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Improving Wellness Engagement With Behavioral Economics

Behavioral economics is the new engagement tool.

Total rewards professionals involved with employee benefits share a common professional objective: to improve the health, well-being and financial security of thousands of Americans. It is no wonder that frustrations arise when employees make suboptimal choices regarding their health-care benefits. Here are a few examples:

- Too many people go to a hospital emergency room for minor emergencies instead of visiting

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Population health improvement initiatives offer employers a significant value proposition.

or contacting another place of service with lower costs and often faster service (e.g., an urgent-care facility, a primary-care physician, a convenience-care clinic, a telemedicine doctor, a 24-hour nurse line).

- Employees fail to obtain preventive health-care exams, even when the exams are free and the employee may earn an economic incentive.
- Some first-time parents forget to enroll their newborn in their employer's medical plan.

There are many suboptimal decisions, but when it comes to health care, those decisions generally cluster in two areas: poor health habits and ineffective health-care consumerism. Although many organizations rely on financial incentives to encourage their employees to make better decisions, recent experience has shown that behavioral economics can be much more effective. A blend of microeconomics and psychology, behavioral economics can help reduce employees' suboptimal decisions, improve lives and generate better outcomes for employers.

This article shows how MaineHealth — a health system with more than 15,000 employees — used behavioral economics to improve employee well-being and control costs. But first, a look at the value and potential impact of wellness programs and an overview of behavioral economics and the perils of focusing on financial incentives to increase wellness participation.

Figure 1 | **Healthy Enterprise Index: Health Costs and Other Outcomes**

Key Outcomes	Top Quartile	All Others	Percentage Difference
Annual health cost (per member per year)	$3,431	$3,769	-9%
Annual health cost Increase	$235	$302	-22%
Turnover	8.1%	12.1%	-33%
Extended absence	3.9%	6.1%	-37%
Workers' compensation cost	0.74%	0.89%	-17%

Source: Sibson Consulting

Value and Potential Impact

Population health improvement initiatives offer employers a significant value proposition. As shown in Figure 1, the key outcomes for employers with scores in the top quartile of Sibson's Healthy Enterprise Index — which quantifies the efforts of employers that have effective wellness programs — are much better than for organizations in the other three quartiles.

Behavioral Biases and Heuristics

Increasing employee engagement in wellness programs is an important issue for many plan sponsors. One common problem is that employees tend to fall back on behavioral biases and heuristics and mental shortcuts that impede participation and obstruct behavior change. (See Figure 2 on page 52.)

It is important to realize that heuristics can serve as either barriers or bridges to behavior change. Behavioral economics can help employers minimize the effects of negative heuristics while they use positive heuristics to encourage employees to make the right choices.

Negative heuristics that behave as barriers include:

- **Endowment effect:** People place a greater psychological value on what they own than on what they would pay to acquire the same item.

The main problem with incentives is that they are not effective in overcoming the behavioral biases and heuristics ...

- **Complexity aversion:** People give up when choices are too numerous or complex.
- **Status quo bias:** People are reluctant to explore change.
- **Probability neglect:** People overvalue low-probability contingencies and undervalue high-probability contingencies.
- **Hyperbolic discounting:** People discount the value of future payouts far more than a present value analysis would indicate.
- **Sentinel event sensitivity:** People are overly swayed by emotionally charged events that may not be at all relevant.

Positive heuristics that can function as bridges to behavior change include:

- **Optimism bias:** People are generally optimistic about their ability to perform a reasonable task.
- **Clue-seeking bias:** People look for clues to what the right choice might be.
- **Bandwagon effect:** People are inherently social and will follow an admired leader.
- **Availability heuristic:** People are swayed by the information in front of them and will often not conduct further research if they believe they are well informed.

The Problem with Financial Incentives

In trying to increase employee engagement, many plan sponsors leap to the incentive conclusion: "We will pay people to engage in wellness." The main problem with incentives is that they are not effective in overcoming the behavioral biases and heuristics that keep many employees from actively participating in the organization's wellness program.

Moreover, incentives can be challenging to design and implement well. While incentives can help raise attention, they sometimes backfire. And, although incentives can influence participation, the correlation is often low.

Financial incentives can miss the mark. If they are:

- **Too low:** they may fail to motivate behavior change
- **Too high:** they may be more expensive than necessary to obtain the desired behavior
- **Too distant:** they may appear to be uncertain or too far off to overcome the personal costs of behavior change today.

Another way financial incentives can fail is if they appear to be crowding out intrinsic motivation. Employees may see them as cheapening a task that they already perceive as interesting, fun or noble.

Financial incentives can also run into problems if the qualification requirements are flawed. For instance, there may be:

- **Too many ways to earn an incentive,** which can be overwhelming.

Figure 2 | Common Mental Shortcuts

Shortcut	Health and Benefits Examples
People are anchored to old value systems	"My parents smoked tobacco and lived to 100 years old. Why should I quit?"
People are inconsistent regarding their present behavior and their future promises	"I know I need to lose weight. I will change my diet when my diabetes gets worse."
People are overly confident and ignore change	"I don't need to wear a seatbelt. My driving must be in the top 10 percent."

Source: Sibson Consulting

- **Too long of a qualification period,** which can cause procrastination and noncompliance.

Organizations that are considering using financial incentives need to ask the following questions:

- Is the change toward a positive habit sustainable?
- Do the incentives encourage unhealthy behavior, such as purging or short-term unhealthy dieting, to meet certain weight or body mass index (BMI) requirements?
- Are the incentives too easy to "game" by those who want to earn the incentive without working toward wellness?

When designing wellness incentive arrangements, some total rewards professionals may ask colleagues in the compensation function for help. This is not necessarily a good idea, because short-term cash incentive plans are often based on a rational model of expectancy theory, in which people who participate in a wellness program or attain a goal expect to earn an incentive.

With behavioral and lifestyle change as a goal, expectancy theory is not as useful as applied behavioral economics techniques incorporating a pre-commitment strategy, which may work better. Under a precommitment strategy, people commit to making a behavior change and receive an incentive payout promptly. If they follow through with the behavior change, they retain the reward. But if they fail to follow through with their commitment, they forfeit the incentive.

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A precommitment strategy leverages two principles:

1 | Behavioral compliance with a large request (e.g., stop smoking, lose weight, etc.) is enhanced if there is compliance with an initial, smaller request (e.g., a pledge to stop smoking or lose weight).

2 | It is far more psychologically challenging to give up a reward already being received than it is to change a behavior in exchange for a future reward promise.

A precommitment wellness strategy can be combined with medical plan choice architecture to create high levels of engagement. Choice architecture refers to how options are configured. Ordering, relative positioning, names used, decision factors identified, defaults used, even colors and fonts influence decisions and choice making.

The MaineHealth Case Study

MaineHealth, one of the nation's top 100 integrated healthcare delivery networks, has focused on employee wellness for many years. Recently, however, participation in health

risk assessments and biometrics had leveled off to about 53 percent, despite an annual investment of $1.6 million in employee wellness incentives. Improving participation was important because engagement in wellness is associated with significant cost differences at MaineHealth. When comparing plan participants who participate in the wellness program with those who do not participate, MaineHealth found:

- Health risks are just as prevalent in both populations
- Per capita health claims on an age- and gender-adjusted basis are $1,200 per year lower among wellness program participants
- Short-term disability claims are $954 lower per claimant among wellness program participants and the duration of disability was reduced from an average of 80 days for nonparticipants to 62 days for wellness participants
- Preventive care compliance among employees with chronic conditions (particularly diabetes) is much higher among wellness program participants.

MaineHealth deployed seven behavioral economic principles to dramatically improve wellness engagement:

1 | To overcome employee inertia, it required all employees to actively re-enroll in a health plan for 2013.

2 | It re-ordered its presentation of plans by putting its new Healthy Saver plan first in the lineup. This is a consumer-driven health plan (CDHP) type program with an employer-funded health savings account (HSA) contribution.

3 | The most popular plan, the health maintenance organization (HMO) plan, was renamed the Healthy HMO plan and presented second in the lineup.

4 | To participate in the Healthy Saver or Healthy HMO plan, employees were required to make a commitment to wellness during open enrollment. To enroll in one of these options, employees had to complete a health risk assessment, have their biometrics (BMI, blood pressure, cholesterol and blood glucose levels) professionally measured (not self-reported) and designate a primary-care physician.

5 | MaineHealth established a basic plan that served as a default option. This plan had lower coverage, no employer-funded HSA contribution and higher payroll deductions than the other plans. This would be the only plan option available to employees who did not complete the eligibility requirements described previously. Because it was an obviously less-desirable option than either the Healthy Saver or the Healthy HMO plans, it was intended to motivate employees to complete their wellness requirements to be able to gain access to the better plans.

6 | A $1,200 annual surcharge was levied on tobacco users who enrolled in any of the health plans. Tobacco use was verified by a urine test. Employees who tested positive were subject to the surcharge until they could show they had successfully stopped using tobacco.

7 | The maximum incentive value for meeting various wellness participation and achievement standards was decreased from $338 to $250.

The results showed:

- Wellness participation by employees enrolled in health benefits increased from 53 percent to 98 percent, while MaineHealth's cost of providing employee health benefits were projected to decrease by 3.1 percent in 2013.
- Tobacco use declined by more than 1 percent in the first three months of the program as more employees took advantage of tobacco-cessation plans.
- Expenditures on wellness incentives increased in the aggregate, but were spread over many more employees in the workforce. The average wellness incentive expenditure per employee decreased from $288 in 2012 to a projected $233 for 2013.
- More than 20 percent of employees who enrolled in a health plan chose the new Healthy Saver CDHP option, which was slightly better than behavioral models projected.
- The percentage of employees who chose not to enroll in a health plan was virtually unchanged from the prior year, meaning that the plan design changes and new wellness requirements did not cause employees to seek coverage elsewhere.

Conclusion

Companies that leverage the principles of behavioral economics can realize attractive gains for their workforce and the organization. A rational approach begins with understanding the suboptimal choices being made by the workforce and the potential value gains associated with improved decision making and behavior change. With a blended understanding of rational microeconomics and irrational consumer behaviors, plan sponsors will be positioned for dramatic gains. WS

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