N. Engl. J. Med.* 357 (2007): 1465-1469 (noting that the corporate cafeteria at General Mills "offers many nutritious, low-calorie choices, including a subsidized salad bar").

⁴⁵ L. Alderman, "Getting Healthy, With a Little Help from the Boss," *New York Times*, May 23, 2009.

⁴⁶ L. Heinen and H. Darling, "Addressing Obesity in the Workplace: The Role of Employers," *The Milbank Quarterly* 87 (2009): 101-122 at 106.

⁴⁷ *Id.*

such programs. But note that many other entities that could promote healthy behaviors suffer from similar deficiencies.

All of these considerations suggest that there is good reason for the ACA to promote employer involvement in incentive programs, if concerns about employer incentive programs can be suitably addressed. We have discussed previously how many commonly levied concerns with incentives programs are difficult to sustain.⁴⁸ In Part III of this Article, we more closely examine two concerns that are particularly challenging: the potential for discrimination, and the potential for coercion or undue inducement.

III. ETHICAL CONSIDERATIONS IN INCENTIVE PROGRAM DESIGN

Incentive programs' potential for discrimination

Employer health incentive programs have the potential to discriminate. The programs are designed to differentiate among individuals based on success in undertaking incentivized activities or achieving incentivized outcomes; they provide a higher financial benefit to successful individuals. This differentiation becomes a concern when some individuals face significantly greater difficulty than others in obtaining program rewards. If society determines that it is inappropriate to tie financial consequences to the factors contributing to this difficulty, then the incentive program would be deemed to engage in unacceptable discrimination. Discrimination concerns would also arise if incentive programs have the purpose or effect of discouraging unhealthy job applicants, encouraging exit of unhealthy employees, or discouraging unhealthy employees from taking advantage of company health benefit packages.⁴⁹

Many factors affect individuals' abilities to respond to health incentives. Individuals' preferences for unhealthy behaviors differ. Shaped by historical, cultural, and environmental influences, these preferences help to determine the costs of sacrificing unhealthy behaviors. Some individuals are more averse to effort than others, and some may face higher costs in exercising willpower. Those engaged in multiple tasks

⁴⁸ S.D. Halpern, K.M. Madison and K.G. Volpp, "Patients As Mercenaries? The Ethics of Using Financial Incentives in the War on Unhealthy Behaviors," *Circulation: Cardiovascular Quality and Outcomes* 2 (2009): 514-516.

⁴⁹ For a paper raising the possibility that employers could use health plan design to encourage sicker employees to seek insurance elsewhere, see generally Amy B. Monahan & Daniel Schwarcz, "Will Employers Undermine Health Care Reform by Dumping Sick Employees?" *Virginia Law Review* 97 (2011): 125 – 197.

involving willpower, such as saving money and losing weight, or who are simultaneously engaged in tasks involving willpower and other cognitively demanding tasks, may find it more difficult to exercise self-control in the short term.⁵⁰

If the actions or activities that an individual must undertake to benefit from an incentive program are not immediately clear, individuals with lower levels of education or health literacy may face considerable challenges in earning rewards. Individuals who lack access to information, or who fail to understand the information they do have, may find it difficult to take the necessary steps to achieve a particular standard, such as lower cholesterol levels. Lower-income individuals will face more burden in paying for things that might help them earn rewards, such as healthier foods, drugs that lower cholesterol, or babysitting services that facilitate trips to the gym or participation in health-related programs. Higher-income individuals face higher opportunity costs when they participate in time-intensive activities such as exercise.⁵¹ The burdens of any health-promoting activities that are time-consuming will be high for those who face greater demands on their time, whether from work or family responsibilities.

Environmental factors may make a difference, too. Individuals who live close to a grocery store that offers healthy foods will more easily maintain a healthy diet. People who live in a neighborhood with safe areas to exercise outdoors will find it easier to exercise. Proximity to and ease of access to health care providers may make a difference if provider involvement facilitates achievement of incentive program targets.

Health status at the time of incentive program implementation also matters. Some individuals may already have met the targets, and, depending on program design, might be rewarded on this basis. Those who have not already met the targets may face physical barriers to doing so; a person with knee problems, for example, may find it more difficult to participate in an exercise program than someone who does not. Individuals' genetic makeups or other physical characteristics might create impediments to losing weight or lowering cholesterol.

⁵⁰ See L.A. Fennell, "Willpower Taxes," *Georgetown Law Journal* 99 (forthcoming 2011): 16-19 (discussing research on the exercise of willpower and noting that "willpower works like a muscle that can become fatigued with use" and that "self-control seems to share a common, limited, depletable fund with other cognitive tasks, such as decisionmaking").

⁵¹ See, e.g., K., *supra* note 23, et al. at 41S (discussing implications of income for incentive program).

This list of characteristics upon which programs could discriminate is already long but probably still incomplete. It is clear that some will face greater barriers than others to engaging in healthy behaviors, just as they do in many other life activities. But this does not imply that incentive programs constitute an unacceptable form of discrimination and therefore should be abandoned.

In fact, one advantage of an appropriately designed incentive program is that it can help individuals overcome barriers they face in trying to avoid disease and disability. The individuals who face the most significant barriers to engaging in healthy behaviors may have the most to gain from incentive programs. Incentives serve as a tool to help offset decision errors that might otherwise interfere with individuals' efforts to improve their own health. In some cases, incentives take the form of additional money that could help counterbalance some of the costs of engaging in healthier behaviors, such as the costs of physician visits, the costs of fresh produce, or perhaps even the costs of exercising willpower. Individuals hoping to live healthier lives may recognize the value of incentives as a tool; one survey suggests that obese individuals are more likely than their normal weight counterparts to support financial incentives for weight management program participation.⁵²

Nevertheless, it is important to try to lower barriers to healthy behaviors and reduce the potential for unacceptable discrimination. Ethics, law, and policy can collectively help to shape incentive program design to reduce the likelihood that the programs will have a discriminatory impact.

Addressing incentive program barriers

In designing incentive programs, employers should be sensitive to factors that hinder employees' ability to benefit from them. Employers do not have an ethical responsibility to address all barriers that their employees may face in living healthier lives. But when an employer introduces a program that differentiates among employees in a way that may increase the impact of these barriers, employers have an ethical obligation to try to mitigate their effects. This is particularly true if employee duties, employer programs, or the workplace environment exacerbate barriers.

To reduce the magnitude of obstacles employees face, employers should consider introducing incentives as one part of a broader wellness program. As Pearson and Lieber have suggested in the context of

⁵² J.R. Gabel et al. at 52.

financial penalty programs, employers should strive to provide “fair and equal opportunities to change behavior.”⁵³ Employers can bring healthier food into the workplace, provide discounted gym memberships, or offer health education programs at convenient times and locations. They can sponsor onsite health fairs where employees can learn more about their risk factors, arrange for health coaches who provide tailored advice about how to improve health, and create health plans with low copayments for blood pressure and cholesterol drugs. These steps and others might help employees overcome the logistical, informational, and financial barriers to taking advantage of incentive programs, ultimately increasing incentives’ effectiveness in promoting health.

Providing this support may be difficult. Many employers lack the expertise and resources necessary to create comprehensive wellness programs. For small employers in particular, some elements of wellness programs offered by the largest employers will be prohibitively costly. But all employers can try to limit the problematic implications of incentive programs through careful incentive program design.

Voluntariness should be a key consideration.⁵⁴ From both a practical and an ethical perspective, it makes sense to condition incentives on changes in behavior that participants can voluntarily undertake, rather than on outcomes whose achievement may not be entirely under one’s control. Pearson and Lieber have argued that to be ethical, penalty programs should incentivize voluntary actions rather than outcomes; a similar argument could be made for incentive programs more generally.⁵⁵ Tying incentives to following the cholesterol-related recommendations of a physician, rather than attaining a particular cholesterol level target, may be ethically preferable because individuals’ genetic makeup may pose an insurmountable barrier to achieving a particular target. Tying incentives to participation in a smoking cessation program may be less ethically problematic than tying incentives to actually quitting smoking, given differences in the degree to which people’s genetic makeups influence the severity of their nicotine addiction. Tying incentives to specific behaviors rather than outcomes has the added benefit of providing clear guidance to employees about the steps they need to take to earn the incentive.

⁵³ S.D. Pearson and S.R. Lieber, “Financial Penalties for the Unhealthy: Ethical Guidelines for Holding Employees Responsible for Their Health,” *Health Affairs* 28 (2009): 845-852 at 847.

⁵⁴ Many commentators have stressed the importance of voluntariness in ethical program design. See, for example, Person and Lieber, *supra* note 53, at 848-849; R. Priester, “Are Financial Incentives for Wellness Fair,” *Employee Benefits Journal* (1992): 38-40 at 39.

⁵⁵ Pearson and Lieber, *supra* note 53, at 847-49.

One way to assess voluntariness is to consider the specific barriers that impede individuals' ability to obtain rewards or avoid penalties.⁵⁶ Thinking about voluntariness in terms of its specific impediments, such as genetics, addiction, or psychological factors, can help employers design appropriate incentive structures. They must identify the impediments that are most problematic and then consider ways to address them. Employers might condition incentives on behaviors rather than outcomes, as suggested above. But employers could also design outcomes-based incentives that are sensitive to individuals' differences.

For example, imagine two programs that incentivize people to lose weight. The first provides rewards contingent on loss of 10% of baseline body weight, whereas the second provides rewards contingent on achievement of a body mass index (BMI) of 25 or less (the cutoff for "normal"). Program 1 may be criticized for being more difficult to attain for those who are only modestly overweight at baseline than for those who are extremely obese at baseline, whereas Program 2 is susceptible to the opposite form of discrimination because it will be easier for the modestly overweight to attain a BMI of 25 than for the severely obese. Such challenges are prevalent, but can often be combated with clever program designs. In this case, incentivizing the achievement of *either* the 10% body weight loss *or* the BMI of 25 would result in a program that is fair *ex ante* with respect to baseline body weight.

More generally, incentives that are tailored to the individual can help to address the problem of individual-specific barriers. Tailored targets might also more effectively motivate health improvement for individuals who are far from the uniform target that might otherwise be adopted.

In suggesting that voluntariness and barriers are key ethical considerations, we do not mean to imply that incentive programs should not impose burdens on employees. After all, healthy behaviors are often intrinsically burdensome, which is one reason why incentive programs might be helpful. Nor do we mean to imply that burdens must be exactly equal. Just as employers cannot fully eliminate impediments to healthy

⁵⁶ In discussing the meaning of voluntariness, Priester has pointed to many such barriers: "The mere existence of alternative courses of action . . . should not count as proof that an individual's unhealthy action is free. Health habits are acquired within social groups (e.g., family, peers) and are often supported by powerful economic, political and cultural elements in the general society (e.g., advertising). In some instances, psychological factors may also preclude or impede authentic, reasoned choices." R. Priester, "Are Financial Incentives for Wellness Fair," *Employee Benefits Journal* (1992): 38-40 at 39. See also D. Wikler, "Who Should Be Blamed for Being Sick?," *Health Education Quarterly* 14 No. 1 (1987): 11-25.

behaviors, they cannot always eliminate pre-existing differences in impediments. Given that these programs may offer considerable benefits to individual employees, including those who face barriers to participation, burdens cannot be the only design consideration. It is important to consider a program's effectiveness and operating costs along with its propensity for unintended consequences.

It may not always be the case, for example, that tying incentives to program participation rather than biometric outcomes is the more ethically appropriate choice. Incentivizing outcomes may be more effective than incentivizing program participation. For example, one study showed significantly higher weight loss for those incentivized to lose weight or limit calories than for those incentivized to attend a weight loss program.⁵⁷ Another study showed that among smoking cessation program participants, those who had financial incentives to quit were significantly more likely to do so.⁵⁸ A program that incentivizes behaviors but fails to change health is wasteful; it diverts resources that could be better used in other ways, including other approaches to health improvement.

Programs that incentivize behaviors might also be wasteful if they promote efforts to achieve better health in one particular way, when another, less costly or more easily attainable route might have been equally or more successful. For example, if incentives for attending the gym were offered as a way to promote weight loss, but a more effective and attainable path to weight loss for many people entails consuming a higher proportion of fresh produce, then placing the incentives on the behavior rather than the outcome would be counterproductive. Indeed, programs that incentivize outcomes may be said to increase voluntariness by giving participants more freedom to choose the methods best suited to overcoming the obstacles they face. Further research is needed to establish the effects of these different types of incentives in practice, but it is clear that effectiveness and efficiency should be among the factors considered in program design.

Incentive program design: Carrots and sticks

Voluntariness of incentive programs is also important in the sense that firms should not require employees to participate in them as a

⁵⁷ R.W. Jeffery, P.D. Thompson and R.R. Wing, "Effects on Weight Reduction of Strong Monetary Contracts for Calorie Restriction or Weight Loss," *Behaviour Research and Therapy* 16 (1978): 363-369 (weight loss study).

⁵⁸ K.G. Volpp et al., *supra* note 28, at 706 ("Members of the incentive group who participated in a smoking-cessation programs had significantly higher rates of cessation than did members of the control group who participated in such a program (46.3% vs. 20.8%, P=0.03).")

condition of employment. Employees concerned that sharing health-related information with an employer might violate their privacy, unacceptably mix their work and personal lives, or subject them to employment discrimination, should be able to decline to participate in such programs without risk of being fired. Employees whose personal obligations make it very difficult to find the time to participate in health education or exercise programs outside of work hours should be free to refuse to participate.

But if there is an ethical obligation to refrain from compelling employees to engage in specific health-related activities, then consideration of employment decisions alone will be insufficient. Conditioning 100% of an employee's pay on target achievement, for example, would be equivalent to basing the employee's ongoing employment on target achievement. But what if we condition 80%? What about 50% of the value of benefits? Or 10%? Would a promise to pay an employee a bonus of an equivalent amount be less problematic?

Designers of incentive programs must decide whether to use carrots (rewards) or sticks (penalties). Their choice may depend on the objective that they are trying to achieve. If the goal is to choose a design that is popular with employees, carrots are probably the better choice. Many of the same employees who support positive incentive programs oppose negative ones. In the previously mentioned employee survey, for example, 70% of respondents supported discounts on health insurance or other monetary incentives for participation in weight management programs, but only 6% supported higher premium contributions for people who decline to participate in these programs.⁵⁹ Some employers that have tried to adopt penalty-based programs have abandoned this approach in response to vocal opposition.⁶⁰

If the goal is program effectiveness, the choice of incentive structure is less clear. On the one hand, rewards are attractive because they seem to fit naturally within a positive, mutually supportive, health promotion environment. On the other hand, penalties might be a more powerful tool for motivating behavioral change. As previously discussed, there is evidence that people are loss averse, in the sense that they feel losses more acutely than equivalent gains.⁶¹ The implication is that an

⁵⁹ J.R. Gabel et al. at 52.

⁶⁰ See, e.g., W.K. Mariner, "Social Solidarity and Personal Responsibility in Health Reform," *Connecticut Insurance Law Journal* 14 (2008): 199-228 at 217-18 (discussing experience of Clarian Health).

⁶¹ See M.M. Mello and M.B. Rosenthal, "Wellness Programs and Lifestyle Discrimination – the Legal Limits," *New Engl. J. Med.* 359 (2008): 192-199 at 197 (noting that "sponsors may be able to gain traction by framing wellness incentives as

employee facing a penalty of \$100 for smoking might be more likely to quit than one who would get a \$100 reward for quitting. But we have little empirical evidence about the relative impact of rewards and penalties within the health-incentive setting.⁶² This is one of many incentive design-related issues in need of further study.

To date, most employers have instituted programs they have characterized as carrots. A recent survey shows, for example, that among large employers tying incentives to biometric measures, 39% gave premium discounts and 48% gave account contributions or cash or cash equivalent rewards, while only 2% imposed a premium surcharge.⁶³ In fact, smoking was the only behavior for which premium surcharges were common, and even in this case, premium discounts and other rewards were used slightly more frequently than premium surcharges.⁶⁴

The ethics of sticks

Despite these reports, it is not clear that all carrots are created equally, as they can often be reframed easily as sticks. For example, Schmidt, Voigt, and Wikler observe that for lower-income workers for whom “the only way to obtain affordable insurance is to meet the targets,” programs’ voluntariness can become dubious and “programs that are offered as carrots may feel more like sticks.”⁶⁵ Thus, these authors raise two closely related ethical concerns: When might incentives structured as penalties become coercive? And when might incentives structured as rewards become sufficiently like penalties that they undermine voluntariness?

The concept of coercion has been explored by many scholars over the years.⁶⁶ While differing theoretical analyses have generated differing

penalties rather than rewards”); K. Sutherland et al. at 40s (discussing loss aversion in context of incentive programs). An early contribution to this area of research was D. Kahneman & A. Tversky, “Prospect Theory: An Analysis of Decision Under Risk,” *Econometrica* 47 (1979): 263-291.

⁶² R.A. Dudley, C. Tseng, K. Bozic, W.A. Smith and H.S. Luft, “Consumer Financial Incentives: A Decision Guide for Purchasers, AHRQ Publication No. 07(08)-0059 (2007) at 17 (“There is no specific evidence from health services research to address whether consumer financial incentives should be structured as rewards, penalties, or a combination of the two.”).

⁶³ National Business Group on Health and Towers Watson, *The Road Ahead: Shaping Health Care Strategy in a Post-Reform Environment* (2011): 16.

⁶⁴ *Id.*

⁶⁵ H. Schmidt, K. Voigt, and D. Wikler, “Carrots, Sticks, and Health Care Reform – Problems with Wellness Incentives,” *N. Engl. J. Med.* (Dec. 30, 2009), e3(1)-e3(3) at e3(3).

⁶⁶ See, e.g., Stanford Encyclopedia of Philosophy, Coercion, <http://plato.stanford.edu/entries/coercion/>.

definitions of the term, one definition that captures many widely recognized features of coercion is “the intentional use of a credible and severe threat of harm or force to control another or to compel him or her to do something.”⁶⁷ A simpler version is that “A coerces B when A threatens to make B worse off than B’s status quo baseline.”⁶⁸ A third permutation is that coercion occurs when “(1) A proposes or threatens to violate B’s rights or not fulfill an obligation to B if B chooses not to do X and (2) B has no reasonable alternative but to accept A’s proposal.”⁶⁹ Using even the most inclusive of these definitions, the only way an incentive could potentially be considered coercive would be if its offer would somehow worsen the situation or violate the rights of individuals who are unable to engage in healthy behaviors.

It is not clear when, if ever, incentive programs would do this. Consider the following example: An employer has four employees, two who smoke, and two who do not. The hypothetical smokers’ health care costs are \$1,000 per year, while the nonsmokers’ health care costs are \$500 per year (see Table 1, Example 1). Dividing the \$3000 in costs equally among employees would result in premiums of \$750 per person per year (Example 2). Examples 3 through 8 in Table 1 show what might happen if the employer institutes an incentive program.

⁶⁷ C. Grady, “Money for Research Participation: Does It Jeopardize Informed Consent?,” *The American Journal of Bioethics* 1 No. 2 (2001): 40-44 at 40 (citing T. Beauchamp and J. Childress, *Principles of Biomedical Ethics*, 4th ed. (New York: Oxford University Press: 1994) at 165).

⁶⁸ A. Wertheimer and F.G. Miller, “Payment for Research Participation: A Coercive Offer?,” *Journal of Medical Ethics* 34 (2007): 389-92 at 390.

⁶⁹ *Id.*

Table 1: Effects of incentive programs on allocation of health care costs

Example	# smokers	# non-smokers	Total costs	Incentive	Smoker pays	Non-smoker pays
Health care costs in the absence of an incentive program:						
1	2	2	3000	None; Actuarially fair rates	1000	500
2	2	2	3000	None; Evenly split rates	750	750
If incentive program is ineffective in altering behavior:						
3	2	2	3000	\$100 surcharge for smokers	800	700
4	2	2	3000	\$100 discount for nonsmokers	800	700
If incentive program alters behavior:						
5	1	3	2500	\$100 smoker surcharge/non-smoker discount	700	600
6	1	3	2500	\$100 reward for not smoking, funded directly by employer	625	525
7	1	3	2500	\$250 surcharge for smokers	812.50	562.50
8	1	3	2500	\$250 reward for quitting	687.50	437.50 for quitter, 687.50 for others

Examples 3 and 4 show that imposing a penalty of \$100 on smokers is substantively similar to offering a reward of \$100 for nonsmokers. In each case, the smoker ends up paying more, and the non-smoker less, than the \$750 they would have paid without an incentive program. One might argue, then, that regardless of whether the incentive is framed as a penalty or reward, it imposes a harm on smokers and therefore could potentially be coercive.

There are a few problems with this analysis, however. One is that definitions of coercion often require more than just threats of harm. It is not clear, for example, that a \$100 surcharge would constitute a “severe threat of harm” or leave smokers with “no reasonable alternative.”

There is also a question about whether payment of \$750 is an appropriate baseline for the assessment of harm. It may be the status quo in the sense that many employers offer insurance and do not discriminate based on health-related factors. Historically, however, employers have not

been obligated to offer insurance, and moreover, as described in Part IV below, they are expressly permitted to offer wellness programs that include incentives.⁷⁰ Employers do not as a general matter threaten employee rights by setting premiums based on health behaviors.⁷¹

Even if we were to treat a premium payment of \$750 as the correct baseline, the incentive program still might not be coercive. The analysis above assumes that behavior does not actually change, despite the fact that the very purpose of the program is to change behavior. If one smoker quits, then the calculations become quite different. As Example 5 shows, the same \$100 surcharge now makes both smokers and non-smokers better off than the status quo. Example 6 demonstrates that if the employer sweetens the pot by using money from outside the benefits pool to fund a reward, both smokers and nonsmokers would pay less than they would otherwise, but the analysis is otherwise the same. Because the incentive program leaves neither group worse off, the program could not be considered coercive. Admittedly, if a higher payment is required to change behavior, as in Example 7, it may not be possible to make the remaining smokers better off than the status quo, and the only alternative would be to turn to a reward targeted directly at smokers (as in Example 8) or funding from outside the pool. The bottom line, however, is that focusing purely on whether incentives are framed as carrots or sticks reveals little about the strategy's potential for coercion.

To add to the analytical complications, it may be that surcharges impose no financial harm at all, even if they do not alter behavior. Bhattacharya and Bundorf have studied the incidence of the health-related

⁷⁰ See legal analysis in Part IV.

⁷¹ This analysis does not completely eliminate the possibility of health benefit-related coercion. Consider health risk assessments (HRAs), which collect information about employees' current health status, health risks, and health history, and serve as a foundation for many wellness programs. (National Business Group on Health and Towers Watson, *The Road Ahead: Shaping Health Care Strategy in a Post-Reform Environment* (2011): 16.) The Americans with Disabilities Act (ADA) limits employers' ability to engage in disability-related inquiries, but allows "voluntary medical histories" as part of an employee health program. (42 U.S.C. § 12112(d)(4).) The Equal Employment Opportunity Commission (EEOC) has suggested informally that the ADA would forbid a penalty in the form of denial of insurance benefits to an employee who declines to respond to a health risk questionnaire containing questions seeking disability-related information. (Letter from Peggy R. Mastroianni, EEOC (March 6, 2009), available at http://www.eeoc.gov/eeoc/foia/letters/2009/ada_disability_medexam_healthrisk.html.) The implication is that the EEOC views the provision of benefits as an appropriate baseline, such that a threat to deprive someone of these benefits if they refuse to complete an HRA has the potential to be coercive, rendering the medical history "involuntary."

costs of obesity.⁷² Their analysis begins by noting that “[a]verage medical expenditures are \$732 higher for obese than normal weight individuals.”⁷³ They then ask who bears these costs. When employees contribute to an insurance pool equally, the natural answer would be “everyone,” as in Example 2 above. But economic theory implies that this answer may be incorrect. As the authors explain, “variation in individual expected expenditures could be passed on to individual workers in the form of differential wage offsets for employer-sponsored coverage. In the absence of risk-adjusted premium payments by workers, if wages did not adjust, firms in a competitive industry could make positive profits by hiring only thin workers. Equilibrium wage offsets based on weight eliminate such arbitrage opportunities.”⁷⁴

In other words, if premiums are not permitted to vary, firms are free to hire whomever they wish, and workers are equally productive, then firms will prefer to hire thin employees because these employees are less costly. Employers will be willing to pay higher wages to obtain these thin employees, until the point at which the costs to the employer (including both wages and health benefits) of both types of employees are equal. Bhattacharya and Bundorf present evidence consistent with this phenomenon in the case of obesity. Specifically, they find that obese workers with employer-sponsored health insurance have lower wages relative to non-obese workers, while employees without such insurance do not experience a wage offset.⁷⁵

What this finding implies is that the effect of a penalty incentive program may be to transform a wage differential into an insurance premium differential. Obese workers would pay an insurance penalty, but the wage gap between obese and non-obese workers would begin to close. As obese workers began to bear more of their own health care costs, they would become less costly to employers; employers might then begin to pay higher wages to attract or retain these now less costly workers. In short, obese workers would pay higher contributions for insurance but this differential would be offset by higher pay. There would be no change in total compensation and therefore no harm, relative to a world in which there was no incentive program. The program’s main effect would be to render the cost differential due to obesity much more visible, perhaps inducing behavioral change that would permit higher wages for the worker and improve the worker’s health.

⁷² J. Bhattacharya and M.K. Bundorf, “The Incidence of the Healthcare Costs of Obesity,” *Journal of Health Economics* 28 (2009): 649-658.

⁷³ *Id.* at 649.

⁷⁴ *Id.*

⁷⁵ *Id.*

One might object that this analysis would not apply in situations where firms do not make a practice of discriminating in their payment of wages (for legal, ethical, or practical reasons), or question whether other health-related behaviors or characteristics would generate the same empirical findings. The implementation and effects of a real-world incentive program are likely to differ from those of the simple example considered here. Nonetheless, the analysis is important because it highlights the potential dangers of analyzing the effects of incentive programs in isolation and emphasizes the need for evaluation of total compensation.

The ethics of carrots

The incentive illustrated by Example 8 in Table 1 differs from Table 1's other incentives in that it targets rewards specifically toward unhealthy individuals who change their behavior. It makes them better off not only relative to their previous selves but also relative to both current smokers and current nonsmokers. Could such a reward constitute coercion?

Leading ethicists argue that the answer is no.⁷⁶ Specifically, they reject the use of the label "coercion" in situations where there is no threat to make someone worse off. Instead, they focus on a different concern: undue inducement.⁷⁷ In evaluating the ethical implications of financial incentives for participation in human subjects research, Emanuel has identified four key characteristics of undue inducement: (1) the incentive must "entail an offer of a welcomed good, a positive incentive," (2) the incentive must appear "excessive or irresistible," (3) "[t]he incentive must produce bad judgments," and (4) these "judgments must in turn engender ethically, legally, or prudentially undesirable activities."⁷⁸ Others defining

⁷⁶ See, e.g., E.J. Emanuel, "Ending Concerns About Undue Influence," *Journal of Law, Medicine & Ethics* 32 (2004): 100-104; S.D. Halpern, "Financial Incentives for Research Participation: Empirical Questions, Available Answers, and the Burden of Further Proof," *American Journal of the Medical Sciences* (2011); Wertheimer and Miller, *supra* note 68.

⁷⁷ Emanuel also identifies a third concern, exploitation, which refers to "the unfair distributions of goods that arise from an interaction" because of weakness in bargaining power. E.J. Emanuel at 101. Wertheimer further explains that for an exploitative agreement to exist, the content must be "unfair or wrong" in some way, perhaps involving an unfair price, or the exchange of a good that should not be exchanged, or a degrading activity. A. Wertheimer, "Remarks on Coercion and Exploitation," *Denver University Law Review* 74 (1997): 889-906 at 898. To the extent that incentive programs are designed to improve health, exploitation would not seem to be a concern.

⁷⁸ E.J. Emanuel, *supra* note 76, at 101.

undue inducement focus more narrowly on the affected individual's decision-making process. According to Wertheimer and Miller, "an inducement is undue only when it predictably triggers *irrational* decision-making given the agent's own settled (and reasonable) values and aims."⁷⁹ Halpern similarly characterizes as undue only those incentives that fundamentally alter risk perception.⁸⁰

The question, then, is not whether wellness rewards are coercive, but instead whether they constitute undue inducement. Under Emanuel's framework, incentives in properly structured wellness programs are unlikely to constitute undue inducements because they promote healthy behaviors, which would rarely fall into the category of "ethically, legally, or prudentially undesirable activities." The risks or drawbacks of participating in wellness programs seem much less of a concern than risks in human subjects research. If this analysis is correct, a wellness incentive cannot be deemed an undue inducement, regardless of its magnitude.⁸¹

On occasion, however, wellness incentives might produce "undesirable activities" or involve some risks. Exercise, for example, could involve health risks for unhealthy individuals. Disclosing information related to disabilities might increase the risk of disability-related discrimination. Might incentives, particularly large incentives, unduly induce employees to engage in incentivized behaviors by distorting their judgment about the risks involved? Research on the effects of incentives in human subjects research suggest that incentives may not have this effect.⁸² One study found that although higher payments led to higher willingness to participate in clinical trials, people's participation decisions were equally sensitive to varying risk levels regardless of how much money they were offered.⁸³ Another study suggested that higher payments might heighten awareness of risk, rather than blind individuals to its presence; it found that people perceived experiments involving higher payments as riskier.⁸⁴

⁷⁹ Wertheimer and Miller, *supra* note 68, at 391.

⁸⁰ Halpern, *supra* note 76.

⁸¹ Emanuel acknowledges this implication of his framework: "[m]onetary inducements for an ethical, legal, and reasonable activity are deemed 'due' no matter how high." Emanuel at 101.

⁸² See Halpern, *supra* note 76 (reviewing studies).

⁸³ S.D. Halpern, J.H.T. Karlawish, D. Casarett, J.A. Berlin and D.A. Asch, "Empirical Assessment of Whether Moderate Payments Are Undue or Unjust Inducements for Participation in Clinical Trials," *Archives of Internal Medicine* 154 (2004): 801-803.

⁸⁴ C. Cryder, A.J. London, K.G. Volpp and G. Loewenstein, "Informative Inducement: Study Payment As a Signal of Risk," *Social Science and Medicine* 70 (2010): 455-464.

In the context of wellness programs, a related concern is that incentives might induce program participants to make decisions based on short-term rewards rather than long-term preferences.⁸⁵ However, individuals' long-term preferences are generally to be healthier, so incentive structures that take advantage of individuals' present-biased preferences serve to correct their decision errors rather than undermine their interests. In short, while wellness program rewards have the potential to constitute undue inducement, they are unlikely to do so.

IV. THE ACA'S LIMITS ON PROGRAM DESIGN

One theme that runs through much of the scholarly discussion of coercion and undue inducement is the importance of determining what kinds of actions are legitimate. Wertheimer has argued that we should not dwell too much on defining the boundaries of coercion, but instead should consider whether particular types of agreements should be enforceable or prohibited.⁸⁶ Statutory and regulatory limits on wellness programs perform this function.

Because previous authors have ably reviewed the myriad legal issues surrounding incentive programs, we will limit our analysis here to a few key incentive program-related provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the ACA.⁸⁷

HIPAA and its associated regulations prohibit group health plans from conditioning eligibility rules, including benefits-related rules, on health status-related factors such as health status, medical history, genetic information, and disability.⁸⁸ They carve out an exception, however, for wellness programs designed to promote health or prevent disease.⁸⁹

The ACA provisions are patterned after the HIPAA regulations. They permit premium discounts, rebates, or other rewards not based on satisfying a health status factor-related standard as long as the programs

⁸⁵ See Wertheimer and Miller, *supra* note 68, at 391.

⁸⁶ Wertheimer, *supra* note 77, at 896, 899 (“The crucial question, after all, is how certain specific characteristics of proposals and acceptances are related to certain specific moral judgments and not whether we call them coercive or exploitative.”).

⁸⁷ See, e.g., M.M. Mello and M.B. Rosenthal, “Wellness Programs and Lifestyle Discrimination—the Legal Limits,” *N. Engl. J. Med.* 359 (2008): 192-199; L. Jesson, *supra* note 39; M.A. Rothstein and H.L. Harrell, “Health Risk Reduction Programs in Employer-Sponsored Health Plans: Part II—Law and Ethics,” *Journal of Occupational and Environmental Medicine* 51 (2009): 951-957.

⁸⁸ HIPAA of 1996, 110 Stat. 1936, Pub L. 104-191; 26 C.F.R. § 54.9802-1, 29 C.F.R. § 2590.702, 45 C.F.R. § 146.121.

⁸⁹ See, e.g., 29 C.F.R. § 2590.702(f).

are available to all similarly situated individuals.⁹⁰ Thus, plans are permitted to reimburse costs for gym memberships or offer rewards for attending smoking cessation programs. In addition, the ACA permits rewards based on satisfaction of a health status factor-related standard if the program meets a series of requirements.⁹¹ The rewards may take many forms, including “a discount or rebate of a premium or contribution, a waiver of all or part of a cost sharing mechanism . . . the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.”⁹² A program involving a reward for maintaining a specified BMI or a penalty for those who use tobacco would be subject to these requirements.

Under the ACA’s requirements for rewards based on satisfaction of health standards, a wellness program must be “reasonably designed to promote health or prevent disease” and cannot be a “subterfuge for discriminating based on a health status factor.”⁹³ Rewards must be available annually, which helps to ensure that they are available frequently enough to motivate change among all interested participants.⁹⁴ Rewards must be available to all similarly situated individuals, meaning that programs must allow for a reasonable alternative standard or waiver when it is medically inadvisable for an individual to try to satisfy a standard, as well as when medical conditions make it unreasonably difficult for an individual to satisfy a standard.⁹⁵ The availability of this alternative standard or waiver must be disclosed.⁹⁶ Finally, rewards based on satisfaction of health status-related standards may not exceed 30 percent of the cost of coverage, including both employer and employee contributions.⁹⁷ The statute grants the Secretaries of Labor, Health and Human Services, and the Treasury the authority to increase this ceiling to 50 percent if such an increase is “appropriate.”⁹⁸

These wellness-related provisions are premised on a few key propositions. First, it is not acceptable to discriminate against individuals based on their health in providing health benefits.⁹⁹ Second, targeted health improvement efforts are nevertheless acceptable. Health plans are

⁹⁰ ACA § 1201, to be codified at 42 U.S.C. 300gg-4 (j)(2).

⁹¹ ACA § 1201, to be codified at 42 U.S.C. 300gg-4(j)(3)(A).

⁹² *Id.*

⁹³ ACA § 1201, to be codified at 42 U.S.C. 300gg-4(j)(3)(B).

⁹⁴ ACA § 1201, to be codified at 42 U.S.C. 300gg-4(j)(3)(C).

⁹⁵ ACA § 1201, to be codified at 42 U.S.C. 300gg-4(j)(3)(D).

⁹⁶ ACA § 1201, to be codified at 42 U.S.C. 300gg-4(j)(3)(E).

⁹⁷ ACA § 1201, to be codified at 42 U.S.C. 300gg-4(j)(3)(A).

⁹⁸ ACA § 1201, to be codified at 42 U.S.C. 300gg-4(j)(3)(A).

⁹⁹ ACA § 1201, to be codified at 42 U.S.C. 300gg-4(a) (applying nondiscrimination requirements to a “group health plan and a health insurance issuer offering group or individual health insurance coverage”).

permitted to distinguish between those who are in poor health or who fail to engage in healthy behaviors, and those who are healthier, in order to develop programs aimed at improving health. Third, rewards tied to health-related standards present greater discrimination risks than rewards tied to program participation, and therefore merit more safeguards. Fourth, legal safeguards take three main forms: a requirement that programs be designed to promote health, a mandate to lower health-related barriers to obtaining rewards, and a limit on the strength of incentives.

Because the central concern of these provisions is discrimination based on health factors, rather than discrimination or fairness more generally, it is not surprising that they fail to acknowledge most of the previously identified barriers to full wellness program participation. For employees with health-related barriers, the provisions ensure the availability of alternative standards. There is no similar provision for relief for those who face barriers related to time, income, environmental, or other factors. Instead, they are left to rely on the limited protection offered by the general requirement that wellness programs be designed to promote health, rather than to discriminate.

When wellness incentives involve the satisfaction of health factor-related standards, another form of protection enters the picture: the reward ceiling. The ACA is generally quite flexible about the nature of permissible rewards; employers can adjust deductibles, copayments, or premiums, for example.¹⁰⁰ In addition, it has little to say about the use of carrots versus sticks. The ACA frequently uses the term “reward,” but does not explicitly reject the use of penalties, and in fact implicitly permits them by characterizing the “absence of a surcharge” as a reward.¹⁰¹ This approach is consistent with the view that there is little substantive difference between rewards and penalties. But the ACA does constrain rewards by limiting their total magnitude to 30% of the total cost of coverage. A recent national survey suggests that the average annual premium for employer-sponsored coverage for an individual worker in 2010 was over \$5,000, which would mean that employer-sponsored health plans could tie up to about \$1,500 to health factor-related standards.¹⁰² The nearly \$14,000 average premium for family coverage implies a ceiling of over \$4,000.¹⁰³

¹⁰⁰ ACA § 1201, to be codified at 42 U.S.C. 300gg-4(j)(3)(A).

¹⁰¹ See ACA § 1201, to be codified at 42 U.S.C. 300gg-4(j)(3)(A).

¹⁰² The Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits 2010, at 1, *available at* <http://ehbs.kff.org/pdf/2010/8085.pdf>.

¹⁰³ *Id.*

This ceiling is tied to employers' and employees' contributions to the benefit plan, not to total health care costs. The effect will be that the richer the benefits package, the higher the rewards that can be offered. This approach makes sense if the justification for rewards is based in part on cost savings of the plan; a more comprehensive plan may pay out more for employees in poor health. It also makes sense given regulators' concern that a "reward (or penalty) might be so large as to have the effect of denying coverage to certain individuals."¹⁰⁴

The ceiling might help limit undue influence or coercion, to the extent that magnitude is a relevant consideration, but it is not particularly well suited for this task. In addition to the fact that the incentive's magnitude might not reflect its power over an individual employee, the ceiling is for incentives in the aggregate, rather than individual incentives. If an incentive program involves many different rewards, the magnitude of each one will be small, perhaps reducing the likelihood of undue inducement. But in theory, an employer with a ceiling of \$1,500 could put that entire amount toward a single incentive. In addition, the limit does not apply to many health-related incentives, including those not tied to health status factors (such as incentives for educational programs) and those offered to employed populations outside of group health plans.

The ceiling may also hinder attempts to use wellness incentives to shift the average costs associated with health risks from the group plan to the affected individuals. Regulators considered but ultimately rejected a standard that would permit rewards that were "actuarially determined based on the costs associated with the health factor measured under the wellness program."¹⁰⁵ To the extent that the ceiling binds, it helps to protect employees against the financial consequences of their health risks. It also helps to limit the extent to which employers can use these financial consequences as a mechanism to discourage generally unhealthy employees from joining or remaining in the employer's workforce, or from taking advantage of the employer's health plan.

The incentive ceiling is a blunt instrument for protecting individuals against the potential dangers of incentive programs. It is concrete and easy to administer, but is an imperfect tool for preventing discrimination, and fails to address many of the potential ethical concerns arising out of incentive programs. Furthermore, it may prevent employers from taking full advantage of incentives' power to alter behavior that is

¹⁰⁴ Notice of Proposed Rulemaking for Bona Fide Wellness Programs, 66 F.R. 1421 at 1422.

¹⁰⁵ Notice of Proposed Rulemaking for Bona Fide Wellness Programs, 66 F.R. 1421 at 1422.

costly in both financial and health terms. While \$1,500 is a lot of money in an absolute sense for most employees, it may be small relative to the value of health gains that could result from persistent incentive-induced behavioral change.

This analysis of the shortcomings of the current HIPAA/ACA ceiling raises the question of whether it might be appropriate to modify it, perhaps by increasing it to fifty percent of the insurance premium, as permitted under the ACA. In Part V, we argue that it might be. However, given our dearth of knowledge about the consequences of incentive programs for health, and the limits in existing regulations' ability to prevent the misuse of incentives, we call for more systematic evaluation of incentive program effects.

V. THE NEED FOR FURTHER RESEARCH AND EVALUATION

It is clear that employer-sponsored health incentive programs have the potential to benefit employees' health. It is equally clear that they have the potential to discriminate. Whether employer health incentive programs prove to be beneficial on balance will ultimately depend on many factors, including incentive program design, employee responsiveness, and regulatory limits. The only way to assess the impact of programs in practice is through systematic research and evaluation.

The ACA takes steps to encourage more research on the impacts of wellness programs in general, presumably including incentives. For example, it calls for the Centers for Disease Control and Prevention to assist employers in evaluating programs' impact on health status, absenteeism, productivity, injury, and medical costs as well as to conduct a national survey of policies.¹⁰⁶ Employers will likely want to determine the effects of these programs on their productivity and medical costs, as these factors may affect their profitability; appropriate assistance may help them do so more efficiently. They are unlikely to have the same incentive to assess the differential burdens that programs may have across their employees. Moreover, employers will have little incentive to invest the resources necessary for careful evaluation or reporting of their experience. They are particularly unlikely to share information about whether the creation of an incentive program has affected the willingness of unhealthy employees to join the company or to enroll in its health plan. And yet all of this information should be taken into consideration when evaluating the implications of a wellness plan.

¹⁰⁶ ACA § 4303, to be codified at 42 U.S.C. § 280I and §280I-1.

One way to address this dearth of information is to require employer reporting. For example, regulators may choose to consider lifting the health incentive ceiling to 50% only when employers document clear plans to monitor and report the effects of the programs on employees' behaviors and the characteristics of the workforce. In addition to reporting on the basic structure of their incentive programs, employers could report annually on the number and types of employees who earned incentives by adopting healthy behaviors. They could also track changes in the health profiles of their workforce and health plan membership over time, using demographic information, claims information, or information provided directly through an employee health risk assessment. Evidence that sicker employees were disproportionately leaving an employer or refusing to participate in health plans involving incentives would indicate that discrimination is at least a potential concern.

In addition, legislators and regulators could facilitate comparative evaluations of incentive programs by requiring employers to submit certain incentive program data to a central pool. They could also require employers seeking to incorporate high levels of incentives into their health plans to contribute a small sum, perhaps one percent of wellness program costs, toward funding these evaluations.

Another way the federal government could improve the evidence base for incentive programs is by supporting employers' use of randomized controlled trials. HIPAA regulations mandate that group health plan benefits "be uniformly available to all similarly situated individuals,"¹⁰⁷ a requirement that helps to ensure that plans do not discriminate based on health factors. Similarly, the ACA requires that health factor-related rewards be "made available to all similarly situated individuals."¹⁰⁸ In order for their effects to be studied, however, incentives must be allowed to vary. Incentives may vary across employers, across employees' benefit package options, and across "bona fide employment-based classification[s] consistent with the employer's usual business practice," such as geographic location or occupation.¹⁰⁹ These sources of variation are problematic, however, from an evaluation standpoint, because the individuals taking advantage of the varying incentive programs are likely to differ in underlying characteristics. Employees in different locations, for example, may have different propensities to engage in healthy behaviors, without regard to the incentives they face. In such a setting, it can be difficult to disentangle the effects of incentives from the effects of participants' underlying

¹⁰⁷ See 29 C.F.R. 2590.702(b)(2)(i)(B).

¹⁰⁸ ACA § 1201, to be codified at 42 U.S.C. 300gg-4(j)(3)(D).

¹⁰⁹ See 29 C.F.R. 2590.702(d).

characteristics. Randomized controlled trials can address this problem by randomly assigning employees to particular incentive programs. Trial participants would not receive “uniform” benefits in the end, but they would all have an equal opportunity to be assigned to a particular incentive program. By making clear that randomized trials are acceptable as a short-term benefit design, regulators may go a long way towards promoting the generation of evidence necessary to fully evaluate the legal and ethical implications of incentive programs.

There are limits to the benefits of each of these initiatives. A reporting requirement could discourage employers from participating in wellness programs, both because of the burdens it would impose and because of the increased scrutiny it would bring. Fees and centralized databases might also tend to chill the development of incentive programs. Employers may be reluctant to allow benefits to vary or unwilling to devote the necessary resources to set up an experiment.

Nevertheless, it is important to find ways to expand research related to incentive programs and health promotion more generally. The better we understand the relationship between particular behaviors and health status, and the more we know about the effects of incentives, the more easily we can evaluate whether an incentive program is truly “designed to promote health or prevent disease,” as required by the ACA.¹¹⁰

CONCLUSION

Individuals often fail to take the steps necessary to improve their own health. Reasons for this failure may include a lack of information, a lack of resources, systematic decision errors, and societal barriers. Employers cannot address all of these problems, but they may be able to tackle some of them. In their efforts to improve health, employers have increasingly turned to financial incentives, a trend consistent with the growing international interest in health incentives.¹¹¹ By supporting the development, evaluation, and regulation of incentive programs in a number of contexts, the ACA will likely reinforce this trend.

¹¹⁰ ACA § 1201, to be codified at 42 U.S.C. 300gg-4(j)(1)(A).

¹¹¹ K. Jochelson, *Paying the Patient: Improving Health Using Financial Incentives*, King’s Fund (2007): 3, *available at* <http://www.wpro.who.int/sites/hcf/documents/Paying+the+Patient+Improving+health+using+financial+incentives.htm> (giving examples of insurer incentive programs in England, South Africa, and Germany).

We believe that appropriately structured incentive programs may be able to improve public health, but that it is important to remain cognizant of the risks that incentive programs pose. By engaging in more systematic evaluation of incentive programs, we will develop a better understanding of not only how best to improve health but also how to design regulations to prevent discrimination, maximize equity, and minimize undue influence.