Senate Health, Education, Labor and Pensions (HELP) Committee

"Examining How Healthy Choices Can Improve Health Outcomes and Reduce Costs"
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Testimony of
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Chairman Alexander, Ranking Member Murray, and distinguished Members of the Committee:

Thank you for the opportunity to speak with you today. My name is David Asch. I am a physician, and a professor at the University of Pennsylvania.

I am here to talk about workplace health programs and their role in the nation's health. My summary message is this: I believe that employer sponsored wellness programs have value to contribute. I believe that even though the health and financial benefits of these programs are often overstated. I believe that even though some of these programs, in the ways they are currently designed, risk treating some employees unfairly. But I am optimistic about these programs going forward, because we are learning how to design them to be much more effective and much more fair.

Americans spend most of their time outside of the health care system. Even those with a chronic illness spend only a few hours a year with a doctor. But we spend 5,000 waking hours each year doing everything else in our lives. And it is during those 5,000 hours when so many of the determinants of our health unfold: how we eat, whether we exercise, smoke, or take our prescribed medications. We can put more and more money into health care, but much of our health is determined in the 5,000 waking hours outside the reach of doctors and hospitals.[1]

Americans spend many of those waking hours at work. And employers have a large financial incentive to advance health—not just because of our system of employment-based health insurance, but also because healthier workers are more productive.

And so, more than three quarters of large employers now have some sort of workplace wellness program, targeting risk factors that together account for most chronic illness. These include:

- Eliminating the use of tobacco

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1. Asch DA, Muller RW, Volpp KG. Automated hovering in health care: watching over the 5,000 hours. N Engl J Med. 2012;367:1-3.

- Controlling high blood pressure
- Reducing obesity
- Increasing exercise
- Lowering cholesterol
- Managing diabetes

Unfortunately, it is a lot easier to know what conditions to target than to know how to do so. Managing these conditions requires substantial behavior change.

Our nation has invested considerably in the science of medical treatment, but less in the science of behavior change. Our knowledge of how to break old habits and develop healthier ones is rudimentary, but it is getting better.

Behavioral economics is one example of how we are learning more about changing behavior. Last week, Richard Thaler of the University of Chicago won the Nobel Prize in economics for recognizing that we all succumb to irrational tendencies that compete with our long term goals.

Increasingly, behavioral economics has been used to help doctors and patients make better decisions. I'm proud to say that the University of Pennsylvania is a world leader in this field.

One such irrationality is called loss aversion. We are much more motivated to avoid a $100 loss than we are to achieve a $100 gain. It doesn't make economic sense, but it is how humans tend to think.

We found this recently when encouraging overweight employees at a large firm to increase their fitness.[2] In one group, employees were given $1.40 for each day they walked at least 7,000 steps. That's a standard economic financial incentive. For another group, we structured it as a loss. $1.40 a day is $42 a month. So, in that group, we gave each employee $42 at the beginning of the month and we took away $1.40 for every day they didn't walk 7,000 steps. An economist would see these two designs as the same: for every day you walk 7,000 steps, you are $1.40 richer. But it turned out that those who received $1.40 were no more likely to walk 7,000 steps than those in a control group that received no financial incentive. However, those who had $1.40 taken away if they didn't walk at least 7,000 steps were 50% more likely to succeed. Mathematically and financially, these two approaches are the same, but one worked and the other didn't.

Most large companies are using financial incentives to encourage healthy behaviors. The vast majority of them do so by adjusting the premiums their employees pay for their health insurance.

2. Patel MS, Asch DA, Rosin R, Small DS, Bellamy SL, Heuer J, Sproat S, Hyson C, Haff N, Lee SM, Wesby L, Hoffer K, Shuttleworth D, Taylor DH, Ulrich V, Zhu J, Yang L, Wang X, Volpp KG. Framing financial incentives to increase physical activity among overweight and obese adults – a randomized, controlled trial. Ann Intern Med. 2016;164:385-94.

Although it may seem obvious that charging higher premiums for being a smoker or being overweight would encourage people to modify their habits, there is little evidence that programs designed that way often work.[3] At best they provide modest financial benefits to employers and unclear health benefits to employees.

These programs offer promise but they also draw criticism. One criticism is that they can be seen as coercive. Programs are more likely to be seen as coercive to the extent they put a lot of money at risk, whether in the form of rewards or penalties. I think that problem is avoidable. Most current employer programs are based on the idea that the more money you put at risk, the more effective the incentive. That's a mistake based on outdated economic thinking and it can create unfairness. We've designed programs that trade on psychological principles of behavioral economics that are often much more effective than programs putting considerably larger amounts of money at risk. Those designs can be more effective, and they can be fairer.

In general, the key fairness question is this: How much can the behaviors we most want to target be modified through incentive programs and how much are we just punishing the people with those behaviors?[4]

To the extent these programs are not effective at changing behavior, then all they are doing is cost-shifting. Employees who smoke or are obese tend to be the poorest, and they will end up paying the highest rates. That kind of cost-shifting just moves around the money, and it is regressive.

I remain excited about well-designed programs that help Americans change the behaviors they want to change: help them quit tobacco, help them lose weight, help them better manage their high blood pressure. Those changes are much less likely to come from typical premium-based financial incentives and much more likely to come from approaches that reflect the underlying psychology of how people make decisions—encouraged by frequent rewards, emotional engagement, contests, social acceptance. These are the ingredients of successful programs and they are missing from most of what employers currently do.[5]

We know so much more now about how to design financial and other incentives to motivate human behavior—far more now than even 10 years ago. I haven't yet seen much of this new knowledge applied effectively by employers but there's no reason why it can't be.

Thank you for inviting me to testify today. I look forward to your questions.

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3. Volpp KG, Asch DA, Galvin R, Loewenstein G. Redesigning employee health incentives — lessons from behavioral economics. N Engl J Med. 2011;365:388-90.
4. Loewenstein G, Volpp KG, Asch DA. Incentives in health: Different prescriptions for physicians and patients. JAMA. 2012;307:1375-6.
5. Asch DA, Rosin R. Engineering social incentives for health. N Engl J Med. 2016;375:2511-3.