

# WikiWIT

## A Toolkit to Help Employers Set the Amounts of Wellness Incentives, Cut Points and Funding Strategies.

### Part 1: Concepts

$$\frac{\text{Med \$ BMI} + \text{Med \$ BP} + \text{Med \$ Chol} + \text{Med \$ Glucose}}{\text{Average}(c \cdot \text{Equity import}, d \cdot \text{Health import}, e \cdot \text{design confident}, f \cdot \text{Communicate confident})} \times \text{Min} \left[ \frac{b \cdot \text{Morale importance}}{a \cdot \text{Morale confident}}, 1 \right]$$

### Cost Sharing Options

		Wellness Incentive		
		Employer	Shared	Employee
Wellness Program	Employer	1	2	3
	Shared	4	5	6
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# Abstract

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This white paper describes WikiWIT, a framework, including a set of equations, employers can use to 1) set the amount of the wellness incentives offered in conjunction with their employee wellness programs, 2) determine the health standard cut point to earn the incentive, and 3) describe the extent to which the cost of the incentive and the wellness program might be paid by the employer or employee or shared among both of them. This white paper is Part I of a two part series. It focuses on concepts. Part II will focus on data from the literature to populate the equations and frameworks.

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[www.healthpromotionjournal.com/WikiWIT](http://www.healthpromotionjournal.com/WikiWIT)

# Introduction

**Background.** The Affordable Care Act (ACA), signed into law March 23, 2010, authorized self-insured employers and group health plans to charge premium differentials of up to 50% of health plan premiums based on employees or members participating in wellness programs, or meeting health standards. Background on the legislation is in Sidebar 1: “Legislative Context of Wellness Incentives.” The legislation has resulted in the majority of large employers integrating financial incentives into their health plan offerings to complement their wellness programs. In 2009, an estimated 36% of large employers offered participation incentives and 8% offered outcome incentives. By 2012, after the passage of the ACA, large employers have moved forward with 80% already offering incentives for participation and 38% for health outcomes<sup>1</sup> and 68% expecting to offer them for biometrics and 71% for tobacco use by 2016.<sup>2</sup> Employers who decide to implement incentive programs have three major questions: 1) How big should the incentives be? 2. What health risk cut points should be used to meet the standards?, and 3) How should the incentives be funded?

**Purpose.** The purpose of this white paper is to describe WikiWIT, a ToolKit to help employers answer these three questions. WikiWIT stands for Wiki Wellness Incentive ToolKit. “Wiki” is a Hawaiian word meaning quick. It has entered mainstream culture through the pioneering efforts of Wikipedia, which set the audacious goal of working to “compile the sum of all human knowledge” through a collaborative effort in which users supply the content.<sup>3</sup> We hope to capture that spirit within the health promotion community to refine WikiWIT.

Future elements of WikiWIT will be released based on insights provided by the collective health promotion community.

## Sidebar 1

### Legislative Context of Wellness Incentives

The Affordable Care Act (ACA), which was signed into law on March 23, 2010 confirmed this authority in statute. Regulations<sup>4</sup> jointly issued on June 3, 2013 by the US Departments of Labor, Treasury and Health and Human Services (Tri-Agency) became effective January 1, 2014, and provided guidelines on implementation. They clarified incentives could be awarded for three types of employer programs: 1) Participatory Only, which covered participating in health screenings, health risk assessment (HRA) questionnaires, educational seminars, and other similar programs. 2) Health Contingent-Activity Only for participation in activities related to a health condition like quitting smoking, weight loss, physical activity and other programs that require active engagement by the employee. 3) Health Contingent-Outcomes based on meeting specific health standards like not smoking, having normal blood pressure or normal blood values. Incentives for Health Contingent-Outcomes or Health Contingent-Activities could collectively be as much as 30% of an employee’s total health plan cost (including the cost for spouses and dependents). An additional incentive of 20% can be added for not using tobacco for a total of 50%. The limits on incentives for Participatory Only programs were not clarified in the regulations, but most employers have assumed the total for all incentives must be within the 50% limit.

The Equal Employment Opportunity Commission (EEOC) stalled in releasing its guidelines and instead issued legal challenges against employers who offered incentive programs in 2012, 2013 and 2014. Under pressure from the employer community and eventually from Congress and the White House, the EEOC released its proposed regulations on April

<sup>1</sup> Towers Watson. Staying@Work. 2011. Available at: <http://www.towerswatson.com/en-US/Insights/IC-Types/Survey-Research-Results/2011/12/20112012-StayingWork-Survey-Report--A-Pathway-to-Employee-Health-and-Workplace-Productivity>

<sup>2</sup> Towers Watson. Staying@Work. 2013. Available at: <http://www.towerswatson.com/en-US/Insights/IC-Types/Survey-Research-Results/2013/12/stayingatwork-survey-report-2013-2014-us>

<sup>3</sup> Wikipedia Purpose Available at: [https://en.wikipedia.org/wiki/Wikipedia\\_talk:Purpose](https://en.wikipedia.org/wiki/Wikipedia_talk:Purpose). Accessed August 20, 2015

<sup>4</sup> Federal Register, Vol. 78, No. 106, June 3, 2013. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans <https://www.federalregister.gov/articles/2013/06/03/2013-12916/incentives-for-nondiscriminatory-wellness-programs-in-group-health-plans>

## Sidebar 1 (cont.)

### Legislative Context of Wellness Incentives

20, 2015,<sup>5</sup> (48 months after the Tri-Agency regulations), with comments due by June 19, 2015. Final regulations were posted by the EEOC on May 17<sup>6</sup>. The biggest change is that the total of all incentives possibly being limited to 50%, the total incentives for health conditions measured in a health screening, including tobacco use, be limited to 30%. In 2006, prior to the passage of the ACA, the Departments of Labor, Treasury and Health and Human Services issued regulations clarifying that employers are permitted to offer incentives of up to 20% of health plan costs without violating non-discrimination guidelines of Health Insurance Portability and Accountability Act (HIPAA) of 1996. The HIPAA regulations related to wellness incentives were not very well understood by many employers, and some thought the incentive amounts were limited to 20% of the employee portion of the health plan premiums rather than 20% of the entire health plan premium. Incentives were relatively rare in workplace wellness programs prior to the passage of the ACA.

The three major components of the WikiWIT are described first, including equations to calculate incentive amounts, protocols to establish cut points to earn the incentive, and a review of options on how to fund the incentives as well as the wellness program. The Calculator includes separate equations for Participatory-Only, and Health Contingent-Outcomes Based incentives. Separate equations are not provided for Health-Contingent Activity Based incentives because we have not yet formulated a coherent rationale for the value of numerators for that type of incentive. Some users may choose to use the Health Contingent Outcomes Equations for those incentives, especially if performance of those activities is the reasonable alternative standard (RAS) option for the Outcomes Based incentive. This is followed by examples of incentive amounts generated from the Calculator for a range of employer situations. Sidebars and exhibits include a brief review of the legislative context of the incentives, details on the equations, and questions to be answered by employers to generate values for some variables in the equations. The white paper ends with some reflections on future enhancements to the Framework and Calculator and an invitation to readers to share their insights. Part II of the Toolkit will include a review of select studies from the scientific and popular literature that provides appropriate data to populate the calculator. The intended audience for this paper is consultants and employers responsible for developing organization-level wellness incentives using the ACA regulations. It assumes readers have a basic understanding of the regulations guiding implementation of the law. As such, it does not include a detailed review of the types of incentives allowed within the ACA, although these are reviewed very briefly in the **Sidebar 1**. Also, this paper does not include a review of the pros and cons of incentives, a review of the relative advantages and disadvantages of one type of incentive over another, or any recommendations on the best strategy for RAS allowed within the ACA, although these are reviewed very briefly in the **Sidebar 1**.

**Scope and Format.** The intention of this paper is to describe the concepts and the equations in sufficient detail that readers can use them independently. However a link is also provided to an online version that calculates suggested incentive amounts based on information entered by users. It also includes a communication forum for users to share feedback on the concepts and equations and suggest enhancements.

<sup>5</sup> Federal Register, Vol. 80, No. 75, April 20, 2015. Amendments to Regulations Under the Americans With Disabilities Act <https://www.federalregister.gov/articles/2015/04/20/2015-08827/amendments-to-regulations-under-the-americans-with-disabilities-act>

<sup>6</sup> Equal Employment Opportunity Commission. EEOC's Final Rule on Employer Wellness Programs and Title I of the Americans with Disabilities Act. Available at: <https://www.eeoc.gov/laws/regulations/qanda-ada-wellness-final-rule.cfm>. Last accessed July 14, 2016

# WikiWIT Components

## Introduction

WikiWIT consists of three major components designed to help employers answer the three major questions: Amount of the incentives, cut points to earn the incentives, and funding approaches. The equations portion include three separate sets of equations for the amounts of the incentives, with sets provided for incentives for 1) Participation, 2) Tobacco Use, and 3) Biometric outcomes. The three equations are shown in Exhibit 1: WikiWIT Equations. The total incentive amount would be the addition of the values for each of the groups of equations if the employer is offering all three types of incentives.

## Equations For Wellness Incentive Calculator

WikiWIT includes seven equations, organized into three groupings. The conceptual elements and structures of the equations are described immediately.

## Contents and Structures of the Equations

### Contents: Conceptual Elements.

The elements of the equations come from two basic sources: judgments by employers on their priorities, perceptions, and expert opinion based in part on reports in the scientific and professional literature. Judgments by employers include the relative priority they place on medical cost equity, health behavior change, enhancing employee morale, their levels of confidence in their ability to design and manage an incentive program, their ability to communicate it effectively and the impact of the wellness incentives on morale. These concepts are described in Sidebar 2: Conceptual Variable on Employers Confidence and Priorities. Values for these variables are drawn from employers' responses to the questions in Exhibit 2: Employer Confidence and Importance Questions. Expert opinion judgments must be made on two types of variables: the amount of financial incentive necessary to motivate an

employee to participate in an aspect of a wellness program and the differential medical cost associated with a specific health risk. The professional and scientific literature in each of these areas is limited, but some studies have been conducted; several of these will be reviewed in Part II of this white paper series.

### Structure: Numerators and Denominators

All except one of the equations has the same basic structure: a numerator that represents the maximum possible value of the incentive, a denominator that has the potential to reduce that value, and a multiplier that also has the potential to reduce that value.

The values of the numerators are driven by findings in the scientific literature on what drives behavior or the additional medical cost associated with each health risk. The denominators reflect employers' self-judged priorities related to cost equity and motivating behavior change and their confidence in their ability to design and manage an effective wellness incentive structure and in communicating it effectively. When employers place high values or are very confident on a factor, the score within the equation for this factor is "1." When employers place a lower value or have lower confidence, the score of the factor is "2" or "3". If all the scores are high i.e., "1", for importance placed on cost equity and improving employee health, and for the level of confidence in designing and managing an effective wellness incentive structure and communicating it effectively, then the sum of scores equals 4. The sum is divided by four, making the value of the denominator 1, resulting in no change in the value of the incentive. If any of the values are low i.e. 2, or 3, the value of the denominator is greater than 1, then the value of the incentive is reduced.

The multiplier reflects the **importance** the employer places on morale being enhanced by the incentive divided by the employer's **confidence** that the wellness incentive will enhance morale. When importance and confidence are equal, the multiplier has a value of 1 and has no impact on the maximum incentive value. When importance is greater than confidence (i.e., has a lower score), the multiplier has

## Sidebar 2

### Conceptual Variable on Employers Confidence and Priorities

*Employer confidence ratings.* Different employers will have different levels of confidence in their ability to design and manage an incentive program, their ability to communicate it effectively and the impact of the wellness incentives on morale. Their levels of confidence in these areas impact the amount of the incentives. Each of these factors is described below.

*Employee Morale.* Employers need to consider the impact of wellness incentives on employee morale. Employers pay competitive salaries and offer a wide range of health, retirement, and other benefits to attract and retain the most talented people. Supporting this goal should be the bedrock of all employer policy decisions, especially policies related to employee benefits. A policy that damages employee morale is likely to reduce productivity, increase turnover, and make it more difficult to attract and retain high-quality employees, all of which are likely to destroy an organization much faster than unsustainable medical costs. Expressed more directly...employers should do everything possible to avoid creating a benefit structure that damages employee morale. Wellness incentives may enhance morale in some organizations, and hurt morale in others. Employers rating of their confidence that the wellness incentives will enhance morale will impact the amount of the incentives.

*Wellness Incentive Program Design and Management.* Designing and managing a wellness incentive program is challenging. Successful design and management of programs requires knowledge of the regulations including the legal appeals processes, understanding of behavioral psychology, intricate record keeping and stringent quality controls. This is a relatively new experience for employers and their consultants. It is likely that employers will make mistakes designing and implementing these programs for at

least one or two annual cycles before they work through all the common problems and develop best practice standards. Employers rating of their confidence in their ability to design and manage the incentive program will impact the amount of the incentives.

*Communication Strategy and Campaign.* The quality of the communication strategy and campaign can have a significant impact on employees' perception of the wellness incentives. A well designed and executed strategy and campaign can make employees excited about the incentives while a poorly designed and executed strategy and campaign can intensify employee concerns. Employers rating of their confidence in their ability to develop and implement an effective communication strategy and campaign will impact the amount of the incentives.

*Medical cost equity.* Employers who place a high priority on cost equity strive to reduce the extent to which employees are forced to subsidize the medical costs of other employees who have higher medical costs because of lifestyle choices they have made. These employers will support larger wellness incentive levels.

*Health behavior change.* Employers who place high priority on stimulating health behavior change will want to ensure wellness incentives are large enough to motivate employees to participate or to change.

*Enhancing morale.* Employers who place a high priority on enhancing morale will want to ensure their beliefs about the impact of incentives on morale will influence incentive values while those who place a low value will be less concerned about it. Also, from an incentive design perspective, employers who place a high value on morale will make a greater effort to set achievable health outcome standards, reasonable alternative standards, develop effective communication strategies and manage their programs effectively.

## Exhibit 1 WikiWIT Equations

### Health Screening and/or HRA Participation Incentive

#### Option 1: Participation Rate Desired

$$1 \cdot \text{Nudge Incentive}$$

#### Option 2: Medical Cost Equity Driven

$$\frac{\text{Med \$ Participate}}{[(c\text{Equity import} + d\text{Health import} + e\text{Design confident} + f\text{Communicate confident}) \div 4]} \times \text{Min} \left[ \frac{{}^b\text{Morale importance}}{{}^a\text{Morale confident}}, 1 \right]$$

#### Option 3: Modified Participation Rate Desired

$$\frac{1 \cdot \text{Nudge Incentive}}{[(c\text{Equity import} + d\text{Health import} + e\text{Design confident} + f\text{Communicate confident}) \div 4]} \times \text{Min} \left[ \frac{{}^b\text{Morale importance}}{{}^a\text{Morale confident}}, 1 \right]$$

### Health Contingent Outcome Based Incentives for Biometric Screenings Not Including Tobacco

#### Option 1: Participation Driven

$$\frac{\# \text{ of outcomes} \cdot \text{Nudge Incentive}}{[(c\text{Equity import} + d\text{Health import} + e\text{Design confident} + f\text{Communicate confident}) \div 4]} \times \text{Min} \left[ \frac{{}^b\text{Morale importance}}{{}^a\text{Morale confident}}, 1 \right]$$

#### Option 2: Medical Cost Equity Driven

$$\frac{\text{Med \$ BMI} + \text{Med \$ BP} + \text{Med \$ Chol} + \text{Med \$ Glucose}}{[(c\text{Equity import} + d\text{Health import} + e\text{Design confident} + f\text{Communicate confident}) \div 4]} \times \text{Min} \left[ \frac{{}^b\text{Morale importance}}{{}^a\text{Morale confident}}, 1 \right]$$

### Health Contingent Outcome Based incentives for tobacco use

#### Option 1: Participation Driven

$$\frac{1 \cdot \text{Nudge Incentive}}{[(c\text{Equity import} + d\text{Health import} + e\text{Design confident} + f\text{Communicate confident}) \div 4]} \times \text{Min} \left[ \frac{{}^b\text{Morale importance}}{{}^a\text{Morale confident}}, 1 \right]$$

#### Option 2: Medical Cost Equity Driven

$$\frac{\text{Med \$ Tobacco}}{[(c\text{Equity import} + d\text{Health import} + e\text{Design confident} + f\text{Communicate confident}) \div 4]} \times \text{Min} \left[ \frac{{}^b\text{Morale importance}}{{}^a\text{Morale confident}}, 1 \right]$$



## Variable and Constant Definitions

**Med \$ participate** = difference in medical costs between participants and non-participants. Default is \$0

**Morale confident** = Response value for morale confidence question. Options are 1, 2, or 3

**a** = relative priority of confidence in the impact of incentives on Morale; default value is 1.

**Morale import** = Response value for morale importance question. Options are 1, 2, or 3

**b** = relative priority of morale enhancement to the organization; default value is 1.

**Equity import** = Response value for cost equity importance question. Options are 1, 2, or 3

**c** = relative priority of cost equity to the organization; default value is 1.

**Health import** = Response value for health improvement importance question. Options are 1, 2, or 3

**d** = relative priority of health improvement to the organization; default value is 1.

**Design confident** = Response value for confidence in ability to design and managing incentive program

**e** = Relative priority of ability to design and manage incentive program; default value is 1.

**Communicate confident** = Response value for confidence in ability to communicate about the incentive program

**f** = Relative priority of ability to communicate about the program; default value is 1.

**Nudge Incentive** = Amount required to motivate a person to perform a simple health related task on a short term basis

**Med \$ BMI** = Additional medical costs associated with elevated BMI

**Med \$ BP** = Additional medical costs associated with elevated blood pressure

**Med \$ Chol** = Additional medical costs associated with elevated total cholesterol

**Med \$ Glucose** = Additional medical costs associated with elevated glucose or HA1c0

**#** = number of health risks incentivized

**Med \$ Tobacco** = Difference in cost of current smokers vs. never smokers.

## Exhibit 2

### WikiWIT Employer Confidence and Importance Questions

#### Confidence

##### Employee Morale

1. How confident are you that adding incentives will enhance morale?
  - a. Very confident= 1
  - b. Somewhat confident= 2
  - c. Not confident = 3

##### Program Design and Management

2. How confident are you that you will be able to design, implement and manage a complex incentive design structure without error?
  - a. Very confident= 1
  - b. Somewhat confident= 2
  - c. Not confident = 3

##### Communication

3. How confident are you that you will be able to develop and launch a communication campaign that will excite employees about the incentive and overcome most if not all concerns?
  - a. Very confident= 1
  - b. Somewhat confident= 2
  - c. Not confident = 3

#### Importance

##### Employee Morale

4. How important is it to the organization that employee morale be enhanced by the incentives?
  - a. Very important = 1
  - b. Somewhat important = 2
  - c. Not important = 3

##### Cost Equity

5. How important is it to the organization that the burden of healthy employees subsidizing unhealthy employees is reduced?
  - a. Very important = 1
  - b. Somewhat important = 2
  - c. Not important = 3

##### Health Improvement

6. How important is it to the organization that the incentive program motivates employees to participate in the program and makes an effort to improve health?
  - a. Very important = 1
  - b. Somewhat important = 2
  - c. Not important = 3

a value less than one, and it reduces the value of the incentive. By definition within the equation, the multiplier cannot have a value greater than 1, so the multiplier will never increase the value of the incentive.

Employers' scoring on the factors in the denominator can reduce the maximum value by as little as 0% and much as 66%. The multiplier can further reduce the maximum value by as little as 0% and by as much as 66%. Combined, they can reduce the maximum by 89%.

Each of the factors in the equation includes a modifier variable (shown as a-f in Exhibit 1. For example, an employer might decide that enhancing morale is a top priority and cost equity is a secondary priority or vice versa. These allow the user to set different levels of priority for each of the factors. The default value of these variables is 1, which means the factors are all weighted the same.

Option 1 for the Participation incentives is the only equation that does not follow the structure protocol described above.

## Health Screening and/or HRA Participation Incentive Equation

The participation equation has three options.

**Option 1: Participation Rate Desired** is appropriate for wellness programs that have very limited scope, for example for wellness programs that provide an HRA and/or health screening, but no skill building programs to help people quit smoking, lose weight, or make other changes. It might also be appropriate when participation in the HRA or health screening is the only thing incentivized. This equation has only one factor, the nudge incentive, i.e., the amount of money expected to be necessary to motivate a person to participate in the health screening. The nudge incentive value can be set based on the level of participation desired. Estimates on the value of the nudge factor will be reviewed in Part II of this white paper series. A generalized form of this equation can be constructed for use in calculating the total incentive value for participating in multiple programs by multiplying the nudge incentive by the number of programs. For the purposes of the HRA and/or health screening, the number of programs is 1.

## Option 2: Medical Cost Differential

is appropriate for employers that prefer to base incentives on the additional medical costs associated with each behavior and when the medical costs are higher for those who do not participate in HRAs or health screenings. The numerator in the left part of the equation, "Med\$Participate" represents these additional costs. The denominator and the multiplier follow the standard structure described earlier.

## Option 3: Modified Participation Rate Desired

is appropriate for more comprehensive wellness programs that provide incentives for meeting health standards in addition to those provided for participating in screenings and HRA. The numerator is the same nudge incentive as option 1 above, but the denominator and multiplier structure is included to create the possibility of reducing its value. The rationale is that additional incentives can be earned by meeting health standards, so there is less need for a large incentive for the HRA or health screening. Those larger incentives for meeting the health standard provide the primary motivation, and the smaller participation incentive provides an initial tangible reward for taking the first step.

## Health Contingent Outcome Based Incentives for Biometric Screenings not Including Tobacco

The equation for biometric screenings outcomes excluding tobacco has two options. Both are variations of the participation incentives described above.

**Option 1: Participation Driven** is appropriate for organizations that prefer to base the incentive on the amount necessary to motivate people to participate. The numerator consists of the financial incentive necessary to motivate the desired portion of the population to participate multiplied by the number of outcomes that are incentivized. The denominator and multiplier are the standard structures described above.

**Option 2: Cost Equity Driven** is appropriate for organizations that prefer to base the incentive on the additional medical cost associated with each of the health outcomes. The numerator consists of the differential costs for each of these outcomes. The illustration shows factors for BMI, blood pressure, cholesterol and glucose. Organizations can include as many or few of these as they prefer based on their priorities. Estimates for these values are discussed later. The denominator and multiplier are the standard structures described above.

## Health Contingent Outcome Based Incentives for Tobacco Use

The equation for tobacco use has two options. Both are variations of the biometric outcomes described above.

**Option 1: Participation Driven** equation for Tobacco Use is the same as the participation driven equations for HRA/Screening participation, with the nudge factor multiplied by 1 in both cases.

**Option 2: Cost Equity Driven** equation for Tobacco Use is very similar to the Cost Equity equation for Cost Equity. The only difference is that the numerator includes the additional medical cost for only one health risk...tobacco use.

## Maximum Values of Incentives

The maximum value for each incentive is the lessor of the maximum amount allowed by the Tri-Agency regulations for the ACA (e.g., 30% for biometric values and 50% total if including tobacco) and the additional medical costs associated with each risk factor. For example, if an employer sets the incentive for BMI at 13% and for blood pressure at 18%, the total would be 31%, greater than the 30% allowed by law. If the employer offered additional incentive for other outcomes, like cholesterol or glucose, the total would be even higher. If the value were not reduced to 30% or less by the multiplication with the denominator or the multiplier, it would need to be reduced directly. This can be done proportionally. For example, BMI would be reduced to 12.58%, 12.6% or 13% ( $13\% \times 30 \div 31 = 12.58$ ), depending on the precision desired by the user,

and blood pressure would be reduced to 17.42%, 17.4% or 17% ( $18 \times 30 \div 31 = 17.42$ ), for a total of 30%. Similarly, if the additional medical costs associated with tobacco were 13%, the maximum for the incentive in this equation would be 13% rather than the 20% allowed by the ACA in addition to the 30% allowed for biometric incentives. (Note, the proposed regulations from the EEOC suggest that incentives for tobacco use be included in the 30% maximum if tobacco use is confirmed through a biometric screening. If the total for blood pressure, BMI and tobacco were 44% ( $13\% + 18\% + 13\% = 44\%$ ), these values would be reduced to 8.86%, 12.27% and 8.86% respectively, so the total does not exceed 30%. This reduction would be necessary if the final regulations from the EEOC retain this 30% maximum amount.) These adjustments would be necessary only if the 31% or 44% values were not reduced to 30% or below by the denominator or the moderator values.

Several examples for participation, biometrics and tobacco use are described in Exhibit 3: Examples using the WikiWIT Equations.

### Exhibit 3 Examples using the WikiWIT Equations

Several examples for participation, biometrics and tobacco use are described below. The values from each example have been selected for illustration. They are reasonable examples based on the limited published literature in this area, but they do not represent consensus estimates based on a thorough review of the literature. Employers' responses to the Exhibit 2 questions are shown in Exhibit 4: Employer Confidence and Importance Questions.

## Participation

### Example 1: Health Screening and HRA Participation Rate Desired

In example 1, the employer is setting the incentive level for participating in the Health Screening and HRA. It decides that one incentive will be offered for completing both of these, and the "Participation Rate Desired" equation will be used because the wellness program is not comprehensive. It wants to achieve an

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80% participation rate and decides the incentive should be \$650 to achieve this level. This represents approximately 10% of the total health plan cost, so 10% is entered into the equation.

**Example 2: Health Screening and HRA Participation Modified Participation Rate Desired.**

In example 2, the employer is setting the incentive level for participating in the Health Screening and HRA, with one incentive offered for completing both. It decides to use the Modified Participation Rate Desired equation because the wellness program is comprehensive and the larger rewards will come from achieving health goals. The employer wants to achieve 80% participation rate, so it starts with the \$650 incentive. This represents approximately 10% of the total health plan cost, so 10% is entered into the equation.

In reflecting on the Employer Confidence and Importance questions, it decides that employee morale, cost equity, and health improvement are all “very important.” The employer is only “somewhat confident” that the program will enhance morale, it can design and administer the program and that it can communicate it somewhat confidently. It decides these factors are top priorities.

Including all these factors in the equation results in an incentive of 2.86% to participate in the health screening and HRA.

**Example 3: Health Contingent Outcome Based incentives for biometric screenings not including tobacco + Health Contingent Outcome Based incentives for tobacco use.**

In example 3, the employer is setting the incentive level for the biometric outcomes. It decides to incentivize BMI and blood pressure, using 13% and 18% medical cost differential values respectively as a starting point in the numerator, and decides not to incentivize cholesterol or glucose because it decides there is no differential medical costs for either of them. They are still included in the health screening because of their clinical importance.

In reflecting on the Employer Confidence and Importance questions, it decides that employee morale, cost equity, and health improvement are all

“very important,” and it is “very confident” that the program will enhance morale, it can design and administer the program and that it can communicate it very confidently. It decides all of these factors are top priorities. Including all these factors in the equation results in an incentive of 31% for the biometrics, which exceeds the 30% maximum allowed by the ACA.

Adjusting the total to 30% results in 12.6% for BMI and 17.4% for blood pressure.

The employer decides to use 13% as the medical cost differential for tobacco as the starting point, and including all the same values as above for the other variables, resulting in a 13% incentive for tobacco, which is less than the 20% remaining allowable by the ACA.

**Example 4: Health Contingent Outcome Based incentives for biometric screenings not including tobacco + Health Contingent Outcome Based incentives for tobacco use.**

In example 4, the employer is setting the incentive level for the biometric outcomes. It decides to incentivize BMI and blood pressure, using the 13% and 18% medical cost differential values as a starting point in the numerator, and decides not to incentivize cholesterol or glucose because it decides there are no differential medical costs for them. The employer decides to include cholesterol and glucose in the health screening because of their clinical importance, even though they are not incentivized. In reflecting on the Employer Confidence and Importance questions, it decides that employee morale and health improvement are “very important” but cost equity is “not very important.” It also decides it is “not confident” that the program will enhance morale and only “somewhat confident” it can design and administer the program and communicate it effectively. It decides that cost equity is a secondary priority and all of the other factors are top priorities.

Including all these factors in the equation results in an incentive of 1.58% for BMI and 2.18% for blood pressure.

Using 13% medical cost differential for tobacco as the starting point, and including all the same values as above for the other variables, results in a 1.58% incentive for tobacco.

## Exhibit 4

### Employer Confidence and Importance Questions Responses for Examples 2, 3, and 4

## Confidence

### Employee Morale

How confident are you that adding incentives will boost morale?

#### Example 2

b. Somewhat confident = 2  
Top priority = 1

#### Example 3

a. Very confident = 1  
Top Priority = 1

#### Example 4

c. Not confident = 3  
Top Priority = 1

### Program Design and Management

How confident are you that you will be able to design, implement and manage a complex incentive design structure without error?

#### Example 2

b. Somewhat confident = 2  
Top priority = 1

#### Example 3

a. Very confident = 1  
Top Priority = 1

#### Example 4

b. Somewhat confident = 2  
Top Priority = 1

### Communication

How confident are you that you will be able to develop and launch a communication campaign that will excite employees about the incentive and overcome most if not all concerns?

#### Example 2

b. Somewhat confident = 2  
Top priority = 1

#### Example 3

a. Very confident = 1  
Top Priority = 1

#### Example 4

b. Somewhat confident = 2  
Top Priority = 1

## Importance

### Employee Morale

How important is it to the organization that employee morale be enhanced?

#### Example 2

a. Very important= 1  
Top priority = 1

#### Example 3

a. Very important= 1  
Top Priority = 1

#### Example 4

a. Very important= 1  
Top Priority = 1

### Cost Equity

How important is it to the organization that the burden of healthy employees subsidizing unhealthy employees is reduced?

#### Example 2

a. Very important= 1  
Top priority = 1

#### Example 3

a. Very important= 1  
Top priority = 1

#### Example 4

a. Not Very important = 3  
Secondary Priority = 2

### Health Improvement

How important is it to the organization that the incentive program motivates employees to participate in the program and make an effort to improve health?

#### Example 2

a. Very important= 1  
Top priority = 1

#### Example 3

a. Very important= 1  
Top priority = 1

#### Example 4

a. Very important = 1  
Top Priority = 1

# Cut Points on Health Standard to Earn Incentives

Employers need to confirm the cut points, or health standards that need to be met to earn the incentive. Two basic options can be used.

One option is to set the standard based on clinical guidelines for optimal health. For example, for tobacco use, the standard might be no use of any form of tobacco or nicotine product, with confirmation through cotinine testing. For blood pressure, it might be having normal blood pressure (less than 120/80), for cholesterol (less than 200), glucose (less than 100), and Hemoglobin A1C (less than 7). A variation on this approach might be to set the standard slightly above the clinical guideline standard to account for measurement error, or give employees a sense of leniency. For example, the standard for blood pressure might be borderline high (less than 140/90). Organizations following this standard need to consult clinical guidelines for each health area.

Another option might be to set the standard based on the point at which medical costs associated with each level of the variable start to increase. For example, the standard to be met for BMI might be the BMI level at which medical costs are lowest. Research establishing these cut points is limited.

## Cost Sharing Options

An effective wellness program may be successful in reducing medical costs by an amount equal to or greater than the program costs, but is probably not likely to reduce those costs enough to also cover the costs of the wellness incentive if the incentives are more than a few hundred dollars. The cost of the wellness program and the incentives can each be paid entirely by the employer, split between the employer and employee, or paid entirely by the employee through the health plan premium and other mechanisms. The three cost options for each results in nine different cost sharing options for the combined costs; six of them are plausible and three are not. All nine are briefly described below. The implausible options are included at this early stage to avoid discouraging development of variations of them that may be plausible.

The approach most appropriate for an employer will be driven by how much value it places on fiscal sustainability, cost equity and employee morale. The likely values for each of these factors associated with each of the options are shown below. The options and the ratings are shown graphically in Exhibit 5: Cost Sharing Options and Exhibit 6: Ratings for Cost Sharing Options

**Exhibit 5**  
**Cost Sharing Options**

Wellness Program	Wellness Incentive		
	Employer	Shared	Employee
Employer	1	2	3
Shared	4	5	6
Employee	7	8	9

**Exhibit 6**  
**WikiWIT Ratings for Cost Sharing Options**

Impact of funding options on key outcomes

Funding Option	Fiscal Sustainability	Cost Equity	Morale Enhancement
1	Weak	Weak	Strong
2	Moderate	Moderate	Unknown
3	Moderately Strong	Strong	Unknown
4	Weak	Weak	Unknown
5	Moderately Weak	Moderate	Unknown
6	Strong	Moderately Strong	Unknown
7	Weak	Weak	Unknown
8	Moderate	Moderate	Unknown
9	Strong	Strong	Unknown

Ratings on Fiscal Sustainability are based on subjective assessments of the literature on the impact of wellness programs and financial incentives on cost savings. There is an abundant literature on the impact of workplace wellness programs on medical costs. There is virtually no empirical literature on the impact of financial incentives on medical costs in the context of workplace wellness programs, but new studies will hopefully emerge in the coming years as more incentive programs are implemented and analyzed through rigorous methods.

Cost Equity is rated “Strong” if the entire medical cost differential of a health risk is paid for by the employees who have that health risk. It is rated as “Weak” if none of the cost differential is paid by the employees who have the risk, and “Moderate” if some of it is paid by the employees who have the risk.

All of the ratings on the impact of funding options on Employee Morale are “unknown” because there is little if any literature to inform this area. Employers need to make their own judgments on this rating. Reviewing the questions in Exhibit 2 may help employers reflect on this issue.

**Option 1.** Employer pays the full cost of the wellness program and the wellness incentive directly. If the wellness program is effective, there is a good chance that medical costs will be reduced enough to pay for the cost of the wellness program in full. However, it is not likely that enough will be saved to cover the cost of the incentive if the incentives are more than several hundred dollars. This approach will be most common with employers who are not focused on reducing medical costs and those who have small incentives.

**Ratings**

**Fiscal Sustainability:** Weak  
**Cost Equity:** Weak  
**Employee Morale:** Unknown

**Option 2.** Employer pays the full cost of the wellness program directly and shares the cost of the incentive with the employee by adding the cost of the incentive to the health plan premium and distributing those costs to the employer and employee through its usual health plan premium cost sharing formula.

This increases the likelihood that the employer will break even on the total cost of the wellness program and the incentives, but does not provide certainty.

**Ratings**

**Fiscal Sustainability:** Moderate  
**Cost Equity:** Moderate  
**Employee Morale:** Unknown

**Option 3.** Employer pays the full cost of the wellness program directly and adds the full cost of the incentive to the employee portion of the health plan premium. This approach will be cost neutral to the employer if the wellness program reduces medical costs enough to pay the full costs of the program. This is probably the approach most common among employers who are implementing incentive programs for existing wellness programs and are offering large incentives. It is also most common among employers who place the highest value on cost equity.

**Ratings**

**Fiscal Sustainability:** Moderately Strong  
**Cost Equity:** Strong  
**Employee Morale:** Unknown

**Option 4.** Employer pays cost of the wellness incentive directly and shares cost of the wellness program with the employee by adding the cost of the incentive to the health plan premium and distributing those costs to the employer and employee through its usual cost sharing formula. This option is unlikely because employers who are willing to pay any of the costs directly are more likely to pay for the wellness program than the incentive because they believe the wellness program will pay for itself by improving employee health. This option is less likely to break even for the employer than option 2 because the incentives normally cost more than the wellness program.

**Ratings**

**Fiscal Sustainability:** Weak  
**Cost Equity:** Weak  
**Employee Morale:** Unknown

**Option 5.** The full cost of the wellness program and the wellness incentives are shared between employer and employee by building them into the health plan premium.

This approach will be used by employers who think of the wellness program as similar to any other type of health service covered by the health plan but place a low priority on cost equity and on saving money through the wellness program.



### Ratings

<b>Fiscal Sustainability:</b>	<b>Moderately Weak</b>
<b>Cost Equity:</b>	<b>Moderate</b>
<b>Employee Morale:</b>	<b>Unknown</b>

**Option 6.** The full cost of the wellness program is shared between employer and employee by building them into the health plan premium and the cost of the incentive is paid by the employee by adding it into the employee portion of the premium. This approach will be used by employers who think of the wellness program as similar to any other type of health service covered by the health plan and also place a high priority on cost equity and a high priority on saving money through the wellness program.

### Ratings

<b>Fiscal Sustainability:</b>	<b>Strong</b>
<b>Cost Equity:</b>	<b>Moderately Strong</b>
<b>Employee Morale:</b>	<b>Unknown</b>

**Options 7-9.** The three circumstances in which the full cost of the wellness program is paid for by employees are described below as three sub-options within option 6 because two of the three are unlikely. Option 6 might occur if the employer offers a range of wellness programs, but requires employees to pay for them on a fee for service basis as they are consumed. For example, the employer might build a fitness center, and recoup the cost by charging membership dues. Similarly, the employer might contract for weight loss or stress management experts to provide courses onsite, but require employees to pay fees to participate in these programs. This approach is not unusual. A less common variation of this approach might be to build the full cost of these programs into the employee portion of the health plan premium and not charge employees on a fee for service basis. Employers who select any of these three options will place a high priority on the wellness program being fiscally sustainable. The difference in the three variations is the importance they place on the incentive program (versus the wellness program) being fiscally sustainable.

**Option 7.** The full cost of the incentive is paid by the employer. This approach is unlikely. If the employer is not willing to pay for the wellness program, something that has a chance of paying for itself through medical cost savings, they are not likely to be willing to pay for the incentive, something that is not likely to pay for itself.

### Ratings

<b>Fiscal Sustainability:</b>	<b>Weak</b>
<b>Cost Equity:</b>	<b>Weak</b>
<b>Employee Morale:</b>	<b>Unknown</b>

**Option 8.** The cost of the incentive is shared by the employers and employee. This approach is unlikely for the same reasons 6b is unlikely.

### Ratings

<b>Fiscal Sustainability:</b>	<b>Moderate</b>
<b>Cost Equity:</b>	<b>Moderate</b>
<b>Employee Morale:</b>	<b>Unknown</b>

**Option 9.** The full cost of the wellness program and the incentives are paid by the employee. Employers using this approach place the highest priority on making the program both fiscally sustainable and cost equitable. This will be the most common of the three option 6 approaches, and may be very common among employers launching wellness programs in response to the new ACA regulations.

### Ratings

<b>Fiscal Sustainability:</b>	<b>Strong</b>
<b>Cost Equity:</b>	<b>Strong</b>
<b>Employee Morale:</b>	<b>Unknown</b>

It is important to note that all of the options above describe variations in the health plan premium. Other options include increasing or decreasing the amount of the deductible or the amount deposited in a health savings account (HSA) or health reimbursement account (HRA).

# Areas for Future Enhancement/Feedback Requested

Feedback is sought on all aspects of Part I of WikiWIT. Ideas should be submitted to the website: [www.healthpromotionjournal.com/WikiWIT](http://www.healthpromotionjournal.com/WikiWIT), and organized under the major categories below. Ideas will be posted for public review after being screened for clarity.

## Major Components.

Part I of WikiWIT has three major components: 1) Equations to determine the amount of incentives; 2) Guidelines for establishing cut points or health standard to earn incentives; 3) Funding Options to guide the extent to which program costs and incentive costs should be shared between employer and employee. Do these four components cover the major issues involved? What, if any, new components should be added?

## Equations for Incentive Amounts

**Focus of Equations.** Seven equations are provided. These are organized into sets for participation, biometric outcomes and tobacco use. Do these equations cover the full scope of the issue? Is it important to provide a set of equations for Health-Contingent Activity Only incentives, or is it appropriate to think of Activity Only elements as Reasonable Alternative Standards flowing from the Outcomes? What other sets of equations are important to add?

## Factors within the Equations.

The equations include factors reflecting employers' levels of priorities relative to morale, cost equity, and behavior change and their confidence that the wellness program will enhance morale and that they can develop, manage and communicate the incentive program effectively. They also include factors representing the differential medical cost for those who do and do not have the risk factors, as well as the amount required to persuade an employee to perform a simple behavior. Are these the most import

ant factors to include in the equations? Which if any should be removed? Which new ones, if any, should be added?

**Equation Structures.** The numerators in all the equations represent values from the literature about medical cost differentials, or the amount required to nudge an employee to pursue a specific behavior. The values of the numerators also reflect the maximum value of the equations. The numerators and multiplier represent employer priorities and levels of confidence. The impact of the denominator and multiplier is to reduce or not change the value of the equation, never to increase it. The two elements of morale are in the multiplier rather than the denominator to allow them to have more impact on the value of the equation than any of the other employer factors, and to allow those two elements of morale to directly influence each other. Does this structure combine the factors in the most appropriate ways? If not, what structure might be more appropriate?

## Factor Modifier

**Weightings.** Each of the factors includes a modifier variable to allow the user to assign a greater or lesser value to any of the factors. The default value for all of the modifiers is 1, which makes all of the factors have equal value. Should the modifiers be retained or deleted? Should the default values be 1, or should the factors be weighted based on findings in the literature or any other reason?

## Cut Points on Health Standard to Earn Incentives

Three different rationales are suggested for setting the cut points for the health standards that must be met to earn the incentives. These are the inflection point at which the medical costs for the risk factor are lowest, the optimal level from a health perspective, based on clinical standards, and slightly above the clinical standards. Should other approaches be considered?

## Cost Sharing Options

The Funding Options section shows nine options for sharing costs of the wellness program and the incentives. Do these nine options reflect the full range of options? Is not, what are other important options? Are the ratings for fiscal sustainability, cost equity and employee morale reasonable for each of the options? If not how should they be modified? What other major factors should be considered?

## Data from Scientific Literature and Practice to Populate Equations

Readers are encouraged to identify studies from the scientific literature that measure the items below.

- ◆ Differences in medical costs among participants and non-participants in HRAs
- ◆ Differences in medical costs among participants and non-participants in health screenings
- ◆ Differential medical costs for BMI, blood pressure, glucose, Hemoglobin A1C and cholesterol
- ◆ Cut points in medical costs for BMI, blood pressure, glucose, Hemoglobin A1C and cholesterol

- ◆ Participation rates in HRAs, health screenings and other wellness programs based on different levels of financial incentives

Readers are also encouraged to share data from practical experience or the practice literature on the following:

- ◆ Participation rates in HRAs, health screenings and other wellness programs based on different levels of financial incentives

## Conclusions

The purpose of WikiWIT is to provide a framework, including a set of equations, to help employers answer three major questions: 1) How big should the incentives be? 2. What cut points should be used to meet the standards? And, 3) How should the incentives be funded? We will refine the WikiWIT based on learnings at the UM-HMRC and more importantly, through ideas shared by the larger health promotion community. All enhancements will be posted on our website and described in future white papers. We are excited about the prospect of working with so many talented professionals on this exciting collective effort. The ultimate goal of this contribution is to help improve the health of all workforces.

[www.healthpromotionjournal.com/WikiWIT](http://www.healthpromotionjournal.com/WikiWIT)