

**Ethical Considerations
for the Use of
Patient Incentives to Promote
Personal Responsibility
for Health:
West Virginia Medicaid
and Beyond**

**American College of Physicians
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Human Rights Committee
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Ethical Considerations for the Use of Patient Incentives to Promote Personal Responsibility for Health: West Virginia Medicaid and Beyond

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Abstract

Proponents and critics alike are passionate about the use of incentives to promote personal responsibility for health. Supporters maintain that individuals should be encouraged to take an active role in promoting their own health and choosing healthier lifestyles; this benefits the individual in improved health outcomes, and may also have a collective benefit in controlling health care costs. Opponents are concerned about introducing such strategies with limited evidence to support their use. They also caution that the linking of incentives to access to care may have a disproportionately negative effect on the disadvantaged and may lead to blaming individuals for health status without consideration of other health determinants.¹ Some health reform policymakers have proceeded with this approach in the design and implementation of new programs. This paper will explore the ethical issues raised by the use of incentives to promote personal responsibility for health, particularly those incentives found in the West Virginia Medicaid program.

The American College of Physicians (ACP) believes that programs that support the patient's role in promoting positive health outcomes should be evidence-based and should focus on increasing access to strategies for prevention and treatment of disease; respect for autonomy; consideration of variables influencing comprehension and learning; and understanding of cultural, religious and socioeconomic factors. Such programs should be grounded in the ethics principles of beneficence and nonmaleficence. ACP supports the use of positive incentives to motivate behavior change as part of a comprehensive strategy to improve patient care and offers recommendations for their development and implementation.

Position 1: Health care systems should promote high quality health care by following evidence-based models when implementing strategies such as the use of patient incentives to promote behavior change.

Position 2: Incentives to promote behavior change should be designed to allocate health care resources fairly without discriminating against a class or category of people. The incentive structure must not penalize individuals by withholding benefits for behaviors or actions that may be beyond their control. Incentives to encourage healthy behaviors should be appropriate for the target population. The American College of Physicians supports the use of positive incentives for patients such as programs and services that effectively and justly promote physical and mental health and well-being.

Position 3: Transparency and clarity are critical to effective implementation of innovative approaches to health care such as the use of incentives to motivate behavior change. Health plans should provide a clear explanation in lay terms of both the benefits and the operational details and should survey stakeholders such as patients and clinicians to ensure that the explanations are adequate.

Position 4: Incentives to promote behavior change should be consistent with the elements of patient-centered care. The incentive structure should support appropriate patient autonomy and participation in decision making, including the right to refuse treatment, without punitive consequences.

Position 5: Incentives to promote behavior change should be designed to recognize and support the physician's ethical duty to provide care, the physician's ethical responsibility to discuss all appropriate care options with the patient in a culturally sensitive manner and the physician's professional obligation to make recommendations on the basis of medical merit. Incentives should support honest, open and fair interactions among patients, health care professionals, health care entities and payors.

Background

What is personal responsibility for health?

Personal responsibility for health, the concept that illness can be prevented by behavior change, can be traced back through Greek and Roman history.² Galen, a disciple of Hippocrates, considered that “people who allowed themselves to harm their bodies when there existed the knowledge and the possibilities of life's action to prevent it were morally culpable.”³ During the Middle Ages and Renaissance, the personal obligation to care for oneself was seen as a responsibility to preserve one's body for God,³ and is still an element of religious belief today for many. In the 1970s, as the United States paradigm for healthcare broadened to include health promotion and disease prevention, programs began to focus on personal responsibility and adopting health-promoting behavior.

Rationale for encouraging personal responsibility for health

The exercise of control over lifestyle options and the adoption of health maintenance and disease prevention behaviors have been clearly associated with reducing the risk of some of the nation's most burdensome chronic health concerns such as cancer, diabetes, cardiovascular and pulmonary disease.⁴⁻⁸ The disease burden not only encompasses diagnostic and treatment costs but extends to productivity, employment, insurance coverage, quality of life, family role changes, extended care needs, transportation and so on. Given the nation's current and projected economic environment, aging population, and the rise of chronic disease, an increased focus on personal responsibility to promote healthy behaviors has merit.

Incentives for promoting personal responsibility for health

In recent years, programs addressing personal responsibility for health have employed both positive and negative incentives to motivate behavior change. Positive incentives include removal of structural barriers such as eliminating or reducing high co-pays, removal of attitudinal barriers through improved patient and clinician education and communication,⁹ and direct rewards for desired behaviors such as cash payments or credits. Negative incentives penalize people for failing to meet stated goals, through for example, loss of benefits. The focus on personal responsibility for health has been adopted globally in countries with universal healthcare using a variety of strategies and practices intended to improve outcomes and control costs. In the United States, projects targeting health behaviors have been launched by state governments and employers offering incentives, although limited data exist to support their use. Congress is currently considering legislation that would expand the ability of employers to promote healthy behavior among employees, using financial rewards or penalties.¹⁰

West Virginia Medicaid Program

To facilitate the discussion, the West Virginia Medicaid program will be used to highlight several of the positions below as it was one of the early, controversial programs to use incentives. This program redesigned Medicaid into a behavior-based two tiered benefit structure, the Basic Plan and the Enhanced Plan. The Basic Plan (default tier) offers fewer services than the Enhanced Plan, which offers unlimited prescriptions and transportation, and programs such as weight management, smoking cessation, diabetes education, nutritional counseling and substance abuse treatment.¹¹ In order to receive the benefits of Enhanced Plan, patients and their doctors develop a "health improvement plan" in which the patient is required to agree to the following: medication adherence, attendance at recommended educational programs, keeping scheduled appointments or notifying the office to cancel, timeliness for appointments to their medical home, visiting the medical home when sick and using the hospital emergency room only for true emergencies. Although the Enhanced Plan offers some services not previously included, the Basic Plan offers fewer services than the original plan.

Position 1: Health care systems should promote high quality health care by following evidence-based models when implementing strategies such as the use of patient incentives to promote behavior change.

The effectiveness of strategies such as the use of patient incentives to promote behavior change should be demonstrated through an evidence-based assessment process prior to implementation. Positive incentives, such as meaningful rewards, may successfully promote beneficial and sustained behavior change unlike negative incentives that are punitive and coercive. Evidence should demonstrate that the use of incentives improves health outcomes and is congruent with the ethical principles of respect for autonomy, beneficence, nonmaleficence and social justice. In the absence of such evidence, untested strategies to incent behavior change must be investigated in clinical trials prior to implementation, with independent review by an institutional review board to assure adequate protection of human subjects. The Institute of Medicine (IOM) has identified the need for data supporting the use of incentives to motivate behavior change as one of the top 100 comparative effectiveness research priorities in its recently released report.¹²

Following changes in federal legislation that extended to states the ability to reorganize health benefit allocation, the West Virginia Medicaid program implemented a benefit plan designed to improve health by promoting personal responsibility. The program was launched statewide in 2007, approximately six months after it was piloted in three counties, which allowed very limited time to evaluate its success.¹³ Health outcomes and behavior change data have not been extensively reported in recent analyses,^{13, 14} but suggest that adult Enhanced Plan members are less healthy and less active.

Evidence that this plan will produce improved health outcomes, provide respect for autonomy, and equitable distribution of health care resources is needed.¹⁵

Position 2: Incentives to promote behavior change should be designed to allocate health care resources fairly without discriminating against a class or category of people. The incentive structure must not penalize individuals by withholding benefits for behaviors or actions that may be beyond their control. Incentives to encourage healthy behaviors should be appropriate for the target population. The American College of Physicians supports the use of positive incentives for patients such as programs and services that effectively and justly promote physical and mental health and well-being.

Proponents of health plans that promote personal responsibility for health consider that personal behavioral choices help determine an individual's health status.² Employers, who have a responsibility to be good stewards of health care programs they administer, believe that use of incentives and wellness programs will decrease health costs and increase worker productivity.¹⁶ But more study is needed of which incentives are most effective in improving outcomes, and their effectiveness compared to other interventions.^{15,17-19} The American College of Physicians supports positive incentives for patients that encourage healthy behaviors including good nutrition, increased exercise, and smoking cessation where there is evidence of effectiveness. Incentives must be designed to

promote behavior change and acceptance of personal responsibility without penalizing or discriminating against individuals with increased health risks or other factors contributing to poor health status. The goal is not to punish, but to level the playing field for those who are in need of additional support to improve or maintain healthy behaviors. ACP has said that “Incentives to encourage personal responsibility for health (Australia, Belgium, Japan, New Zealand, Netherlands, Switzerland and Taiwan) can lead to healthy behaviors, improved health outcomes and responsible utilization of health care services. These countries restrain costs without punishing people who fail to adopt recommended behaviors or lifestyles.”²⁰ We are mindful, however, that some critics have noted that offering enhanced benefits to patients who meet externally imposed metrics of personal responsibility is by definition denying those benefits to those who cannot meet those criteria and could be considered inherently unjust.

The American College of Physicians encourages physician support of health education and initiatives offered by community groups²¹ and employer-sponsored cost-effective wellness programs.²² The American Cancer Society Action Network (ACS CAN), the American Diabetes Association, and the American Heart Association support employer-sponsored evidence-based comprehensive wellness programs with appropriate regulation to protect against discrimination based on health status as well as the right to privacy.²³ These advocacy organizations do not believe that the use of financial incentives linked to health insurance premiums, deductibles or other patient costs are an appropriate way to motivate behavior change.²³

It is important to consider society’s role in health outcomes, particularly in the Medicaid population. Erika Blacksher argues that “health choices and the outcomes to which they contribute tend to be structurally patterned by socioeconomic status, race, and ethnicity. Socially disadvantaged groups are disproportionately exposed to health risks, are more likely to engage in unhealthy behaviors, and experience worse health and shorter lives than those who are better off.”^{4,24} Thus, these individuals might not have the means to achieve certain behaviors unless system barriers are addressed. Access to health care may be limited by cost or transportation needs. “Food deserts” or low-income geographic areas with few affordable, healthy food options present nutritional challenges.²⁵ Nonadherence to medical recommendations may result from poor communication between the patient and physician, unwanted side effects of medications, out-of-pocket costs, complexity of recommendations and cultural barriers.²⁶ Patients in this population who experience these barriers may actually be the ones who would most benefit from enhanced services.^{27,28} Penalizing individuals for behaviors without consideration of factors that may be beyond their control is unfair.

Approaches to personal responsibility that penalize patients with negative incentives or ask for physician participation in activities that potentially breach the physician’s first and primary duty to the patient,²¹ violate the principles of medical ethics and the Physician Charter on Professionalism.²⁹ ACP has said that, “The denial of appropriate care to a class of patients for any reason is unethical.”²¹ If, on theories of justice, health care is a social good, then there is a social obligation to strive “to provide access, without financial or discriminatory barriers, to services that adequately protect and restore normal

functioning.”³⁰ Furthermore, it is the physician’s responsibility to advocate particularly for the most vulnerable and disadvantaged populations.^{29,31}

Position 3: Transparency and clarity are critical to effective implementation of innovative approaches to health care such as the use of incentives to motivate behavior change. Health plans should provide a clear explanation in lay terms of both the benefits and the operational details and should survey stakeholders such as patients and clinicians to ensure that the explanations are adequate.

Open and honest communication between the health plan administrators and its members is critical. Health plans should clearly communicate the benefits and the operational details of the plan in language patients can understand. As the *ACP Ethics Manual* stresses, patients must be well informed in order to make intelligent health care decisions in partnership with the physician.²¹ The *Ethics Manual* also notes the need for the physician to provide sufficient information for informed decision-making.²¹ Because effective communication requires both the conveyance of information from the speaker but also feedback from the listener of his or her understanding, ACP recommends the development of structured mechanisms to solicit feedback from stakeholders.

In the case of West Virginia, the redesigned Medicaid program automatically enrolls patients in the Basic Plan. To receive enhanced benefits, patients must sign a new Member Agreement that lists general requirements such as keeping appointments and taking medications as ordered, as well as an individualized health improvement plan developed by the physician in collaboration with the patient. Preliminary evaluation of the West Virginia Medicaid program revealed that at two years after implementation, only 10% of eligible adults and 13% of eligible children were enrolled in the Enhanced Benefits plan due to ineffective notification and education.¹³ Patients reported limited knowledge and understanding of the program prior to and after enrolling and clinicians reportedly learned about the program from confused patients with new paperwork.¹³ Not only did clinicians not understand benefit structures or the enrollment process, they thought that they might be responsible for monitoring compliance.¹³ Early feedback from patients and clinicians can help programs focus on how to communicate enrollment processes and understand the expectations of stakeholders.

Position 4: Incentives to promote behavior change should be consistent with the elements of patient-centered care. The incentive structure should support appropriate patient autonomy and participation in decision making, including the right to refuse treatment, without punitive consequences.

The *ACP Ethics Manual* states that treatment should be initiated after the patient and physician have agreed on the problem, goal of therapy and course of action.²¹ Patient autonomy requires that physicians empower patients to take an active role in their care. Physicians may offer recommendations for treatment but decision-making should be a shared process, respecting the patient’s informed acceptance or rejection of the physician’s recommendation. In the West Virginia program, patients are required to “comply” with a recommended plan of care in order to qualify for an enhanced benefit package of medical services.

The West Virginia Medicaid program and others may be motivated by laudable goals including the improvement of care and outcomes, along with enhanced efficiency and cost savings, however, there is a fundamental tension here between patient autonomy and welfare on the one hand, and the role of government or employers in promoting the common good on the other.

Position 5: Incentives to promote behavior change should be designed to recognize and support the physician’s ethical duty to provide care, the physician’s ethical responsibility to discuss all appropriate care options with the patient in a culturally sensitive manner and the physician’s professional obligation to make recommendations on the basis of medical merit. Incentives should support honest, open and fair interactions among patients, health care professionals, health care entities and payors.

Physicians have a moral duty to care for all patients.²¹ The ACP *Ethics Manual* stresses the importance of maintaining a professional relationship and only discontinuing that relationship under exceptional circumstances. Prior to terminating a relationship, a physician must attempt to address a patient’s concerns and to resolve any differences, and must assure that adequate care is available elsewhere.

Health plans should not interfere with the ability of patients to communicate freely with physicians and other health care clinicians. The physician should not be required to reveal information about the patient that could jeopardize the patient-physician relationship. A physician cannot properly treat a patient who is untruthful about adherence to a medical plan for fear of loss of health benefits. Programs that use negative incentives may interfere with the physician’s ability to exercise independent medical judgment in developing an individual plan of care. Patient-physician relationships build on trust, mutual respect and honest communication. The ACP *Ethics Manual* discusses the shared obligation of patients, clinicians, government, insurers, health care institutions and health care industries to recognize and support “the intimacy and importance of relationships with patients and the ethical obligations of clinicians to patients.”²¹

What is the balance between the patient advocate role which is supported by the ethical principles of beneficence, nonmaleficence and respect for patient autonomy and the role as steward of health care resources derived from the ethical principle of distributive justice? The American College of Physicians *Ethics Manual* defines beneficence as “a duty to promote good and act in the best interest of the patient and the health of society”; nonmaleficence is “the duty to do no harm to patients”; respect for patient autonomy is “the duty to protect and foster a patient’s free, uncoerced choices”; and “the principle of distributive justice requires that we seek to equitably distribute the life-enhancing opportunities afforded by health care.”²¹ The *Ethics Manual* highlights the physician obligation to promote the welfare of patients in the increasingly complex healthcare system as well as the responsibility to steward finite healthcare resources in order to provide the greatest good for the greatest number.²¹ The physician’s ethical obligation to society includes assisting policymakers and the community to “recognize and address

social and environmental causes of disease.”²¹ The Institute of Medicine (IOM) also expressed this view in a 1995 report on social and ethical impacts of biomedicine calling for health care professional associations to “recognize their special obligation to investigate the ethical implications of biomedical developments and advocate for the interests of the public and of patients, especially when those adversely affected by change are unable to advocate for themselves.”³²

Conclusion

Although there is a need for more evidence supporting such measures, personal responsibility for health has been embraced as a way of improving health outcomes and controlling healthcare costs. However, motivating behavior change is much more complex than can be accomplished with a single strategy and requires both an individual commitment to health as well as societal collaboration to eliminate barriers.³³ The IOM recommends that critical determinants of health including age, gender, race, ethnicity and socioeconomic status be carefully considered in designing, implementing and interpreting results of social and behavioral interventions.³⁴ In addition, programs must be designed to allocate benefits equitably; must not include penalties, should support the patient-physician relationship and the physician’s ethical and professional obligations to care for patients; should not discriminate against a class or category of people; should facilitate patient-centered care; must respect patient autonomy; and should follow evidence-based models. Potential unintended consequences such as the promotion of negative behaviors in order to qualify for incentives or the shifting of resources from more effective interventions should be evaluated. A multi-faceted approach is required to improve health outcomes.⁸ As Blacksher notes: “the call for personal responsibility should be accompanied by an awakening of our shared responsibility... directed at promoting health for all.”³⁵ Promoting individual behavior change must be part of a larger comprehensive collaborative approach involving all stakeholders.

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