
MARKET WATCH

Financial Penalties For The Unhealthy? Ethical Guidelines For Holding Employees Responsible For Their Health

Penalty programs must offer employees fair and equal opportunities to improve their health.

by **Steven D. Pearson and Sarah R. Lieber**

ABSTRACT: As health care costs continue to rise, an increasing number of self-insured employers are using financial rewards or penalties to promote healthy behavior and control costs. These incentive programs have triggered a backlash from those concerned that holding employees responsible for their health, particularly through the use of penalties, violates individual liberties and discriminates against the unhealthy. This paper offers an ethical analysis of employee health incentive programs and presents an argument for a set of conditions under which penalties can be used in an ethical and responsible way to contain health care costs and encourage healthy behavior among employees. [*Health Affairs* 28, no. 3 (2009): 845–852; 10.1377/hlthaff.28.3.845]

RISING HEALTH CARE COSTS and increasing rates of chronic illness threaten the future of the U.S. health care system.¹ Purchasers and health plans have responded with a variety of strategies to try to contain costs while maintaining or improving quality. Employee health education and wellness programs, disease management, pay-for-performance (P4P), public reporting of quality performance, tiered formularies, tiered physician networks—all of these strategies have been tried, but none has been able to tame the rise in chronic disease rates or overall health care costs.

Recently, a growing number of self-insured employers have devised new strategies, using financial incentives to promote healthy behav-

ior and thereby reduce preventable health care costs.² Major corporations, including Dell, Scott's Miracle-Gro, Meritain Health's Weyco Inc., and Clarian Health are directly rewarding or penalizing employees for changing unhealthy behavior such as smoking and, in some cases, for achieving targets on "biometric" outcomes such as weight, blood pressure, and cholesterol level.³ Nearly half of employers surveyed in 2007 by Hewitt Associates reported that they now offer employees incentives to participate in health promotion services; just over two-thirds planned to use more-aggressive wellness and disease management programs by the end of 2008.⁴

The federal Health Insurance Portability and Accountability Act (HIPAA) sets bound-

.....
 Steven Pearson (spearson@icer-review.org) is a visiting scientist at the National Institutes of Health (NIH) Clinical Center Department of Bioethics in Bethesda, Maryland, and president of the Massachusetts General Hospital Institute for Clinical and Economic Review in Boston, Massachusetts. Sarah Lieber (Lieber@post.harvard.edu) is a research fellow in the NIH Clinical Center Department of Bioethics.

aries on the use of financial incentives for behavior change or biometric outcomes by requiring all workers covered under a particular employer-sponsored health plan to pay the same premiums regardless of their health status. In July 2008, however, federal agencies finalized rules granting some exceptions from HIPAA to certain wellness programs. According to these rules, employers can offer rewards or penalties of as much as 20 percent of the total cost of covering an employee.⁵ In December 2007 the U.S. Department of Labor issued guidelines that narrow the definition of types of supplemental coverage through which employers can provide such incentives, but interest in these programs remains high: companies such as BeniComp Group and Vital Measures, a unit of United-Health Group, help design and manage incentive programs for a growing clientele of both small and large employers.⁶

Early reports and anecdotal information suggest that direct financial incentives can effectively motivate employees to change their health behavior, but employers are facing a backlash from organized unions and others who contend that workplace incentive programs, particularly penalty programs, are unethical.⁷ Employers that use penalty programs have said that they are acting in the best interest of both individual employees and the collective workforce, which has a shared interest in keeping health care premiums in check. To some employees and workers' rights protection groups, however, penalty programs are a thinly veiled, discriminatory attempt to make sicker employees shoulder increased health care costs.⁸

Given the growing interest in using direct reward and penalty programs, and the starkly competing views of whether they are fair and ethical, all such programs should be subject to careful ethical analysis. Consideration must be given to determining whether it is possible to

strike a proper balance between holding employees responsible for their health and providing a fair system of health insurance that protects individual liberties.

This paper analyzes the arguments for and against employee health incentive programs, with a focus on penalty programs. Positive incentive programs (rewards) raise many of the same ethical concerns, but penalties heighten the potential for coercion and inequity. Nonetheless, penalty programs seem poised to play a larger role if early anecdotal reports of their success are confirmed more broadly. The goal should be to establish an ethical balance between holding employees responsible and protecting their liberties.

Ethical Foundation For Penalty Programs

■ **Economic harms.** Before exploring in detail how to achieve an ethical balance,

we first consider the underlying justification for penalty programs. Employers have an ethical duty to provide responsible stewardship for the health care programs they administer that pool limited resources to help cover health care costs. The primary principle supporting employers' use of penalty programs is that employees should be held responsible if, through their voluntary actions, they harm fellow employees. Given that costs are shared, an unhealthy employee will drive up costs for others who are contributing to the collective pool. The impact of unhealthy behavior and its attendant outcomes is significant: health care costs for "moderately" obese workers are about 21 percent higher than they are for workers of normal weight, costing employers an additional \$670 per employee each year. Similarly, health care costs are 75 percent higher for "severely" obese workers (an additional \$2,441 annually per employee).⁹ Such costs burden fellow employees by leading to lower wages and higher premiums for group insurance coverage.

"The primary justification for penalty programs must rest on the economic harms imposed on others when employees engage in unhealthy behavior."

■ **“Benign paternalism” versus coercion.** Another argument advanced to justify penalty programs is that, ultimately, their goal is to motivate behavior change that benefits the individual as well as the group. By itself, this “benign paternalism” is a weak justification, easily counterbalanced by the specter of coercion. The primary justification for penalty

programs must rest on the economic harms imposed on others when employees engage in unhealthy behavior. Considerations of the key concepts underlying when and how it is ethical to hold employees responsible for these harms form the core of the criteria that we propose for ethical penalty programs (Exhibit 1).

EXHIBIT 1
Criteria For Ethical Penalty Programs Encouraging Employee Behavior Change

Selecting targets for penalties

Criteria	Examples/methods
Measured targets are failures to take voluntary actions to improve health behavior: Information on unhealthy behavior is shared with employees Employees are informed what actions to take to improve health Actions are voluntary; ability to take action not undermined by biological, psychological, and sociological factors	Example: Even though informed of the health benefits of these actions and free to adopt them, employees: Do not take cholesterol-lowering medication Do not attend diet counseling sessions Do not get cancer screening Do not enroll in smoking cessation programs Example: Programs targeting smoking should not penalize employees for the presence of nicotine in the body; instead, employees should be penalized for not entering a smoking cessation program
Biometric outcomes are not the measured target for penalties	Example: Employees should not be penalized for high cholesterol levels, because some are genetically predisposed to high cholesterol
No discrimination: Behavior selected leads to poor health outcomes and increased health care costs Selection not based on stigmatization of the behavior or of individuals prone to the behavior	Transparency: selection process and justification for selection made public Evidence-based: behavior selection supported by robust empirical data
Accommodation for fundamental behavior	Examples: sexual activity, child bearing, outdoor sports, and recreation

Administration of penalties

Fair and equal opportunities to change behavior: Programs provide necessary tools to take voluntary actions to change unhealthy behavior All employees have equal access to services for behavior change and improved health	Health education Examples: nutrition counseling, prevention and health management information sessions Health promotion tools Examples: weight-loss programs, on-site gym facilities, health clinics, health coaches, pharmacies, smoking cessation programs
Opt-out appeals process Exemptions permitted on medical or personal grounds	Example: an employee with severe osteoarthritis is exempted from participation in exercise classes
Fair notice Employees have reasonable time to take actions to improve their health	Example: employees are given six months to reflect, quit smoking on their own, or prepare to be penalized on not entering a smoking cessation program if they are still smoking
Fair magnitude of penalty Fair limits set so that penalty acts as incentive to change behavior, not to recoup health care costs	Lowest monetary value needed to motivate change in behavior Penalty amounts scaled to personal salary
Privacy protection	Careful adherence to HIPAA confidentiality rules

SOURCE: Authors’ analysis.

NOTE: HIPAA is Health Insurance Portability and Accountability Act.

Responsibility For Unhealthy Behavior

Penalty programs should hold employees responsible for behavior that leads to poor health and increased health care costs only if employees voluntarily refuse to take action to change their behavior.

■ Key elements of voluntary action.

First, employees must be informed. Employers must assure that employees are fully aware of the medical—and economic—reasons why they should change their unhealthy behavior. Second, there must be clearly defined steps that employees can take to try to change their behavior. And third, employers must provide or assure that all employees have equal and unencumbered access to the programs, medications, or other interventions that can help change such behavior. Income, job duties, or other barriers beyond employees' control must not be allowed to become a barrier to the tools to support behavior change.

■ **Beyond a person's control.** Although some behavior that increases health risks may be under a person's full control, the ability to change behavior is often diminished in several ways. Many biological, psychological, and sociological factors undermine a person's control over his or her behavior; people are frequently restricted in their ability to change their behavior because of "encumbrances on the will," which "preclude or impede authentic, reasoned choice."¹⁰

Consider the example of smoking, one of the most common targets of penalty programs. For smoking to be an ethically acceptable target of a penalty program, the act of quitting smoking would have to be voluntary. But the effects of nicotine addiction undermine a person's ability to follow through on a choice to quit. The act of continued smoking is thus not fully voluntary, and therefore smoking itself is not behavior for which a smoker should be held fully responsible.

■ **A result of choice.** In contrast, choices made concerning whether or not to attempt to quit smoking are far more voluntary for most people. If an employee is made aware that en-

tering a smoking cessation program could help him quit smoking, the employee can voluntarily choose to enter—or not to enter—the program. Should he voluntarily decide to forgo this option, his failure to act justifies holding him responsible for not taking the necessary steps toward improved health. Thus, although the ultimate goal is to motivate employees to change their unhealthy behavior such as smoking, the actual measure by which employees are judged should only be the failure to take voluntary actions to change behavior and improve health. Health programs should not penalize employees for the mere presence of nicotine in the body. Rather, it would be reasonable to penalize an employee for not enrolling in a smoking cessation program so long as that employee has an informed and unencumbered choice to take this step toward improving his or her health.

Responsibility For Biometric Health Measures

An obvious corollary to the argument above is that an important distinction needs to be made between holding employees responsible for behavior and holding them responsible for biometric health outcomes such as obesity, hypertension, or high cholesterol levels. People do not voluntarily choose their health outcomes—poor personal health is not a simple product of informed voluntary choices. Biological, environmental, and socioeconomic factors greatly affect health, regardless of how a person behaves.

■ **The obesity example.** Here obesity provides a valuable example. The causes of obesity are a complex web of factors and may include detrimental workplace design and other workplace policies over which employees have no control at all. Employees cannot exercise a truly voluntary choice not to be obese. On a practical level, workplace health programs might need to use certain biometric measures such as weight, blood pressure, and cholesterol to assess problematic areas in an employee's health. But penalty programs should not assign financial penalties using these measures themselves as targets. Rather,

as in the case of smoking, penalty programs should only target the voluntary action of informed employees should they choose not to take steps made available to them to try to improve their health. For obesity, penalty programs might target participation in nutritional counseling offered in the workplace; for hypertension, the target might be attendance at regular monitoring sessions; and for high cholesterol, the penalty target might be adherence to prescribed medication. If employees take the intended actions to improve their health, they should not be penalized, even if they do not achieve the ultimate health goal.

■ **The case of medication adherence.** Penalties for medication adherence conflict with competent patients' general right to decline any treatment, and therefore they must be framed cautiously and narrowly. Penalty programs should only consider as potential targets treatments prescribed by an independent physician who has judged, in discussion with the employee, that the medication is likely to confer a positive net health benefit on the employee. If this condition can be met, then it is reasonable to consider adherence to the prescription as a voluntary action for which an employee can be held responsible.

Discrimination

A separate ethical concern for penalty programs lies in the risk that types of behavior will be selected as targets because of discrimination. The evidence linking behavior with poor health and increased costs must be evaluated in an even-handed way; penalty programs should not be based on moral judgments made by employers in a discriminatory and stigmatizing manner.

The risk is that penalty programs will find it easiest to focus on behavior and outcomes that are generally viewed as "socially unacceptable" within a workplace community or

society at large. As one commentator has written, "Not all choices leading to illness are counted alike. Those that are targeted tend to be sins—sloth, gluttony, lust, to use their old-fashioned names—or to be behavior, such as drug addiction, of the marginalized."¹¹ It is hard not to notice that all of the early penalty programs target employees who are obese and employees who smoke. Were other potentially costly types of behavior considered in the selection process? Is it for evidence, practicality,

or other reasons that penalties were not focused on excessive alcohol intake, failure to get cancer screening, engagement in risky outdoor sports, or other potentially unhealthy types of behavior that might have imposed unfair financial burdens on the workforce?

To avoid discriminating and stigmatizing practices, a transparent and evidence-based process should guide

the selection of targets for any penalty program. The components of a fair, evidence-based process to select targets for penalties mirrors those described as the basis for legitimate efforts to set limits fairly in all health care systems.¹² Thus, a central component of penalty programs must be that decisions regarding which types of behavior receive penalties are made with the participation of employees and use publicly accessible, evidence-based reasons as justification.

Accommodation For Fundamental Behaviors

Another ethical criterion for penalty programs is the exclusion of penalties for "unhealthy" types of behavior that society acknowledges to be fundamental elements of personal freedom and identity. Holding employees responsible for the costs of any behavior that increases health care costs would undermine the liberty of choosing for oneself how to live one's life.¹³

For example, penalties should not be con-

“Holding employees responsible for the costs of any behavior that increases health care costs would undermine the liberty of choosing for oneself how to live one’s life.”

sidered for behavior such as sexual activity, bearing children, and most recreational activities and sports. Although these types of behavior may entail increased health risks and costs, they are widely accepted in our society as critical components of self-expression, free choice, and personal identity. Admittedly, it is a matter of judgment whether some activities that increase risks and costs, such as “extreme” sports, are worthy of accommodation on this basis. Do these activities constitute essential elements of personal expression, or are they merely risky, superficial enjoyments that merit consideration as the target of penalties? The answer lies in value judgments that may vary legitimately among the employees and cultures of different organizations. Thus, as with avoidance of discrimination in target selection, an ethical penalty program must ground its decisions to exempt certain types of behavior in a fair, participatory, and transparent decision-making process.

Fair Administration Of Penalty Programs

■ **A partnership between employer and employees.** Given that the core ethical justification for penalty programs is that employees should be held responsible for voluntary actions that cause harm to others, the voices of employees should help guide the key decisions about how to implement any penalty program. A positive example exists in the employee smoking cessation program created in 2008 by the insurer Humana.¹⁴ The program description states that it is being designed by a project team of employees including a mix of tobacco nonusers, former tobacco users, and current tobacco users. Whether through mechanisms like this or through working with representative groups such as employee unions, employers must reach out to engage employees in a partnership to guide the administration of an ethical penalty program.

■ **Access to health promotion tools.** As described above, employers considering a penalty program must also recognize their responsibility to provide health promotion tools that can give every employee a fully voluntary

choice to attempt to modify unhealthy behavior. Even small businesses with limited resources can offer cost-effective tools to employees to improve their health. In the areas of smoking and obesity, these tools might include health coaching, online support tools, time during working hours to exercise, and reduced copays for certain medications and health services. Other innovative strategies to give all employees the means to improve health include weight-loss competitions, organized corporate races, and outdoor activities.¹⁵

■ **Opt-out processes.** Another important element of fair administration of penalty programs is the establishment of an opt-out process for employees who have legitimate medical or personal reasons that make it impossible for them to participate in the health-promoting behavior that is targeted by ethical penalty programs. For example, an employee with severe arthritis might not be able to take part in exercise classes meant to reduce obesity; similarly, an employee might have contraindications to taking cholesterol-lowering medications.

An opt-out requirement is in keeping with new nondiscrimination provisions in HIPAA. According to these federal regulations, incentive programs should have a “reasonable alternative standard” that exempts employees from penalties when it is unreasonably difficult or medically inadvisable to meet certain health benchmarks.¹⁶ Under these regulations, employees can justify their appeals with the testimony of a medical professional and must be offered an alternative target for a health behavior change or biometric outcome. One way to implement this kind of process would be to establish a review committee of managers, employees, and medical professionals.

It is important to note that HIPAA’s current provisions for a reasonable alternative standard seem only to apply to “wellness programs” that presumably use “rewards.” Federal regulations in the future should specify more clearly that these requirements apply to penalty programs as well.

■ **Fair notice.** Employees should be given enough lead time both before and after the im-

plementation of a penalty program so that they have a reasonable chance to plan how they will approach the challenge of changing their health behavior. For example, smokers might be given six months' notice that there would be a penalty program instituted that targets documented smoking cessation or attendance at smoking cessation classes. Then, once implemented, the program would give smokers six months to either quit on their own or enter a cessation program. To determine what would constitute a fair amount of time to change a specific type of behavior, health programs should look to empirical data and personal accounts from employees for evidence on how long it generally takes to change certain behavior and the factors that influence this length of time.

■ **Fair magnitude of penalty.** Penalty programs must ensure that the magnitude of penalties is fairly selected. The goal of penalties should not be to recoup costs attributed to unhealthy behavior. The economic harm that penalty programs might cause individual employees may strike low-income workers particularly severely; penalties should serve only as incentives to encourage changes in behavior, not as tools to drive at-risk employees out of their health insurance. The ethical balance sought for penalty programs therefore requires that penalties be scaled only to motivate employees to adopt healthier behavior.

The magnitude of penalties necessary to motivate behavior change will always be difficult to estimate, but there should be a transparent and collaborative process for setting the amount. Existing HIPAA regulations set reward cutoffs at 20 percent of the cost of health care coverage without giving any rationale for this limit.¹⁷ Using any single flat rate for penalties might disproportionately burden low-income employees while providing less of an incentive for highly compensated employ-

ees to change health behavior. Thus, if it is administratively possible, motivational penalties should be scaled in some way to an employee's personal salary or wages and seek to use the lowest magnitude that will provide a reasonable incentive to change behavior.

■ **Privacy protection.** In accordance with current HIPAA policies, medical data or information that is used to assign penalties to employees must be kept confidential. Health records and information should be accessible to

“Penalties should serve only as incentives to encourage changes in behavior, not as tools to drive at-risk employees out of their health insurance.”

only third-party health plan administrators or other outside vendors authorized by the employee. After collecting and storing employee health information, these outside organizations can only use de-identified data to determine risk factors within a workforce and subsequently design health interventions.¹⁸ Employers in penalty programs will not be able to access this information or dis-

criminate against employees based on their health records.

DESPITE MANY THREATS to its future, employer-based health insurance is still the dominant form of health care coverage in America. As health care costs continue to rise and employers adopt new strategies to contain costs, clear ethical guidelines need to be established to ensure that when employers use financial incentives, there is an appropriate balance between holding employees responsible for increased health care costs and protecting individual liberties.

The workplace offers a unique environment in which employees can be encouraged to improve their health and provided the appropriate medical attention and services to help them change unhealthy behavior. In society at large, it is difficult to hold people responsible for being unhealthy, especially given that there is no universal health care system in place and

people do not have fair and equal opportunities to improve health. In the workplace, however, it is possible to identify a shared interest among employees in healthy behavior and restraint on health care costs. The workplace offers an excellent access point for the delivery of health promotion and behavior-change tools, which can empower those who are at risk and enable them to change their health for the better. Therefore, unless a deus ex machina appears on the horizon, it is likely that financial incentive programs for health in the workplace will gain increasing attention. Penalty programs may have an important role within this movement, but they should only be considered after broad reflection by employers and employees on the important criteria that must be met if these programs are to be used in an ethical way.

.....
This research was supported in part by the Intramural Research Program of the National Institutes of Health (NIH). The opinions expressed are the authors' own. They do not represent any position or policy of the NIH, Public Health Service, or Department of Health and Human Services.

NOTES

1. R. DeVol and A. Bedroussian, *An Unhealthy America: The Economic Burden of Chronic Disease*, October 2007, http://www.milkeninstitute.org/pdf/chronic_disease_report.pdf (accessed 18 February 2009).
2. K. Jochelson, *Paying the Patient: Improving Health Using Financial Incentives*, 13 December 2007, http://www.kingsfund.org.uk/publications/other_work_by_our_staff/paying_the.html (accessed 17 February 2009).
3. B. Baker, "Now, the Stick: Workers Pay for Poor Health Habits," *Washington Post*, 13 November 2007.
4. Business Wire, "Hewitt Study Shows Companies Plan to Invest More in the Health of Their Employees," 19 April 2007, http://www.redorbit.com/news/health/907738/hewitt_study_shows_companies_plan_to_invest_more_in_the/index.html (accessed 19 February 2009). A case study of one company, Clarian Health, is available online at <http://content.healthaffairs.org/cgi/content/full/28/3/845/DC1>.
5. "Nondiscrimination and Wellness Programs in Health Coverage in the Group Market," *Federal Register* 71, no. 239 (13 December 2006): 75014-75055.
6. V. Knight, "Wellness Programs May Face Legal Tests: Plans That Penalize Unhealthy Workers Could Get Tighter Rules," *Wall Street Journal*, 16 January 2008.
7. R. Ozminkowski et al., "Long-Term Impact of Johnson and Johnson's Health and Wellness Program on Health Care Utilization and Expenditures," *Journal of Occupational and Environmental Medicine* 44, no. 1 (2002): 21-29; E. Finkelstein et al., "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, no. 9 (2007): 981-989; Associated Press, "Employees Starting to Pay for Poor Health: Are You Obese or Have High Blood Pressure? Your Insurance May Go Up," 10 September 2007, <http://www.msnbc.msn.com/id/20625381> (accessed 20 January 2008).
8. Baker, "Now, the Stick"; and AP, "Employees Starting to Pay for Poor Health."
9. D.M. Huse, "Obesity in the Workforce: Health Effects and Healthcare Costs," April 2007, http://employer.thomsonhealthcare.com/uploaded/Files/Cost_of_Obesity_in_the%20Workplace.pdf (accessed 13 February 2008).
10. D. Wikler, "Who Should Be Blamed for Being Sick?" *Health Education Quarterly* 14, no. 1 (1987): 11-25.
11. D. Wikler, "Personal and Social Responsibility for Health," in *Public Health, Ethics, and Equity*, ed. S. Anand, F. Peter, and A. Sen (Oxford: Oxford University Press, 2005), 107-133.
12. N. Daniels and J. Sabin, "The Ethics of Accountability in Managed Care Reform," *Health Affairs* 17, no. 5 (1998): 50-64.
13. S. Shiffrin, "Egalitarianism, Choice-Sensitivity, and Accommodation," in *Reason and Value: Themes from the Work of Joseph Raz*, ed. R. Wallace et al. (Oxford: Oxford University Press, 2004), 270-302.
14. Gregory Matthews, Consumer Innovations, Humana, personal communication, 18 July 2008.
15. S. Okie, "The Employer as Health Coach," *New England Journal of Medicine* 357, no. 15 (2007): 1465-1469.
16. "Nondiscrimination and Wellness Programs in Health Coverage."
17. *Ibid.*
18. Okie, "The Employer as Health Coach."