



Fit for the Job: What Can Workplace Wellness Programs Deliver?

FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

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FRIDAY, NOVEMBER 6, 2009
11:45AM–12:15PM—Lunch
12:15PM–2:00PM—Discussion

LOCATION

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OVERVIEW

For decades some employers have attempted to improve health, productivity, and worker morale and to lower costs through a variety of health education and other programs in the workplace, commonly referred to as workplace wellness programs. Wellness programs have received renewed attention from employers and workers as health care costs have continued to climb at a rate that exceeds growth in wages and many other costs of doing business. Recent media attention has focused on the small but possibly growing number of employers whose wellness programs have added financial stakes for employees to participate and even achieve certain health outcomes. This session will explore the types of workplace wellness programs and evidence of their effectiveness, as well as the ethical concerns around wellness programs and legal parameters that affect program design. Speakers will also discuss provisions in health reform legislation that relate to workplace wellness programs.

SESSION

By now, the high and rising cost of health care and health insurance is a familiar economic reality for American employers and workers. The majority of Americans—58.5 percent—had employment-based insurance for all or some part of 2008.¹ Premiums for employer-sponsored family health insurance coverage increased 131 percent between 1999 and 2009; in 2009, the average annual premiums for employer-sponsored insurance are \$4,824 for an individual and \$13,375 for a family.² Although the share of the premium paid by employee varies significantly by geography, benefit packages, and other factors, employees pay on average 17 percent of the premium for individual and 27 percent of the premium for family coverage.³

As health care costs have continued to climb at a rate that exceeds growth in wages and many other costs of doing business, employers have looked for ways to intervene in the factors driving health care costs and cost growth. Disappointed by other efforts to manage health care spending, some employers have attempted to reduce the prevalence of chronic disease through workplace wellness programs, also known as work site health promotion programs. Researchers Goetzel and Ozminkowski define workplace wellness programs as “employer initiatives directed at improving the health and well-being of workers and, in some case, their dependents. They

include programs designed to avert the occurrence of disease or the progression of disease from its early unrecognized stage to one that's more severe.⁴ Wellness programs may focus on primary prevention directed at populations that are generally healthy, secondary prevention targeted at individuals who are at high risk for declining health because of biometric indicators such as high cholesterol or behaviors such as smoking, or elements of tertiary prevention for people with existing conditions such as diabetes.⁵ Programs can take many forms, from general education to targeted interventions like smoking cessation and weight loss counseling to disease management. They may also use incentives—including financial ones—to encourage participation or to achieve certain standards, provided they meet all relevant legal requirements (discussed below).

Workplace wellness programs have received renewed attention because of the continued rise in health spending, the identification of behaviors—such as smoking and consuming a poor diet—that contribute to the prevalence of chronic diseases, and the estimates of spending to treat illness resulting from behaviors many consider modifiable. In an article on addressing obesity in the workplace, Heinen and Darling observe that “[e]mployers have come to realize that they can’t control medical claim costs if they don’t start changing the demand for care driven by diabetes, heart disease, sleep apnea, depression, back and neck problems, and many other health conditions caused or exacerbated by obesity.”⁶ In addition to attention from employers, policymakers have also shown interest in promoting workplace wellness programs. Earlier this year, the Healthy Workforce Act, which would provide tax credits to employers who provide health awareness education, risk assessments, and behavioral change programs such as counseling, was reintroduced with bipartisan sponsorship in the Senate and the House of Representatives.⁷

Wellness programs that include financial incentives such as lower premiums for employees who engage in healthy behavior or achieve certain biometric standards have received recent media attention.⁸ These incentive programs—described as “more stick and less carrot”⁹—are the latest incarnation of decades-long efforts by some employers to promote wellness in the workplace in order to reduce costs and improve productivity. Such programs are considered controversial by some and have raised ethical and privacy concerns¹⁰ that are reflected in the regulations establishing the standards for nondiscrimination in reward-based wellness programs.

Group insurers’ wellness programs with financial rewards or penalties must conform to the nondiscrimination provisions of the Health



Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, which were finalized in December 2006. In general, HIPAA requires that if a group health plan provides a benefit, it must be uniformly available to all “similarly situated” individuals in the group.¹¹ Under HIPAA, group health insurers cannot deny or charge more for benefits because of health factors including health status, physical and mental illnesses, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.¹² However, there is an exception that allows plans to offer wellness programs and still comply with the nondiscrimination provision. If obtaining a reward is not contingent on an individual satisfying a standard related to a health factor, or if no reward is offered, the program complies with the nondiscrimination requirements. Examples of such programs include a diagnostic testing program that provides a reward for participation rather than outcomes, a program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking, or a program that reimburses all or part of the cost for memberships in a fitness center.¹³ If obtaining a reward *is* contingent on an individual satisfying a standard related to a health factor, the wellness program must meet five requirements to comply with the HIPAA nondiscrimination rules:

- The total reward generally must not exceed 20 percent of the cost of coverage under the plan.
- The program must be reasonably designed to promote health and prevent disease.
- The program must give individuals eligible to participate the opportunity to qualify for the reward at least once per year.
- The reward must be available to all similarly situated individuals. It must allow a reasonable alternative standard (or waiver of initial standard) for obtaining the reward to any individual for whom it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the initial standard.
- The plan must disclose in all materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of a waiver of the initial standard).¹⁴

As one legal scholar notes, compliance with these five criteria is merely one step in developing a benefit structure that conforms to all applicable laws and regulations because many other federal laws, such as the Americans with Disabilities Act, the Family and Medical Leave Act, and the Civil Rights Act—as well as state laws—may govern the benefits offered by health plans.¹⁵

One often-cited example of a wellness program that rewards attainment is Safeway's Healthy Measures program, which varies an employee's premiums to reflect his or her score on four health measures: tobacco use, weight, blood pressure, and cholesterol levels.¹⁶ Another example is the Alabama State Employees' Insurance Board–approved plan whereby active state workers (but not their families or retirees) will be eligible for a \$25 per month premium discount starting in 2011 if they are deemed not at risk, on the basis of on baseline readings for blood pressure, cholesterol, glucose, and body mass index.¹⁷ If employees are deemed at risk, they can still receive the discount as long as they (i) have physician certification stating they have received counseling or have a health condition that prevents improving the risk factor, (ii) have participated in an approved wellness program, or (iii) have reported improvement in the risk factor.

Although examples of these programs have received recent attention, evidence suggests that incentive programs are not currently widespread. The 2009 Kaiser Family Foundation/HRET survey of employers found that 4 percent of respondents offered a lower premium and 1 percent offered a lower deductible as an incentive to workers to participate in a wellness programs.¹⁸ Wellness programs that provide education, health assessment, or options such as on-site fitness centers or gym membership discounts were found to be much more common.¹⁹

Since the release of the final regulations clarifying the wellness program exception to HIPAA's nondiscrimination requirement, interest in programs that reward employees for achievement of health outcomes may be growing. A 2007 survey of approximately 450 large employers by Hewitt Associates found that employers are looking to alter the health risks of their employees; almost two-thirds of respondents said they plan to take "aggressive, multiyear steps to help employees improve their health" while holding participants accountable for their behavior.²⁰

In addition, interest in such programs could see a boost, depending on the outcome of health reform legislation. At the time of this writing, both Senate committee versions of health reform bills would expand the ability of employers to offer financial rewards to participate in wellness programs or achieve certain health outcomes. The Affordable Health Choices Act passed by the Senate Committee on Health, Education, Labor, and Pensions (HELP) contains language that would increase the HIPAA-allowable reward for employees who participate in wellness programs from a 20 percent premium discount to 30 percent, and would allow the Secretaries of the



Departments of Health and Human Services, Labor, and Treasury to increase this reward to 50 percent under some circumstances.²¹ The Senate Committee on Finance's "Chairman's Mark of the America's Healthy Future Act of 2009" contains language that would "codify and enhance provisions of the HIPAA nondiscrimination regulations, which allow rewards to be provided to employees for participation in or for meeting certain health standards related to a wellness program."²² Like the HELP bill, it would permit group health plans to provide rewards based on participation in wellness programs, cap rewards for satisfying a health-related standard at 30 percent of the cost of coverage (defined as the employer and employee share of the premium), and allow Secretarial discretion to increase the cap to 50 percent provided it satisfies current HIPAA criteria (see above), which would become specified in law.

Despite the interest in wellness programs and the inherent appeal of the benefits of prevention, stakeholders on all sides may harbor reservations about their value. Concerns about these programs come in two general categories: (i) concerns about whether they are effective and (ii) concerns about privacy, discrimination, and fairness. Much of the evidence on the effectiveness of wellness programs is anecdotal, because employers do not typically evaluate the effectiveness of their programs. Studies that do exist may suffer from threats to internal and external validity, such as biased samples, high attrition rates, and lack of controls, as noted by the Centers for Disease Control and Prevention's Task Force on Community Preventive Services in its findings on the review of literature evaluating work site health promotion programs.²³ Noting these limitations, the Task Force concluded that its systematic review of available studies of programs for obesity prevention,²⁴ promotion of physical activity,²⁵ and smoking cessation²⁶ provides strong or sufficient evidence that such programs are effective in the workplace.²⁷

In addition to questions about effectiveness, concerns about discrimination and privacy as well as philosophical opposition may make employers and employees wary of wellness programs, especially those that include financial rewards or penalties. Some object to wellness programs with incentives because they see them as attempts to discriminate against sicker employees by making them pay more for their health care. Questions also remain about how much behavior is within an individual's control, and what current science can tell us about how modifiable a behavior really is. In addition, such programs raise concerns about the privacy of health information. In a *Health Affairs* article published earlier this year,

authors Pearson and Lieber analyze the arguments for and against incentive programs. They note that “penalties heighten the concern for coercion and inequity. Nonetheless, penalty programs seem poised to play a larger role if early anecdotal reports of their successes are confirmed more broadly. The goal should be to establish an ethical balance between holding employees responsible and protecting their liberties.”²⁸

This session will discuss the motivations for employers to adopt wellness programs or refrain. Speakers will discuss the range of wellness programs, including those that use incentives such as discounted premiums, to encourage health plan members to engage in certain behaviors or achieve certain health outcomes. Presentations will address the evolution of workplace wellness programs and the evidence on the nature and durability of the results that programs can deliver. The session will also explore the privacy and ethical concerns raised by these programs and address the legal parameters regarding which types of workplace wellness programs are permissible. Finally, speakers will discuss governmental interests (for example, obtaining evidence of what works to support policy, protecting workers from discrimination) in these types of programs and which types of policies would promote those interests.

KEY QUESTIONS

- What are the reasons that employers adopt or do not adopt wellness programs? How do employers make decisions? How do different goals result in the use of different wellness program designs (such as programs with financial rewards) or other cost control efforts (such as benefit design changes)?
- What kind of results do wellness programs achieve, and how are they measured? Do they make people healthier? Are they cost effective? Do they improve worker satisfaction? Do they affect worker morale or productivity?
- In the design of incentive programs, where do employers draw the line in deciding what to penalize and reward? How do programs determine whether health conditions are the result of modifiable behaviors?
- Do employers who expect behavioral change in employees have a similar responsibility to promote health in the workplace and facilitate those behaviors with access to, for example, fitness facilities, healthy food options, flexible hours to allow for exercise?

- In addition to HIPAA, what federal and state laws and regulations affect the nature of wellness programs, the incentives that employers may provide, and the information available for monitoring compliance?
- What role should the federal government play in promoting wellness programs and protecting employees?

SPEAKERS

LuAnn Heinen is vice president and director, Institute on the Costs and Health Effects of Obesity at the National Business Group on Health. She will begin the session by discussing employers' use of wellness programs, including who is using them (for example, small vs. large employers) and why, the forms that such programs take and the behaviors that are targeted, and the challenges employers face in deciding whether to adopt and maintain programs. **Ron Z. Goetzel, PhD**, is research professor and director at the Institute for Health and Productivity Studies, Emory University and vice president of consulting and applied research with Thomson Reuters Healthcare. He will discuss the evidence base for work site health promotion programs. He will also discuss program design and implementation strategies that have been effective, the metrics for measuring effectiveness, and the role that public policy plays in developing effective programs. **Lucinda Jesson, JD**, associate professor and director of the Health Law Institute at Hamline University, will discuss the laws and regulations applicable to workplace wellness programs design and monitoring. She will discuss those programs that have obligations for personal responsibility or behavior modification as well as the federal role for protection from discrimination and protection of privacy. **Ann Kempfski** is the director of health policy with the SEIU. She will discuss worker perspectives on the range of workplace wellness programs and provisions in health reform bills related to wellness programs.

ENDNOTES

1. Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2008*, U.S. Census Bureau, Current Population Reports, P60-236, (Washington, DC: U.S. Government Printing Office, 2009).
2. Kaiser Family Foundation and Health Research & Educational Trust (KFF/HRET), *Employer Health Benefits, 2009, September 2009*, p. 14; available at <http://ehbs.kff.org/pdf/2009/7936.pdf>.

3. KFF/HRET, Employer Health Benefits, 2009, p. 74.
4. Ron Z. Goetzel and Ronald J. Ozminkowski, "The Health and Cost Benefits of Work Site Health-Promotion Programs," *Annual Review of Public Health*, 29 (April 2008): p. 304.
5. Goetzel and Ozminkowski, "The Health and Cost Benefits of Work Site Health-Promotion Programs," p. 304.
6. LuAnn Heinen and Helen Darling, "Addressing Obesity in the Workplace," *Milbank Quarterly*, 87, no. 1 (2009): pp. 101–122.
7. See "Sens. Harkin, Cornyn And Reps. Blumenauer, Bono Mack Reintroduce Healthy Workforce Act," press release, Web site of Sen. Tom Harkin, April 2, 2009; available at <http://harkin.senate.gov/blog/?i=4d931ef6-d529-4d45-920e-1e4f7eb82655>.
8. See for example, Anna Wilde Mathews, "When All Else Fails: Forcing Workers Into Healthy Habits," *The Wall Street Journal*, July 12, 2009; "Employers Find that Taking Care of Workers' Health Pays Off With Lower Insurance Costs," *The Memphis Commercial Appeal*, August 17, 2009; "Cutting Health Costs: Discounts For The Healthy?" National Public Radio, Morning Edition, October 7, 2009, available at www.npr.org/templates/story/story.php?storyId=113549864&ps=rs#commentBlock; David S. Hilzenrath, "Wellness Incentives Could Create Health-Care Loophole," *The Washington Post*, October 16, 2009, available at www.washingtonpost.com/wp-dyn/content/article/2009/10/15/AR2009101503036.html?hpid=topnews.
9. "Plans, Employers Join Obama in Targeting Tobacco, Using 'More Sticks than Carrots,'" *Health Plan Week*, 19, no. 23 (June 29, 2009).
10. Steven D. Pearson and Sarah R. Lieber, "Financial Penalties for the Unhealthy? Ethical Guidelines for Holding Employees Responsible for Their Health," *Health Affairs*, 28, no. 3 (May/June 2009): pp. 845–852.
11. "Similarly situated" refers to employment related factors such as full- and part-time status in the firm.
12. Employee Benefits Security Administration, "FAQs About the HIPAA Nondiscrimination Requirements," U.S. Department of Labor; available at www.dol.gov/ebsa/faqs/faq_hipaa_ND.html.
13. "FAQs About the HIPAA Nondiscrimination Requirements."
14. "FAQs About the HIPAA Nondiscrimination Requirements."
15. Lucinda Jesson, "Weighing the Wellness Programs: The Legal Implications of Imposing Personal Responsibility Obligations," *Virginia Journal of Social Policy and the Law*, 15 (2008); available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1335497.
16. Steven A. Burd, "How Safeway is Cutting Health-Care Costs," *The Wall Street Journal*, June 12, 2009.
17. National Conference of State Legislatures, "State Employee Health Benefits," updated October 15, 2009, available at www.ncsl.org/default.aspx?tabid=14345#wellness; and Louis C. LaBrecque, "Alabama Program for State Employees Seeks to Raise Awareness of Risk Factors," *Government Employee Relations*, BNA, Inc., 46, no. 2270 (September 9, 2008): pp. 1004–1005.

18. KFF/HRET, *Employer Health Benefits, 2009*, p. 204.
19. KFF/HRET, *Employer Health Benefits, 2009*, p. 202.
20. "Hewitt Study Shows Companies Plan to Invest More in the Health of Their Employees," *Business Wire*, April 19, 2007; available at www.insurancenewsnet.com/article.asp?n=1&neID=20070419290.2_99520061dd3670c9.
21. See "In Historic Vote, HELP Committee Approves the Affordable Health Choices Act," press release, Committee on Health, Education, Labor, and Pensions, U.S. Senate, July 15, 2009; available at http://help.senate.gov/Maj_press/2009_07_15_b.pdf
22. "Chairman's Mark: America's Healthy Future Act of 2009," Committee on Finance, U.S. Senate, p. 93; available at www.finance.senate.gov/sitepages/leg/LEG%202009/100209_Americas_Healthy_Future_Act_AMENDED.pdf.
23. Goetzel and Ozminkowski, "The Health and Cost Benefits of Work Site Health-Promotion Programs," p. 309.
24. For the specific interventions reviewed see Task Force on Community Preventive Services, "Worksite Programs to Control Overweight and Obesity," *The Community Guide*, October 2007; available at www.thecommunityguide.org/obesity/workprograms.html.
25. Specifically, the Task Force found evidence to recommend "point-of-decision prompts to encourage the use of stairs" (see www.thecommunityguide.org/pa/environmental-policy/podp.html) and the "creation of or enhanced access to places for physical activity combined with informational outreach activities" (see www.thecommunityguide.org/pa/environmental-policy/improvingaccess.html).
26. The Task Force found evidence to recommend programs that use "incentives and competitions when combined with additional interventions" such as education or smoke-free workplace policies for smoking cessation. They found insufficient evidence on the effectiveness of "incentives and competitions" alone (see www.thecommunityguide.org/tobacco/worksite/incentives.html).
27. For additional detail on Task Force findings and recommendations, and links to supporting evidence, see www.thecommunityguide.org/worksite/index.html. For a discussion of the findings see Goetzel and Ozminkowski, "The Health and Cost Benefits of Work Site Health-Promotion Programs," pp. 308–309.
28. Pearson and Lieber, "Financial Penalties for the Unhealthy?" p. 846.