Wellness and Prevention: An Overview

Introduction

Health care costs have been rising at an alarming rate in recent years throughout the United States. In the year 2008, expenditures on health care surpassed $2.30 trillion, an increase of more than three times the $714 billion spent in 1990.[i] These costs have been shouldered by both employers and employees. For example, many employers have faced escalating premium costs or been forced to contribute substantially more of their annual profits to fund self-insured plans. At the same time, many employees have seen their spendable income reduced as they have faced a combination of higher contribution rates for coverage coupled with higher deductibles and co-pays.

General Inflation Rate versus Medical Inflation Rate

The inflation rate in the United States over the last 10 years has averaged 2.40 percent. The medical inflation rate has proved to be substantially higher impacting the financial resources of employers, employees, and older individuals.[ii]

There are many reasons for this cost escalation including increases in the following:

- use of sophisticated technology in the detection and treatment of disease[iii]
- reliance on pharmaceuticals and prescription drugs
- age of the population—maturing of the Baby Boom generation, the largest cohort in American demographic history
- incidence of chronic diseases such as cardiovascular disease and diabetes[iv]

One of the most promising ways to slow the pace of these escalating costs is through the implementation of wellness and prevention programs throughout the private employer-based health care system. Many working-age Americans rely on their employers to provide them with benefit packages that include health insurance. These same individuals spend the majority of their waking hours at worksites where help in making appropriate lifestyle choices can have a major impact on their physical health and quality of life as well as on the costs incurred by the American health care system.

Objectives

The purpose of this course is to provide you with an understanding of the positive role of worksite wellness and prevention programs. After reading and reviewing this lesson you will be able to:

- describe the meaning and purpose of the workplace wellness movement and know the difference between wellness and prevention
- explain wellness from historical and economical perspectives
- know what tools and technologies are used to develop programs
- understand the basics for crafting goals, objectives, and action steps to implement wellness initiatives
- recognize the importance of all the elements, including the roles of upper management and the wellness committee, legal aspects, and ways in which wellness links with other programs like disease management and value-based insurance design

What Do We Mean by Wellness?

We hear the word wellness frequently. The word appears in mainstream media and the insurance industry press as well. To different audiences, however, it means slightly different things. The Merriam-Webster dictionary defines wellness as "the quality or state of being in good health especially as an actively sought goal."[v] For many, the term simply means freedom from diseases.

Michael Samuelson, Founding President and CEO of the Health & Wellness Institute, succinctly defines "personal wellness and worksite (community) wellness" this way:

> ***well·ness****, \ˈwel-nəs\: a dynamic objective and subjective progression toward a state of complete physical, intellectual, emotional, spiritual and social wellbeing and not merely the absence of disease or infirmity. Incremental improvements can occur from pre-conception up to and including a person's last breath.*[vi]

Using Samuelson's definition, wellness at the worksite—by extension—is:

> *...any activity, policy, attitude, and physical plant circumstance that facilitates a person's progression toward complete physical, intellectual, emotional, spiritual and social wellbeing and not merely the absence of harm*.
>
> *…COMPLETE actualization is not likely to happen for most of us in this lifetime. It is the continuous progression of incremental (mostly small) improvements that we seek to achieve…and, particularly important for the CFOs to measure.*
>
> *It is also important to emphasize both the objective (science of life) elements of wellbeing and the subjective (art of living) drivers. The former is intellectual and universal but the latter is visceral and personal. Visceral is a response to and a driver for both passion and purpose*. Personal passion and sense of purpose *are the keys to sustained engagement.*[vii]

Others see wellness as multidimensional—being more than the absence of disease.[viii] Those who take this approach, such as the National Wellness Institute, usually see wellness as a holistic pattern taking into account six factors:

- social
- occupational
- spiritual
- intellectual
- emotional
- physical well-being[ix]

- The **social dimension** emphasizes an individual's interdependence with his or her community. It includes harmonious relations with one's family.

- The **occupational dimension** focuses on preparation for work that is personally suitable and through which the individual finds fulfillment. Having a positive attitude toward work and contributing to the community through one's work activities—both as a paid worker and unpaid volunteer—are also aspects of this dimension.

- The **spiritual dimension** of wellness focuses on one's meaning and purpose in life. Along one's journey in this dimension, an individual may experience a variety of feelings including doubt, fear, and disappointment, and develop a system of beliefs, values, and goals.

- The **intellectual dimension** of wellness encourages an individual to seek knowledge and develop skills calling upon resources within the educational system and his or her community.

- The **emotional dimension** of wellness asks us to be aware of our feelings and self-aware of our potential, including a realistic assessment of our limitations. Emotional wellness also includes maintaining satisfying relationships with others, both providing and seeking the support and assistance of others throughout the life journey.

- The final aspect of this multidimensional approach is **physical well-being**. The physical aspect of wellness includes regular physical activity, promotion of cardiovascular health, and acquisition of knowledge about food and nutrition. This aspect of the multidimensional approach also discourages the use of tobacco products and excessive consumption of alcoholic beverages.

Well-designed workplace wellness programs do seek to enrich the social, occupational, intellectual, and emotional well-being of participants. They also seek to promote physical well-being—a primary focus of this course—by making the workplace supportive of healthy behaviors. For example:

- Nutritional guidance – through classes that not only highlight the food pyramid but include cooking demonstrations on proper preparation and storage
- Smart eating – by removing high sugar and calorie-laden sodas from cafeteria vending machines

- Organized physical exercise – through the installation of an onsite gym or partial payment of monthly health club membership dues
- Promotion of walking – through the installation of walking paths in corporate parks
- Smoking cessation – by subsidizing the cost of patches and other tools designed to reduce nicotine dependence
- Stress management – conducting stress management workshops at the workplace

Financial health is another aspect of the multidimensional viewpoint of wellness since poor management of finances can lead to the breakdown of one's social condition. Significant stress can lead to illness and it, too, is a contributing factor in poor job performance and lower productivity.

Some employers offer their workers tools to deal with impediments to their wellness, such as financial counseling in case of mortgage delinquencies or professional support to deal with the emotional issues that come with the care of an aging parent, through employee assistance programs (EAPs).

What Do We Mean by Prevention?

Well-designed workplace wellness programs not only seek to promote wellness, but they also take into consideration prevention. What do we mean by prevention? The dictionary offers this definition: "The act of preventing or hindering."[x]

Prevention within the context of health care is focused on disease prevention. This includes not only the prevention of the initial occurrence of disease but also arresting its progress once it is detected.[xi] Disease prevention activities seek to stop the initial onset of disease by focusing on risk reduction factors such as weight reduction for those with pre-diabetes. Once detected, these programs seek to slow disease progression and reduce consequences through such actions as organized programs that often include patient education, medication adherence (taking prescriptions as recommended), and care management.

Clinicians usually see prevention at three different levels:

- primary
- secondary
- tertiary

Primary prevention employs strategies intended to avoid the development of the disease. This level of prevention is applied to generally healthy people, before disease, injury, or dysfunction occurs.[xii]

Example: After a new product introduction meeting, employees, including Jill, express their satisfaction with results by hugging and shaking hands. However, Jill notices that many people present at the meeting have been sneezing. To lower her risk of becoming infected, Jill quickly washes her hands.

Example: Jim learns through a medical report on the evening news that a major outbreak of the flu is expected in his city. Rather than wait and risk becoming ill, Jim takes advantage of free flu shots offered by his company.

Secondary prevention focuses on the treatment of existing disease in its early stages. In other words, after the disease has occurred but usually before the individual notices that anything is wrong. In many cases, the disease once detected can be cured.

Example: Walt is an outdoorsman who moved to the Sun Belt several years ago. During his annual physical, Walt's doctor checks for suspicious skin growths and notices an irregularity indicating early-stage cancer. Walt feels fine but his doctor has detected cancer and will be able to recommend treatment at an early stage when it is curable.[xiii]

Tertiary prevention targets the person who already has symptoms of the disease. The goals of tertiary prevention are to slow down the progress of the disease, prevent the occurrence of other problems ("complications"), and prevent pain.[xiv] It also aims to reduce the amount of disability caused by a disease—and, where possible, restore lost function(s).[xv]

Example: Same facts as Example Three except that by the time Walt undergoes his physical, cancer has become readily apparent causing disfiguration and pain. Walt's doctor refers him to a specialist who suggests a mix of surgeries and newly approved medications to remove cancer and alleviate the pain.

Example: Gladys suffers a stroke which results in difficulty walking and some loss of her speech function. Her doctor recommends rehabilitative physical therapy to improve her walking and speech therapy to restore her ability to orally express thoughts.

Some clinicians cite the fourth level of prevention; namely, **quaternary prevention** which looks at the pros and cons of following a course of medical treatment while offering a patient acceptable alternatives. This level of prevention describes activities taken to mitigate or avoid unnecessary or excessive treatments and interventions,[xvi] a temptation that can arise in part due to the combined availability of information through such sources as the Internet and the increasing use of technology.[xvii] An excellent introduction to this topic can be found in Shannon Brownlee's landmark book, *Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer*.[xviii]

Example: A 75-year-old man visits his physician and learns that recent medical tests indicate early-stage prostate cancer. Radical surgery is an available option but before scheduling such a procedure, the physician and his patient discuss whether this is the best course of treatment. An acceptable alternative might be to take a "wait and see" approach given the traditionally slow progress of the disease in an older man.

Another approach to preventing disease among employee populations is to deter "bad" behavior. **Environmental prevention** discourages workers from engaging in behaviors that increase their risk of disease by focusing on the "temptations" and/or lack of tools for good behavior presented in the work environment.

Example: Senior managers at HealthCorp notice that many of their younger workers are smoking in the back of buildings on the corporate campus and not taking advantage of company-sponsored smoking cessation programs. Concerned about the increased risks posed by smoking, HealthCorp bans smoking from both inside and outside buildings on the corporate campus.

Example: Loretta works in the human resources department of Heavy Wares, Inc., which has just started a wellness program. During a break in the company lunchroom, Loretta notices that the vending machines stock chips, cookies, and candy along with full-calorie soda. When she reports this to the wellness committee, vending machine selections are changed to offer more nutritious options and many of the calorie-laden selections have been removed.

Cost of Chronic Diseases for Individuals

The incidence of chronic diseases, such as cardiovascular disease and diabetes, has risen dramatically in recent years among workers and the American population as a whole. Many of these chronic conditions are a result of lifestyle choices such as smoking, poor dietary choices, and lack of exercise.

Wellness and prevention programs have much to offer individuals who have the opportunity to participate in them. Failure to take advantage of the opportunities offered by these programs often carries a price in terms of both quality of life and finances. For the individual, the costs associated with a chronic disease can be substantial, including:

- lower quality of life
- poorer financial circumstances
- increased risk of disability and inability to engage in or pursue employment
- reduced longevity

- **Lower quality of life**
  Chronic diseases can limit a sufferer's everyday activities and become debilitating. Diabetics, for example, must carefully monitor their diet. This can prove highly restrictive for individuals who enjoy worldwide travel. Diabetes can also result in amputations substantially limiting one's mobility and, in some instances, requiring one to leave home and live in a community setting more appropriate for wheelchair use and other supportive care.

- **Poorer financial circumstances**
  Living with a chronic disease can be very expensive. Medications to control the disease can carry high out-of-pocket costs—particularly if they are branded versus generic. Living with a chronic disease may also limit one's employment and income potential. The sufferer, for example, maybe unable to engage in the physical labor for which they were trained or unable to put in the long hours associated with many managerial positions.

- **Increased risk of disability and inability to engage in or pursue employment**
  Chronic diseases are a leading cause of disability in the United States, according to the Centers for Disease Control and Prevention (CDC). In some circumstances the disability is limited and an individual can continue working or quickly return to work. In other circumstances, such as stroke, an individual's ability to participate in the workforce is severely limited. This can effectively cut or completely curtail their earnings. In some cases, they may be forced to rely on a mix of public and private benefits. In more severe cases, they may become financially bankrupt and forced to depend solely on public benefits both for income and medical services.

- **Reduced longevity**
  Chronic diseases, such as heart disease, cancer, and diabetes, are leading causes of death. Chronic diseases account for nearly 70 percent of all deaths in the United States—roughly 1.7 to 1.8 million each year.[xix] Compiled from CDC statistics for 2007, Figure 1 ranks the 10 leading causes of death in the United States.

Figure 1 Ten Leading Causes of Death in the United States[xx]

Rank	Disease	Number of Deaths	Rank	Disease	Number of Deaths
1	Heart disease	616,067	6	Alzheimer's	74,632
2	Cancer	562,875	7	Diabetes	71,382
3	Stroke	135,952	8	Influenza and pneumonia	52,717
4	Chronic lower respiratory diseases	127,924	9	Nephritis, nephritic syndrome, and nephrosis	46,448
5	Accidents (unintentional injuries)	123,706	10	Septicemia	34,828

Benefits of Wellness and Prevention to Individuals

Research results published by the CDC indicated that in 2005 133 million Americans—almost one out of every two adults—had at least one chronic illness.[xxi] In the preceding discussion, we

examined the risks of chronic disease and costs in terms of quality of life and personal finances. In the following section, we suggest there's hope for curbing the implications of these statistics.

Many chronic diseases are directly impacted by the choices we as individuals make every day—the food choices we make, the amount of exercise we do, and the good and bad health habits in which we engage. Simple steps such as moderate exercise can reduce the risk of obesity, a leading cause of diabetes and other health problems. Simply following the doctor's orders when it comes to taking prescribed medications is another step. For example, taking a daily dose of a prescribed medication can lower one's blood pressure and risk of a heart attack and ensuing disability. And, on a more cosmetic level, exercise programs can enhance one's looks as many gym enthusiasts will attest.

Beyond disability, many deaths due to chronic diseases can be prevented and treated successfully if detected early—once again pointing to the importance of wellness and prevention programs for individual workers and their participating family members. Many programs provide participants with individualized health risk assessments (HRAs) coupled with standard tests to detect elevated blood pressure and high blood sugar levels often associated with pre-diabetes. They also emphasize preventive care, such as screenings for cancer, so important to early detection when treatment is often highly successful and less invasive.

Wellness and Prevention Benefits for the Individual: A Sampling

- ✓ Better physical appearance
- ✓ Enhanced reserves of energy
- ✓ Decreased risk of chronic disease for non-sufferers
- ✓ Better management of chronic diseases for sufferers
- ✓ Increased ability to handle challenging employment conditions
- ✓ Longer life coupled with a better quality of life

Opportunities for Sponsoring Organizations

A successful wellness and prevention program offers sponsoring organizations the opportunity to:

- lower the rate of growth of employee health care costs
- reduce workforce absences
- reduce work-related accidents and injuries
- increase productivity
- reduce workforce turnover

Lower the Rate of Growth of Health Care Costs

Average health care costs for American employers continued to grow at an estimated rate of 7.3 percent recently despite the worst contraction in the overall economy since the Great Depression.[xxii] Many small and midsize companies have faced even higher increases. More disturbing, this pattern has continued for many years. These costs represent not only outlays for medical costs, such as physician visits and treatments but increasingly expenditures for prescription drugs. Companies, particularly those in the small to the midsize range, are increasingly faced with a draconian choice—either drop or substantially reduce employee health care benefits or face business closure.

Wellness and prevention programs offer an alternative to lower the rate of this rising medical cost trajectory. Simply put, a healthier workforce requires less medical care. For example, offering onsite influenza shots can quickly reduce visits to doctors' offices and emergency rooms when flu season strikes. For further example, encouraging employees to exercise through reduced gym membership fees can ward off pounds and prevent the onset of many obesity-related ailments, such as diabetes, that can quickly add to health care costs.

Health Care Costs: Rising Percentage of the Gross Domestic Product

Health care costs currently represent 17 percent of the gross domestic product (GDP).[xxiii] It is estimated that unless steps are taken this number will rise to almost 20 percent within the next 10 years, putting these costs on an unsustainable trajectory as they squeeze out other needs such as education and infrastructure.[xxiv]

Wellness and prevention programs can and will vary in size and scope. Smaller programs may focus primarily on prevention. Midsize programs may offer a mix of preventive steps and off-site exercise opportunities for their employees. Larger programs may offer onsite clinics and disease management programs with links to research hospitals. All these programs have touchstones within them that help to reduce rising health care costs.

Reduce Workforce Absences

Participants in wellness and prevention programs tend to have fewer absences than nonparticipants. Why? As we will see later in this course, the evidence indicates that participating employees tend to be healthier and thus less subject to the types of illness which force unscheduled absences from work due to health care issues. For starters, fewer absences mean less workplace disruption. Fewer absences can also translate into lower costs for temporary help or overtime pay for other employees.

Reduce Workplace Accidents and Injuries

Healthier employees tend to be more attentive to their tasks and work environment. This reduces the odds of being involved in workplace accidents and sustaining injuries. This, in turn, lowers employer costs by reducing workers' compensation premiums as well as other employer-provided disability benefits. For example, the Mack Molding Company, a leading custom plastics manufacturer, reported substantially lower worker compensation costs, in addition to lower health insurance rates increases, as a result of its wellness program.[xxv]

Increase Productivity

A well-designed wellness program can increase productivity in two key ways. First, as we have previously noted, by decreasing the number of unscheduled employee absences. And second, by decreasing presenteeism—perhaps most easily explained as when an employee is physically present but not fully functional while on the job. For example, presenteeism can occur when a chronically ill worker experiences pain which deflects his or her ability to think. Thus, although the employee is physically present and an unscheduled absence is not recorded, the quality of the work performed has suffered and most likely the quantity of work output as well.

Reduce Employee Turnover

The initiation and maintenance of a well-designed wellness and prevention program demonstrates to employees that an employer cares about their well-being and not just about their contributions to the bottom line. It is important to remember that it costs money to find and train employees, and, unfortunately, not every hire is the right fit for an organization.

Studies confirm that American productivity has indeed increased over the last several years, even as companies and their workers faced an uncertain economic environment. Studies also indicate that the strains brought about by a floundering economy have loosened employee loyalty. Those who feel they have met the demands for increased work output and/or longer hours without appreciation will leave when the opportunity arises.[xxvi] And, these opportunities are indeed arising as the economy rebounds. For example, the Bureau of Labor Statistics recently reported that the number of employees voluntarily quitting their positions was up in 2010 over 2009.[xxvii]

Employers who have taken steps to show they care and recognize that the recent economic pressures of the Great Recession called for extraordinary actions by their employees have a better chance of retaining valuable workers. Investment in a wellness and prevention program that adds to the sense of loyalty felt by employees is a small cost to bear considering these workers are often the very force that creates and drives profits—the lifeblood of many businesses.

Health Care Cost Drivers: A Closer Look

We examined the escalating history and current trajectory of health care costs. Now, let's take a closer look at the factors responsible for medical costs outpacing the general rate of inflation.

Experts place the blame on six primary drivers:

- preventable conditions and avoidable care
- unnecessary care
- lack of care coordination
- administrative inefficiency
- provider inefficiencies and errors
- fraud and abuse[xxviii]

We will briefly look at the role of wellness and prevention programs in reducing the velocity of these health care cost drivers.

Preventable Conditions and Avoidable Care

Simple steps can avoid disease. Early detection can often eliminate disease or help to eradicate its most serious effects. Preventive services are frequently a part of employer-sponsored health plans. Under the provisions of recent health care reform, many of these services can now be obtained without cost.

Employee Education

Another simple and inexpensive weapon in a wellness arsenal is employee education about the benefits offered under their existing health plans and ways they can access them. For example, employees may be unaware that they have access to free flu shots. Yet, increasing the percentage of those taking advantage of this option can significantly lower the need for later and more costly doctor visits.

Prevention Intervention

The American lifestyle of sedentary living and overeating, as previously noted, lends itself to the development of chronic diseases. Here, once again, prevention plays a big role in reducing health care costs. If steps are taken early on, many of these lifestyle risks can be avoided. Following a proper diet, exercising, and losing weight are tools used to combat both diabetes and heart disease.

Wellness programs can play a significant role in putting employees on a detour that bypasses many chronic diseases. Programs that incorporate nutrition education, meal preparation techniques, and simple incentives to exercise, such as the distribution of free pedometers and

team contests, offer a healthy alternative to the unhealthier and more common American lifestyle choices.

Disease Management

Where a chronic disease is already present, the unfortunate truth is that many sufferers are unaware of steps they can and should take to delay or avoid more serious complications. Many wellness programs incorporate a disease management component that includes patient education and, where appropriate, incentives to encourage adherence to prescribed medications designed to control or arrest the progress of the disease. These programs have been shown over time to lower company outlays for health care while improving the quality of life of the sufferer.

Unnecessary Care

The traditional fee-for-service payment system, so prevalent in today's American system, tends to reward the quantity but not necessarily the quality of health care services received. At the same time, individuals learning of potential treatments through the Internet or other communication and advertising mediums may demand health care services without understanding their limitations, side effects, or related costs. Here again wellness programs can play a role. As wellness programs evolve and interact more closely with a company's health plan, employees can be encouraged to seek out available advice as to alternative treatments.

Taking another step forward, some wellness programs may seek to provide employees with coverage that includes patient-centered medical homes which by increasing physician-patient interaction can provide a readily accessible forum for patients to discuss and weigh their care options, thereby avoiding unnecessary care or taking advantage of simpler, less invasive alternatives.

Lack of Care Coordination

Closely related to the cost driver of unnecessary care is lack of care coordination. Wellness programs that incorporate disease management programs to treat ailments such as heart disease, diabetes, and asthma seek to provide a coordinated care experience to participating patients. This holistic approach has proven to be an effective tool not only in reducing costs but more importantly, improving the quality of life.

Other Drivers

Other drivers of health care costs include administrative inefficiency, provider inefficiencies and errors, as well as fraud and abuse.

Administrative and Provider Inefficiencies

Administrative inefficiency often comes about when treatment is provided to a patient by a variety of providers who do not necessarily speak or share records. This can result in duplication of tests, gaps in treatment, and different approaches to treatment which can add to the cost of care in both financial and human terms. Wellness programs offer one way to reduce the incidence of each of these factors through disease management programs.

Disease management facilitates dialogue among the health care professionals providing patient treatment so that a comprehensive treatment plan can be developed and made accessible to all on the team of providers. Records are typically shared among these professionals and often facilitated through the implementation of an electronic records system. This, in turn, helps to avoid such cost drivers as duplicative testing. Furthermore, the care coordination offered by disease management makes it less likely that a patient will, in effect, fall between the health care system's cracks and experience gaps in the monitoring or treatment of his or her disease.

Wellness programs offering coordinated care of chronic diseases also offer a framework for the reduction of provider inefficiencies and errors. Allowing these professionals to gain experience by focusing on specified health conditions enables them to acquire the expertise likely to improve patient care and reduce the potential for errors.

Health Care Fraud and Abuse

The vast majority of health care professionals seek to be honest in their billing for services. While relatively few seek to bill for services that have not been performed or grossly overbill or misrepresent services that have been rendered, the dollar figures of health care fraud and abuse are enormous.

Wellness programs serve a pivotal role in helping to combat health care fraud and abuse. First, by providing a way to lower the incidence of disease, wellness and prevention programs decrease the opportunity for unscrupulous providers to offer treatment. Second, it is through these programs that many workers will often learn that they are suffering from chronic disease and, in turn, seek out and receive legitimate treatment. Third, through wellness education programs, participants gain the knowledge to better understand treatment options and spot unscrupulous provider fraud and abuse activity.

Finally, moving forward, as wellness programs gain the opportunity to work more closely with patient-centered medical homes (PCMHs) and the accountable care organizations (ACOs) that link them together with hospitals and other care facilities, the opportunity for fraud and abuse will not only be reduced but these coordinated medical record systems will make it easier to detect and prevent these practices.

Summarizing the Wellness Impact on Health Care Drivers

Whether large or small, a wellness and prevention program can lower health care costs by focusing on simple changes in lifestyle choices that can prevent illness. Education is a key factor. Through counseling, those suffering from the disease can learn about alternative treatments that can often be less invasive and more cost-effective in terms of financing and quality of life issues.

As wellness and prevention programs gain in scope and sophistication, they can work in conjunction with health plans and providers to coordinate care through implementation of such innovations as patient-centered medical homes where teams of care providers work together, share patient information, and ultimately provide quality care while lowering the trajectory of health care costs.

Challenges to the Implementation of Wellness Programs

There are challenges to implementing, administering, and successfully maintaining wellness and prevention (hereinafter simply referred to throughout the course as wellness) program. The challenge begins with the decision of whether or not to offer a wellness program. If so, how should it be designed? As the program evolves, other objectives will need to be met:

- Gaining employee participation—a key ingredient to the success of any wellness program
- Justifying program costs by calculating the return on investment (ROI) as well as the benefits of focusing efforts on employee population groups suffering from chronic disease
- Complying with the legal rules that apply to wellness programs
- Understanding the role of consumer choice plans, flexible spending accounts, health reimbursement arrangements, and how health spending accounts along with high deductible health plans can complement a company's wellness initiatives
- Linking the wellness program to the needs of pre-retirees and offering retirees ways to maintain the gains experienced through government-sponsored programs such as Medicare Advantage
- Helping employees recognize the health issues caused by being overweight and obese

- Combating the growing health care risk of smoking among today's younger workers

- Working with health care plans as they integrate disease management programs for those suffering from chronic illnesses such as heart disease and diabetes into wellness program initiatives

- Recognizing how a value-based health plan can reinforce the messages of a wellness program while lowering the trajectory of employee health care cost increases

- Understanding the potential role of patient-centered medical homes (PCMHs) and accountable care organizations (ACOs) in delivering quality and affordable care to wellness participants

- Maintaining program excitement and participation as senior executives and program administrators create a culture of health within an organization

Summary

Worksite wellness programs offer employers and their participating employees the opportunity to work together to improve overall employee health and well-being and bend the cost curve trajectory. At the same time, wellness programs can be designed to lower the incidence (prevent) of chronic disease and help to mitigate its effects once developed. Opportunities to lower absenteeism, decrease presenteeism, and improve profitability through increased productivity are measurable benefits to employers. And as the economy improves, building a culture of health fosters loyalty that helps employers retain workers—often a firm's most valuable asset.

Designing a Wellness Program

Introduction

Most Americans will develop some form of chronic disease throughout their lifetime, whether it is cancer, cardiovascular disease, diabetes, or something else. Unhealthy behaviors related to diet and a sedentary lifestyle can contribute to the onset or worsening of chronic illness. For workers, this can lead to increased absences, loss of productivity, and disability, all of which impact an employer's bottom line. To combat this negative impact on business output companies are turning to workplace wellness programs to improve the health of their workforce.

Objectives

After completing this lesson and answering the quizzes, you will be able to:

- define goals and objectives for workplace wellness programs
- recognize the different needs and resources of large vs. small employers
- understand the importance of the health risk assessment
- know which issues, elements, and options to consider for program design

Defining Goals, Objectives, and Action Steps

To become an effective player in the marketplace and attractive to consumers, a successful business usually starts with a detailed and well-conceived business plan laying out company objectives and strategies. Devising a company wellness program should use similar planning in the development of goals and objectives, albeit on a more limited scale. Well-designed workplace wellness programs can help low-risk employees maintain their health and high-risk employees make lifestyle changes that will improve their quality of life and lower their health care costs.

Unhealthy Evidence

In the creation of its Partnership for Activity and Nutrition, the Wisconsin Division of Public Health addresses health trends that have an economic impact in the workplace.[xxix] For example:

- Modifiable lifestyle factors account for 25 percent of employee health care costs.
- Medical costs attributable to obesity are estimated to be 36 percent higher than for those of normal weight. Obese employees are 75 percent more likely to experience high rates of absenteeism compared to normal weight employees.

Definition of Worksite Wellness Plan

A worksite wellness program is defined as a coordinated and comprehensive set of strategies that include programs, policies, benefits, environmental supports, and links to the surrounding community designed to meet the health and safety needs of all employees.[xxx] Wellness program planning is not a one-size-fits-all endeavor. The employee population for each organization is unique even within the same industry or geographic location.

Defining goals and objectives within a formal wellness program strategic plan will help ensure that the specific needs of the company and its workforce are met. Goals and objectives should not be a facsimile from the standard wellness playbook. Programs that place a high value on healthy outcomes for employees and consider personal preferences have the best chance for engaging worker participation, achieving lasting success, and lowering health care costs for employers.

Statement of Goals and Objectives

The goals and objectives are statements of broad, long-term accomplishments expected from the worksite wellness program. Each goal has one or more objectives established to ensure the goal will be accomplished. The goal of each strategy should be to achieve employee behavior change. Ideally, objectives should be clear, time-limited, and stated in such a way that it is easy to determine if success has been achieved.

Typically in a wellness program's first year of implementation goals might include the following:

- Reduce the number of employees who smoke from 30 percent to 25 percent by the end of the calendar year
- Reduce the rate of employee sick leave usage by more than 2 percent compared to the previous year
- Increase employee company satisfaction survey results by 10 percent versus the previous year

Steps to Take Before the Launch

In the short term, action steps are formulated to achieve one or more wellness program goals. An action step may include health risk assessments as a health plan covered expense for new plan enrollees. The budget and size of the organization will dictate the type of program and scope of activities a company can undertake. According to the Institute of WorkComp Professionals (IWCP), there are five steps that companies should follow before launching a wellness program:

- Step 1 – Evaluate

  Know your cost drivers. Analyze workers' compensation, health claims, and absenteeism data to identify common issues and trends. Understand the legal regulations governing wellness programs.

- Step 2 – Do a workplace assessment

  Examine the physical and cultural framework in which the wellness program will operate. Consider opportunities for onsite physical activity, partnerships with community wellness providers, local gyms or health and nutrition classes, onsite vending machines and cafeteria facilities, etc. Identify the interests and motivation level of employees as well as barriers to employee participation through surveys, wellness committees, along with an analysis of past efforts.

- Step 3 – Educate

  For several years, businesses have been shifting more of the costs of health insurance to workers through increased premiums and higher deductibles. Since 2005 workers' contributions to premiums have gone up 47 percent, while wages have increased 18 percent. Employees are feeling the pinch. Show them how participating in a wellness program can affect premiums as a result of making less use of medical care.

- Step 4 – Obtain management support

  A wellness program will not succeed without the ongoing support of management. Communicate the goals of the program and assess the commitment of supervisors and management.

- Step 5 – Identify goals and metrics for measuring success

  When implementing a wellness initiative, senior management will want to see a return on investment. Establishing a consensus on the goals or metrics for measuring outcomes or ROI of the program will help shape the program and ensure its success.

Establishing Timelines and Budget Parameters

In addition to defined goals, objectives, and action steps, successful wellness programs also include well thought out timelines and budget parameters. Implementation timelines and budgets illustrate company goals and define the commitments made by leadership ensuring appropriate spending and other criteria. Those objectives and action steps also reflect the specific needs of the employer and can vary widely by industry to reflect the wellness needs of different employee populations. For example, the health status and needs of workers in a manufacturing plant or air traffic control tower are very different from those employed in a dental office or an accounting firm.

And even within businesses, employee needs can vary among departments and occupations. Wellness initiatives need to consider the culture of the workplace and the composition of its staff, taking into account the health-related occupational needs of professional workers and manual laborers alike.

Another key distinction in developing workplace wellness programs involves the resources available and the size of the employer. Large employers are more likely to have dedicated funds available to finance workplace wellness as well as the space to offer onsite programming, workout facilities, and other program components. A new trend involves large employers adding onsite health clinics for their employees.

> ***Example:*** Headquartered in Sussex, Wisconsin, QuadMed is a nationwide leader in employer-sponsored health care. The company develops and implements innovative programs designed to provide superior care for employees and significantly reduce health care expenditures. Adhering to its model of self-funded employee health care, QuadMed operates five clinics for its parent company, Quad/Graphics, as well as clinics for Briggs & Stratton, and Miller Brewing Company in southeastern Wisconsin. QuadMed was founded in 1990 by Quad/Graphics. With annual sales of $2 billion, it's the largest privately held printer of magazines, catalogs, and other commercial products.

While small employers obviously cannot start up their onsite medical clinics, they can implement feasible wellness programs if they are properly designed. Many smaller employers, for instance, provide financial support for employee's gym memberships or may purchase inexpensive pedometers to help employees increase their walking exercise routines.[xxxi]

Large and smaller employers have begun contracting with wellness program development and consulting firms while some large employers may have the resources to develop the programs using in-house staff. As the wellness program movement has burgeoned, the sophistication of wellness programs has increased exponentially. Wellness programs have gone far beyond offering tai-chi and pilates exercise programs during the lunch break. Wellness programs now include detailed health risk assessments, case management, employee-tailored wellness strategies, and a myriad of other approaches.

Expansion of Wellness Program Applications

Some employers are tapping new data-rich sources that go beyond traditional wellness programming and delve into metrics to improve employee health outcomes. One such example is E-Care Solutions based in Thiensville, WI. E-Care Solutions seeks to help employers by using data to assess employee health risks and devise strategies to effectively and carefully contain employee health costs.

E-Care Connect is a program devised by E-Care Solutions for controlling and avoiding unnecessary health care costs through the interactive and coordinated participation of employees, employers, and health care providers. Applications are integrated to create an

interactive venue that guides employees through an online personal health assessment and then takes them into risk resolution and health management modules.

Employer-specific modules meet corporate needs in managing health benefits and health information. They also provide the structure through which individuals utilize employee applications.

Employee modules are designed to simplify the benefit registration process. The interactive tools foster wellness by creating a heightened awareness and empowering employees to actively participate in managing their health.

Who Designs the Program?

In developing wellness programs, there are several management models to choose from. Often large employers employ in-house staff to implement and manage the entire process. Smaller employers with more limited resources may hire wellness consultants and have them interact with an onsite employee who manages the program within their overall scope of responsibilities. An in-house manager or program administrator gives employees an internal go-to person who can field questions after the program is implemented by an outside consultant.

> ***Example:*** In 1992, in response to rising health care costs, the city of Gainesville, Florida, launched a program called LifeQuest designed to help employees self-direct their health care. The city's risk management department contracted with LifeQuest to reduce the city's exposure to risk and develop comprehensive and cost-effective wellness programs to manage and improve the city's response to those risks.
>
> The LifeQuest program centered on helping employees makes small lifestyle changes that would result in big differences in their quality of health. Innovative practices under the LifeQuest program include:
>
> - ✓ Every new employee hired by the city begins employment with a health assessment
> - ✓ High-risk individuals are encouraged by supervisors to utilize LifeQuest programs
> - ✓ Awards are given to employee "Athlete of the Year" for successfully achieving and maintaining healthy body weight
> - ✓ Fitness club memberships are extended to spouses
>
> The LifeQuest program has helped the city of Gainesville achieve tremendous health insurance premium cost savings. The annual cost of their premiums now ranks among the lowest in the nation.
>
> LifeQuest programming offers participants telemedicine for more cost-effective provider-patient health care conversations; remote videoconferencing, web-based patient education, and home

videoconferencing for family therapy and counseling sessions staffed by registered nurses, registered dietitians, and certified athletic trainers.

Diabetes and heart disease screenings within the LifeQuest program have resulted in an estimated $270,000 in savings annually.[xxxii]

Role of the Health Risk Assessment (HRA)

A health risk assessment (HRA) is a health questionnaire used to provide individuals with an evaluation of their health risks and quality of life. Commonly an HRA incorporates three key elements: an extended questionnaire, a risk calculation or score, and some form of feedback, either a face-to-face meeting with a health advisor or an automatic online report.[xxxiii] A report-style paper form, an online delivery at home or via the worksite intranet, or interviews with an in-house health care representative are some of the various ways to present feedback from an HRA. The intensity of follow-up depends on the level of commitment to reducing health care costs. It can range from feedback alone, with counseling, and/or incentives for participation in the workplace wellness program, or any combination of these variables.

The Centers for Disease Control and Prevention (CDC) define an HRA as "a systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function, and/or prevent disease."[xxxiv]

However, it is generally accepted that HRAs are most effective at promoting behavior change when they form part of an integrated, multi-component health promotion program.[xxxv] Applied in this way, the HRA is used primarily as a tool to identify health risks within a population and then target health interventions and behavior change programs to address these areas.

There is a range of different HRAs available; however, most capture information relating to:

- demographic characteristics – age, sex
- lifestyle – exercise, smoking, alcohol intake, diet
- personal and family medical history (in the U.S., due to the current interpretation of the Genetic Information Nondiscrimination Act (GINA), questions regarding family medical history are not permitted if there is any incentive attached to taking the HRA)
- physiological data – weight, height, blood pressure, cholesterol
- attitudes and willingness to change behavior to improve health

The main objectives of an HRA are to:

- assess health status
- estimate the level of health risk, and
- inform and provide feedback to participants to motivate behavior change to reduce health risks.

HRA Role in Beginning a Wellness Program

The health risk assessment (HRA) is a tool used either when the wellness program begins operation or implemented for new employees to assess their overall health and risk of disease. When beginning a wellness program with current employees, HRAs are

a valuable tool and establish the foundation on which successful wellness programs are built. HRAs are valuable in assessing individual employee's health and are used to determine health issues within the workforce to establish and target health improvement strategies based on aggregate issues.

Ongoing Role of the HRA in an Established Program

Data gained from HRAs can be collected to design intervention strategies for specific components of a company's workforce. Identifying groups of employees with similar health risks and then devising strategies to improve outcomes is a valuable data resource that HRAs provide.

On an ongoing basis, the HRA should be repeated yearly to provide ongoing and up-to-date workplace wellness program data. A self-administered or an online HRA is a convenient and inexpensive method of gathering workplace wellness program information.

Employee Incentives to Complete HRAs

Health risk assessments have become important tools to help employees understand and start managing their health. However, getting employees to fill out a risk assessment and, more importantly, to use the resulting insight to become proactive about their health is a challenge of its own.

According to a survey of more than 2,900 companies conducted by Mercer, an HR consulting group, the proportion of employers asking employees to fill out health risk assessments rose from 53 percent in 2006 to 65 percent in 2008 and 73 percent in 2009. In 2009, nearly a quarter of these employers (23 percent) offered some type of incentive, with an average value of $150 for completing an assessment.[xxxvi] Among those employers offering incentives for risk assessment participation:

- 45 percent offer cash
- 32 percent lower employees' premium contributions
- 14 percent contribute to the employee's health savings account or flexible spending account

Other incentives include token rewards, such as a t-shirt or hat, and lower health care costs in the form of lower deductibles, co-pays, and coinsurance. A few employers (4 percent) make risk assessment participation a requirement for health care coverage eligibility, a strategy that creates its risks.[xxxvii]

Legal Issues and HRAs

While there are benefits in promoting workplace wellness, issues regarding state and federal regulations require companies to monitor how wellness programs operate. Legal issues surrounding the use of medical information may leave some employers at risk for noncompliance when financial incentives are based on medical information obtained through health risk assessments.

GINA Legislation

The **Genetic Nondiscrimination Act of 2008**, also known as GINA, prohibits the use of genetic information to determine conditions that affect a person's health insurance coverage or employment status. These measures prevent companies from discriminating against employees based on genetic information. The health-risk assessments used within a workplace wellness program may infringe upon an employee's GINA rights depending on how a program is set up. While family history medical information may be very useful, it can also be very problematic regarding GINA guidelines. Employee information regarding medical history or family medical history falls within the definition of genetic information under GINA guidelines. As a result, companies who offer financial incentives that alter employee health coverage costs may run into legal issues regarding GINA legislation guidelines.

HIPAA and Privacy Issues

Generally, in wellness programs operated by a covered entity directly or by a business associate, communications about such programs are not marketing because they are about the covered entity's health-related services. Therefore, these programs are not subject to the **Health Insurance Portability and Accountability Act** (HIPAA) rules concerning marketing and private health information.

HIPAA regulations note, for example, that program design must not only have a reasonable chance of improving health or preventing disease but maybe neither too burdensome in terms of time required nor a subterfuge for discrimination based on health. And programs can't feature any "highly suspect" or experimental methods. The following are wellness programs that qualify:

- full or partial reimbursement of fees for fitness centers
- a reward for participating in a diagnostic test (such as blood pressure) that doesn't depend on the result
- waiver of co-pays for preventive care such as mammograms or prenatal care
- reimbursement for stop-smoking programs even if the employee doesn't stop
- a reward for attending periodic health seminars

The Americans with Disabilities Act (ADA)

As a general matter, the ADA prohibits employment-based discrimination against individuals with disabilities and limits employers' ability to conduct medical inquiries by requiring that such inquiries must be justified by job-relatedness and business necessity. According to the Equal Employment Opportunity Commission (EEOC), a well-crafted wellness program may comply with the ADA as long as:

- participation in the program is voluntary
- the information gathered in conjunction with the program is retained using the ADA confidentiality measures
- the information is not used to discriminate against employees

While employers should be able to institute procedures to ensure that information gathered in conjunction with their wellness programs is maintained following the ADA confidentiality measures and that the information is not used to discriminate against employees, they may have a difficult time proving participation is voluntary. The EEOC advises that a wellness program is "voluntary" as long as employees are neither required to participate in the program nor penalized for choosing not to participate.

Design Elements and Options: Large vs. Small Employers

Wellness programs are increasing among large employers, according to MetLife. The company's Sixth Annual Employee Benefits Trends Study found 57 percent of large employers in 2008 offered a wellness program, up from 49 percent in 2006. Small employers still appear to require more convincing about the effectiveness of wellness programs; for the past two years, only 16 percent report offering such a program.[xxxviii]

According to the same study, about 80 percent of employers who offer a wellness program offer incentives for using them and only 9 percent impose fees on employees who don't meet wellness guidelines. Of employers who offer wellness programs, 51 percent feel their benefits program is a big draw when attracting employees to their company, and 70 percent say it is important for employee retention. Only 22 percent of employers without wellness programs say their employee benefits are a big part of their company's appeal, and 50 percent say their benefits programs help with employee retention.[xxxix]

Options available to larger employers in wellness program benefit design that largely are not available to smaller employers include some or all of the following. Self-funded plans can tap into wellness and preventive-care benefits either through an independent third-party administrator or under an administrative services-only contract with a health insurance carrier. Conversely, some employers team up with multiple wellness vendors and the health plan to map out some health promotion strategies. This may entail whether to position the preventive benefits with wellness initiatives. Some employers bundle preventive care with their wellness programs, which include health risk assessments, health coaches, disease management**,** and nurse-line services.

Health Coaches

Many wellness programs include the services of health coaches who are trained in directing behavioral change. Health coaches typically possess degrees in Exercise Science, Health Education, Exercise Physiology, and Counseling. Health coaches are trained to assist individuals in recognizing current health concerns as well as preventing future health issues by designing positive interventions. Results from an HRA help identify the individual’s specific need(s) to be addressed when working with a health coach.

Medical Costs

Wellness programs can make a dramatic impact on the reduction of overall health care expenditures for an employer. To do this, medical costs need to be monitored closely and tracked in comparison to the time frame when the wellness program began. Having baseline or historical data on employee medical costs is critical for establishing a benchmark before the program began. For example, how much has the company been paying for insurance or self-insurance over several years? What does it look like over ten years? This will help establish a trend line moving forward. The employer should be prepared to see a trend line that shows a substantial rise in costs. Employers need to also make the comparison in a trend line of continued costs if no wellness program had been implemented.

Operational Costs

In large organizations that include staff oversight of the wellness program, devotion of staff time may be as much as 20 hours per week during the implementation phase of three to six months. If contracting an outside vendor entirely, wellness program costs can fluctuate widely. The Wellness Council of America (WELCOA) estimates the average cost per employee to be between $100-$150 annually.[xl] Following are some cost estimates of sample programs:

Minimal approach (i.e., largely on paper—newsletter, flyers)	$1-$7 annual
Moderate program with some interventions	$8-$15 annual
Medium program with several activities	$16-$35 annual
A fairly comprehensive program	$36-$75 annual
A very comprehensive program	$76-$112 annual

Large Employer Program Options

Another important factor is the amount of employee turnover that occurs within the business. If the business is in the retail or restaurant industry where high employee turnover is the norm, a wellness program will deal with inherent obstacles that impede efficiency. If an employer generally has a low turnover of employees, they will enjoy a longer period to judge the results of the wellness program and a greater opportunity to reap rewards if successful. Conversely, higher turnover creates less incentive for the employer to invest in wellness programs, so any program, if enacted, must be designed accordingly.

Small Employer Program Options

When selecting wellness program components, small employers typically have fewer options to choose from because they often possess a more limited program budget, available facilities, and programming options due to having fewer employees. However, many small employers have found ways to implement a health promotion program that works for them. They keep the expenditure and effort to a minimum and still have results that are beneficial for everyone.

According to bloggers on Worksite Wellness at www.worksitewellnessprogram.org, there are multiple ways to include health and wellness in small business and these options don't require a consultant or a fancy fitness center. Key components that are needed include a committed senior staff and a wellness committee of a handful of dedicated employees. Some low-cost, high-return strategies small employers can implement without breaking their budgets are:

- implement a regular wellness newsletter or post a weekly wellness tip in a community area of the workplace
- utilize promotions that are already designed, such as *Healthy Workplace Week*

- purchase pedometers for employees and track their steps, offer incentives, or create a workplace competition
- create a company culture that discourages sedentary behavior and encourages physical activity such as exercise breaks during the workday
- rent a nearby school or community health club and offer exercise classes
- bring in a local fitness instructor to teach classes or lead stretch breaks
- offer smoking cessation programs or promote the Tobacco Quit Line (800-Quit-Now)
- hire an ergonomics professional to evaluate workstations
- provide a wellness subsidy for a variety of health and leadership activities and courses
- install safe bike parking
- serve healthy alternatives at company meetings and lunches

Summary

Business owners have many options to choose from in tailoring worksite wellness programs to meet employee needs. From intensive data-driven programming to a simple wellness newsletter for a small employer, these initiatives can make an important difference in improving employee health and well-being. Programs with the best chance for lasting success are those that engage employees in activities they value and convey the message that their employer cares about achieving quality health outcomes.

Tools and Techniques to Gain and Improve Employee Participation

Introduction

The success of a worksite wellness program is heavily dependent on employee participation. If employees fail to participate, the dollars spent on setting up a wellness program are for the most part wasted. Rather than an investment in the welfare of a company's human capital assets, the money spent represents a drain on corporate profits. Getting employees to participate is the key to improving their health and well-being, reducing a company's rising trajectory of health care costs, and, as we will see moving forward, increasing employee productivity and higher profitability.

Objectives

After studying this lesson, reviewing the 11 case studies, and completing the quick quizzes, you will be able to:

- understand key facts about the four cohorts working today
- recognize the need to consider age, gender, and diversity in wellness program design
- grasp the important roles of senior management and the wellness committee
- use the tools and techniques for conducting an employee interest survey, creating incentives, communicating, and engaging employees in wellness activities

An Invitation to a (Wellness) Party

What if you threw a party and nobody came? Would you consider the event a success?

Probably not. Would you think about having another party for the same people soon? Once again, probably not.

A wellness program that fails to attract participants is likely to face a quick shutdown and a quiet death. Those responsible for establishing a failed program are likely to distance themselves from any wellness initiatives for a very long time. This makes it very important to carefully consider employee participation before your initial launch.

The Importance of Knowing Your Workforce

The ratio of employee participation in a worksite wellness program is likely to dramatically increase if the program includes services and activities that appeal to individual workers. Are they all around the same age? Do they all share the same ethnic background? Do they share similar interests? Do they all live in the same community and share similar commutes?

In today's workplace, the answers to at least some of these questions are likely to be No. This makes it important to consider the composition of your workforce. One way to start this process is to consider the age factors. Employees of different ages often have different physical capabilities. They also are likely to have different preferences in their approach to company-sponsored programs and different ways they like to communicate. One way to begin this process is to consider the generational cohorts in your organization.

Case Study Part 1: Initial Steps

Jim is thinking about starting a worksite wellness program. As a manager at his company, he knows it makes good business sense, and he knows the value of healthy living. At age 52, Jim has found for the first time in his life that he has to watch his weight. For the past four months, he and two of his colleagues—Hal and Joe—have been using their lunch hour to take a brisk walk around the office complex. They have all lost a few pounds, feel less stressed-out at the end of the day, and seem to have more energy. Jim has become a believer. He said to himself: *This healthy living stuff is great! Everyone at the company should do what I've been doing!*

Jim approaches Lori, a newly appointed vice-president in the company's Human Resources Department, about the concept. Lori recently switched jobs and although she's receptive to Jim's suggestion, she has seen a wellness program fail at her last company because only the younger employees took any interest in the activities offered organized sports twice a week. Lori, age 36, mother of two young children, explains her reservations about bringing his suggestion to other senior managers until he creates a plan of activities that will interest a wide range of employees.

Aware of Lori's concerns, Jim decides to ask fellow employees for input on how they would feel about participating in a wellness initiative at work without giving any specifics. The answers Jim receives are surprising. His proposal is not being met with the type of enthusiasm he expected. Less than 10 percent of the people he speaks with indicate that they would participate. Jim does not understand.

Understanding the Age Factors: Four Generations in the Workforce

Today four generations are working side-by-side in America. Known as the Silent Generation, Baby Boomers, Generation X, and the Millennials or Generation Y, these demographic cohorts have been defined by marketers and studied by economists. The wide age spread is a relatively new phenomenon in the work world brought about in part by a turbulent economy, the rise of the service sector, and changing lifestyles. Each generation has preferences in the way they like to communicate and interact. Given the different ages and stages, each cohort has distinct health care concerns as well, including different expectations in what they would seek from a wellness program.

Table 1 Four Generations in the Current Workforce

Cohort	Birth Years	Size [approximate]	Age Range [2011]
Silent Generation	1925-1945	38 million	64-80
Baby Boomers	1946-1964	76 to 78 million	45-63
Generation X	1965-1981	51 million	27-44
Generation Y	1982-2002	75 to 80 million	

Note: Different commentators mark the beginning and end dates of each generation with slightly different years. For example, some mark 1943 as the beginning of the Baby Boom generation despite the still low birth rate due in part to the lifting of the Great Depression. There is also some variance among commentators regarding the beginning and end dates of Generation X. Some, such as Neil Howe and William Strauss, see it beginning in 1961 which would then include Barack Obama among its members. In this regard, it is important to keep in mind that individuals born during these cusp years between generations often have a blend of characteristics connected to both cohorts.[xli] This blending also occurs between Generations X and Y. Howe and Strauss mark 1982 as the first year of the Millennials.[xlii] Other commentators, such as Jessica Sincavage, see it beginning as early as 1976 and ending in 2001.[xliii]

What Defines a Generation?

A generation encompasses a series of consecutive birth years spanning roughly the length of time needed to become an adult. Its members share a location in history and as a consequence exhibit distinct beliefs and behavior patterns.[xliv]

Who Are the Individuals in Each of These Generational Groups?

We will take a closer look at the birth year parameters and some of the life experiences that influence the preferences of the four demographic cohorts. We will also look at their work styles. Putting these factors together—age, life experiences, and work styles, we will consider the best approaches to engaging each of these groups in worksite wellness activities.

Case Study Part 2: Weighing the Benefits and Risks of Becoming a Champion

As Jim sees it, for employees the benefits of worksite wellness programs include weight reduction, improved physical fitness, increased stamina, lower levels of stress, along with increased well-being, self-image, and self-esteem. Were Jim to ask employees if they would like to achieve these results, the answer would be "Yes." But the challenge comes when we start trying to determine what individuals are willing to do (or not do!) to achieve these outcomes. And that becomes the million dollar question for Jim as he begins the process of determining needs and interests for the worksite wellness program.

If Jim fails to be effective at this point in the design of the initiative, it may result in low participation and little or no improvement in overall employee health. That implies that the program will be unlikely to yield the desired results of lower health care expenditures. Additionally, low participation levels leave a higher percentage of employees with potential health risks that could otherwise have been reduced. And that is not the result intended. This could prove to be a bad career move for poor Jim.

To avoid a bad outcome, Jim must ensure that his program gains traction with potential participants; it must be designed and presented so it piques employee interest and results in their continued involvement. To accomplish this, employees must feel that they have

The Silent Generation [Birth Years: 1925 to 1945]

The Silent Generation represents the smallest cohort, only 38 million, born between the years 1925 through 1945. The decline in births is attributed to the economic uncertainty of the Great Depression followed by the disruption of World War II. Also known as the Swing cohort, they are the oldest members in today's workforce.

Growing Up

Historic events bred a sense of caution and respect for authority in the Silent Generation, characteristics that remain with them today.[xlv] Also, members of this generation were witness to the rise of the Soviet Union, the Cold War, and exposed to the Communist hearings during the McCarthy era, which may explain their generational sense of a need for fairness and process.[xlvi]

Early Adult Experiences

The Silent Generation entered the workforce at a propitious time as America experienced a post-war economic boom. This created many opportunities for members of this generation to get an early start on their careers. It also allowed many members of this generation to marry young and begin their families.

The relatively small size of this generation translated into less competition both at the higher rungs of education and at the workplace than what was experienced by larger generational cohorts. Many members of this generation earned technical, college, and graduate degrees, equipping many of their members for today's service economy positions.

The cultural upheaval of the Sixties and Seventies impacted many members of the Silent Generation. Often raised in an atmosphere of strict conformity, the removal of restrictions caused many to reevaluate life choices. As greater opportunities arose for women in the workforce, some decided to pursue careers. Others—both men and women—reevaluated their marital commitments leading to rising divorce rates. The economic impact of these decisions on the Silents is still being sorted out today.

Mid-Life Experiences

The majority of older members of the Silent Generation have withdrawn from the workforce, relying on a traditional package of retirement benefits that include guaranteed pensions, Social Security, and private savings. Younger members of the Silent Generation are still present in the workforce and may be reliant on a more mixed set of benefits to fund their futures. As they reached mid-career, these younger members faced the reality of downsizings and reduced benefits as the American economy reacted to a series of upheavals. Some saw their guaranteed pension benefits frozen and projected retirement income effectively reduced.[xlvii] Others experienced a shift from pension guarantees to the nonguaranteed income provided through 401(k) plans. Some have health benefits through an employer while others look toward Medicare when they reach age 65.

Recent Economic Events

The financial meltdown of recent years has caused many Americans, including members of the Silent Generation, to rethink their work and retirement plans. Facing depleted retirement accounts, some have decided to remain employed. Others who opted for retirement before the crisis have been forced to seek work to balance their budgets.

Implications for Wellness Programs

The continuing presence of Silents in the workforce means that wellness programs must adjust not only for the needs of older workers but to meet a diversity of interests. Programs must legally provide alternatives where financial incentives are offered to those who can reach set goals, such as reduced body mass index. The types of programs that appeal to younger workers such as memberships in co-ed gyms may not appeal to older individuals sensitive about their appearance in exercise attire.

Since they are older, Silents are likely to face a higher risk of chronic diseases, like arthritis, heart disease, and diabetes. Wellness initiatives that offer the opportunity to better control these ailments are likely to be of interest. For example, a company-sponsored Tai Chi class offered in conjunction with the American Arthritis Association.[xlviii] At the same time, commentators have

noted that Silents like to contribute to the workplace and mentor.[xlix] This makes them ideal candidates to tap for your wellness committee.

Prepare Your Wellness Program for 65+ Workers

Individuals aged 65 to 74 years are expected to show strong growth in their participation rate in the U.S. labor force in coming years. In 2018 it is anticipated that roughly 40 percent of those 65 to 69 will be part of the workforce—nearly double the level in 1978. Participation by those 70 to 74 is estimated to be over 20 percent.

Source: Mitra Toossi, Labor Force Projections to 2018: Older Workers Staying More Active, Monthly

Increased Labor Force Participation by Older Workers

Those 55-and-older are the only group that significantly increased its participation in the United States labor force in 2008 and further increases of labor force participation are expected by this group in the future. This is due to a variety of factors including:

- A more educated older workforce
- Greater emphasis on service work versus manual labor
- Changes in Social Security laws which have increased the age of normal retirement (previously 65 now 66 for many)
- Social Security benefit incentives encouraging work beyond normal retirement age
- Shift from defined benefit to defined contribution pension plans and corresponding shift of retirement income risk to employees
- Amendments to Age Discrimination Act eliminating mandatory retirement age
- Recent financial crisis and its impact on retirement benefits
- Potential scarcity of labor due to smaller entry of younger workers and attendant exit by Baby Boomers encouraging employers to keep older workers on the job

In 1988 participation by workers 55-years-and-older was 30 percent. In 2008, it increased to 39.4 percent. The Bureau of Labor Statistics projects that this rate will reach 43.5 percent by 2018.

Source: Mitra Toossi, Labor Force Projections to 2018: Older Workers Staying More Active, Monthly Labor Report,

Baby Boomers [Birth Years: 1946-1964]

The return of veterans at the end of World War II marked the beginning of the Baby Boom generation. Their desire to settle down following the turmoil of war ushered in the beginning of a massive increase in the number of births. This marked increase in births continued from 1946 through 1964. Depending on the source, the Boomer cohort consists of roughly 76 to 78 million individuals. Currently, it is the largest generation in the American population.

Growing Up

The early life experiences of many Boomers were influenced by the strong post-war economic growth experienced by the American economy which enabled many families to move to homes in newly developed suburban communities, own a car or cars, and live relatively comfortably on one breadwinner's salary. Higher education remained relatively affordable allowing many Boomers—both men and women—to obtain college and advanced professional degrees.

Early Adult Experiences

The entry of the Baby Boomers into adulthood and the workforce were marked by the less propitious world and economic events. Their coming of age was marked by American participation in the Vietnam War. This war resulted not only in widespread civil dissent but also sparked an era of inflation further fueled by oil embargoes and high energy costs. These factors made it increasingly difficult for families to live on one salary. As a result, many Boomer homes became dependent upon two wage earners. The number of women entering the workforce and remaining in it while raising their families during these years increased substantially.

Changing Benefit Structures, Economic Events, and Retirement Implications

The American business community has experienced an increasingly competitive environment since Boomers first entered the workforce. As a result, many have experienced firsthand the restricting of the traditional retirement package from one of employer-provided guaranteed income for life (defined benefit pensions) to an increased reliance on the investment of set employer contributions and personal savings (401k plans).

This trend has made retirement savings subject to the risks of stock and bond market gyrations, including those that accompanied the opening months of the Great Recession. Simply put, many Boomers are poorer than they were previously and at far greater risk of running out of money than their parents or older Silent siblings, the beneficiaries of an earlier guaranteed system.

At roughly 76 to 78 million strong, Baby Boomers are the largest generation in the American population. Accordingly, their presence in the workforce is oversized. Although they are nearing the age when earlier generations withdrew from the workplace, many Boomers wish to delay retirement to achieve greater economic security. This can also be good for business. Boomers bring with them a wealth of experience and a strong work ethic. Assuming a continuing

economic recovery increasing the possibility that their withdrawal may lead to a worker shortage is another reason for employers to encourage them to remain on the job.

Boomers see themselves as redefining retirement. Rather than complete withdrawal from work, many Boomers are seeking a more gradual withdrawal that includes continued engagement with work and perhaps reduced or more flexible hours.

Implications for Wellness Programs

Many Boomers work in service-related industries. These environments are far more dependent on mental abilities and interpersonal skills than physical strength. This makes work possible at later ages but does not stop the clock when it comes to age-related illnesses that can impair productivity. For example, many Boomers are likely to suffer from arthritis. Thus, a low impact exercise program could be appropriate. Boomers are also likely to become increasingly concerned about the onset of chronic diseases such as Type 2 diabetes and high blood pressure. Wellness programs that include targeted initiatives (often referred to as disease management) designed to detect, delay, and control these types of chronic diseases may be a good fit for an aging member of this cohort.

Financial incentives (such as lower co-pays for prescription drugs) are also likely to prove appealing and increase Boomer participation rates—so long as they are not specifically age-segregated. Boomers see themselves as pioneers in the “new retirement” mode, so they are likely to shun wellness activities that are specifically targeted to older individuals or tagged as activities for seniors. In this regard, how a program is labeled can play a role in the participation it garners.

Boomers acquired a reputation for self-centeredness in their youth, but they are now responsible for parents facing failing health. Wellness programs that are linked to Employee Assistance Programs (EAPs) can be of great help to these workers. Having someone knowledgeable to consult about issues such as moving a parent from the family home to handling the finances of older relatives, not only helps solve problems but relieves some of the stress these individuals face. This, in turn, helps at work, reducing presenteeism and improving productivity.

Generation X [Birth Years: 1965 –1982]

Sandwiched between two huge cohorts (Baby Boomers and Millennials), Generation X with its mere 51 million members has been described as a “dark-horse demographic condemned to nicheville.”[l] Generation Xers have faced an influx of social change.

Growing Up

Members of Generation X grew up in an era marked by dysfunction and upheaval in social mores, family relationships, and schools. They also experienced as children the economic aftershocks brought about by rising oil prices, downsized businesses, and inflation gyrations. While many of their parents participated in the cultural awakening of the 1960s and 1970s, they faced a less child-centric environment. During this era, divorces became more acceptable and easier to obtain. This resulted in many Gen Xers growing up in broken homes. As increasing numbers of women entered the workforce, many Gen Xers also became latchkey kids due to tight family budgets and limited quality child care alternatives, forcing them to become more self-reliant than earlier and later cohorts. At the same time, educational systems began to fail in many jurisdictions because of lowered budgets and increased emphasis on other public services.

The contraction of the American economy during this period required many businesses to restructure and adopt a less paternalistic attitude toward their employees. Many Gen Xers saw their parents lose jobs and benefits as businesses downsized. These collective experiences have ingrained in members of Generation X a distrust of institutions, including the businesses which employ them. These experiences have also made Gen Xers more focused on achieving a manageable balance between work and family. Flexibility is important to this cohort.

Early Adult Experiences

Gen Xers entered the workforce as computer technology began to be broadly introduced. Due to a combination of their smaller numbers and a revived economy, jobs were relatively plentiful. This enabled members of this generation to be less dependent on organizations and more likely to change positions and take charge of their careers. As early adopters of technology in an era of increased computer usage, many found their skills to be in demand. For the technically savvy, formal education became less of a concern when meeting employer expectations.

Recent Adult Experiences

Gen Xers are now focused on family issues. As a group they have been late to marry and when they do have sought to create a far more stable home atmosphere than many experienced growing up. Having seen corporate loyalty go unrewarded in their youth, as a group they seek a work-life balance.[li] Recent shocks to the economy have decreased the ability of this generation to switch employment. This situation, however, is likely to reverse as the aftereffects of the Great Recession abate.

At the same time, they are cognizant that many of the social support systems available to their parents—including Medicare and Social Security—are likely to undergo change and translate into reduced benefits in the future. This will mean Gen Xers will face increased responsibility for creating their financial security, and for many continued work into their senior years.

Implications for Wellness Programs

Members of Generation X, because of their self-reliant nature, are more likely to change jobs than other cohorts.[lii] This makes it important for businesses who wish to retain them to demonstrate an interest in their well-being. The establishment of a wellness program is one way to do this.

At the same time, highly structured wellness programs with set hours of activities are unlikely to meet their needs. For Gen Xers raising families, limited time is likely to be an issue for both men and women. They require wellness activities that offer flexibility, the opportunity to participate at different hours, different days of the week, and in some cases different locations. Subsidized memberships at gyms open from morning to night may prove attractive to some. Individual coaching on diet and exercise may also prove attractive—particularly if available online.

You may also wish to consider linking your wellness program to consumer-directed plans, particularly for this age cohort. Many Gen Xers are grappling with family demands including the need to balance budgets while looking after their children's health. The tax benefits offered through flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), and health savings accounts (HSAs) can help free-up dollars to meet health care expenses in addition to earmarking funds for such purposes. In situations where a member of the Gen Xer's family requires ongoing medication, such as a child with asthma, the availability of these dollars can help assure prescription drug adherence as well as better health and overall lower health care expenditures by avoiding costly trips to emergency rooms or more serious hospitalizations.

Generation Y – The Millennials [Born: 1983-2001]

There are about 80 million "Millennials" and they are rapidly taking over the workplace. In 2007 Morley Safer of CBS News warned bosses to get ready for this new breed of workers about to attack everything they held sacred: from giving orders, to their white shirts and ties. Millennials are said to be the most wanted generation in the workforce today.

Growing-Up

Unlike earlier generations, many of their parents purposefully planned for and welcomed their arrival into the world.[liii] With fewer children per family, parents often went to the extreme in planning the lives of these kids, filling every day with organized activities. This involvement came to be known as "helicopter parenting," as fathers and mothers hovered around their children overseeing everything from their schooling to social activities. In contrast to Generation X, many Millennials experienced stable home lives.

Growing up in more affluent communities, they also experienced school systems that included computer technology and fostered collaborative learning. Earlier members of this generation also benefited from first a recovering and then a growing economy during their early years, allowing their parents to invest in them and their interests. This has tended to create a greater sense of trust in organizations than shared by members of Generation X.

Early Adult Experiences

Generation Y began to enter the workforce as the economy was cooling. As workers at entry levels, they have experienced firsthand what has been described as the worst economic shock to the American economy since the Great Depression. However, many still benefit from parental involvement and support. And some have been encouraged to pursue graduate education full and part-time as a way to distinguish themselves and advance their careers.[liv]

Members of Generation Y have grown up with technology and are comfortable with it and its uses. They have also grown-up with substantial racial and ethnic diversity making this less of an issue than for earlier generations. This coupled with the homeland security events of September 11, 2001, has created a socially conscious generation that is team-oriented. Millennials tend to like flat organizational structures that reflect this team orientation and regard themselves as partners in work projects. They respect older workers, appreciate their mentoring, and wish to work with them as colleagues.[lv]

Implications for Wellness Programs

As collaborative individuals, Millennials will want to be considered partners in the planning of wellness activities. Their team approach to work is likely to spill over into the types of activities that appeal to them, such as organized sports or other health-related activities. Because time can be an issue for some as they pursue additional education or begin their families, wellness activities should also take advantage of their technical savvy. For example, participation in virtual teams that allow exercise activities to be measured remotely and made available to selected online communities.

Table 2 Four Generations at Work: Key Facts

Description	Silents	Boomers	Gen Xers	Millennials
Education	Many members took advantage of post-war affluence and the GI Bill to pursue higher education	Large numbers of the Baby Boom generation, both men and women, pursued higher education providing a foundation for work in today's service economy	Valued technical education and self-education; focused on technology over broad degreed programs	The technology incorporated into their education
Work Habits and Values	Highly loyal and respective of work hierarchy	Hard work marked by long hours	The pragmatic approach to work while seeking flexibility	Comfortable with collaborative work; seek feedback

Communication Preferences to Consider	Hardcopy newsletters, brochures, and personal calls from wellness organizers	Hardcopy newsletter and brochures combined with clearly identifiable electronic messages about the wellness program	Periodic hardcopy materials coupled with electronic messages	Periodic hardcopy materials coupled with electronic messages and online media
Language Considerations	English	English	English, Spanish	English, Spanish, and other first languages
Key Messaging	Wellness program as your path to better health	Appeal to vanity and sense of work ethic; for instance, exercise will provide you with a more youthful appearance and increase your productivity	Health your way, your time	Join the wellness community
Wellness Activities to Consider	Tai Chi Class [Arthritis Association] Individual counseling on chronic diseases such as diabetes	Cardio for energy and revitalization versus cardio to solve blood pressure problems Employee Assistance Program (EAP) for elder and other issues	Coaching either by phone or online Linkage to consumer-driven benefits such as FSAs, HRAs, and HSAs to help with family medical costs	Organized company classes and sports

Considering the Ethnic Mix: Cultural Diversity in the Workplace

Recent years have seen a substantial increase in migration to the United States. Many of the new immigrants come from Latin American and Asia. These populations have a variety of preferences in the types of activities they like to pursue and differences in cultural habits and languages in which they prefer to communicate. Does your workforce have substantial representation from Latin America? If it does, you should consider providing program information in Spanish as well as in English, or even in Mandarin if a significant number of your workers are from China. In such situations recruiting an employee representative from these groups to serve on your wellness committee is likely to be a wise move.

Role of a Wellness Committee

Workers have varying needs and preferences when it comes to wellness programs. Identifying the services and activities to appeal to various segments of the employee population can be difficult. One of the best ways to uncover these needs and preferences of your workforce is through a wellness committee.

Definition of a Wellness Committee

A wellness committee is a group of motivated employees who agree to work with senior management to create a wellness program that appeals to a broad cross-section of employees, varying by age, physical ability, health needs, and interests.

Case Study Part 3: Recruiting the First Wellness Committee Members

Later in the week, while walking with his lunchtime buddies, Jim throws some thoughts and questions out to Hal and Joe:

If we start this wellness initiative, employees will be asking, "What's in it for me?" What does the WIIFM look like? How do I go about convincing employees that participating in such a program is valuable? How do I design the program so that it meets the diverse needs of our employee base? How do I design a reward system that motivates them to engage with the program, and continue to be engaged after the novelty wears off?

Jim just recruited a core cadre of wellness committee members from his walking group!

As you can tell from Jim's situation, establishing a wellness committee doesn't have to be a complicated task. However, this is a very important foundational aspect of your program

Recruiting Committee Members

Ideally, members of the wellness committee should represent the different segments of your employee population. You'll want to recruit members who can represent older and younger workers, who can speak for different ethnic backgrounds, and support views of employees at various levels of your organization from the top down. One of the first places to start in this process is to consider the generations working within your organization.

Generational Considerations

Baby Boomers in their fifties are more likely to be interested in a program emphasizing cardio aerobics than a twenty-something Millennial. Conversely, a program focused on strength and weight lifting may prove impractical for older individuals suffering from arthritis. Offering activities that specifically appeal to different age segments within your population is important to program design and communication. By recruiting older, middle-aged, and younger workers to serve on your committee broadens the program with a wider array of ideas.

Gender Considerations

In addition to age and generation, consider your company's gender mix. If your workplace has a mix of men and women, your wellness committee should match. This will help the committee to identify and suggest activities likely to appeal to both sexes. For example, the men in your organization might prefer to participate in solo activities that can be tracked in a competition, while the women may express a strong preference for organized group classes.

Ethnic Considerations

Ethnic differences should also be considered as you set up your wellness committee. Some groups, for example, may consider it taboo for men and women to participate in exercise together. Other groups may have a strong interest in adult participation in certain sports.

Volunteers

As you establish your wellness committee, don't forget volunteers. Individuals who believe in wellness and who take their health seriously are likely to be some of the best advocates of your wellness program and what it has to offer employees, whether they are senior executives, mid-tier managers, product specialists, or line workers.

Case Study Part 4: The Wellness Committee Team – Shaping Up

Jim has successfully recruited the first team members. So far, these include: Jim, at age 52, part of the Baby Boomer cohort as are his walking buddies, Hal and Joe, and Lori, age 36, from upper management.

Lori and Jim discuss the need for other members. Since over 20 percent of the company's workers are female Baby Boomers, Lori suggests Jim approach Rhonda, one of his friends from the Accounting Department and a new member of his walking group.

Jim, who has two children of his own starting work, also thinks it would be a good idea to get a sense of what would appeal to younger workers. Lori agrees to discuss this with her assistant, Melissa, a new employee who just graduated from college. Melissa's parents migrated to the U.S. from Paraguay, so Melissa is bilingual with full command of both English and Spanish. Jim also reaches out to Will, another Millennial, who works as a programmer in the IT Department. Will is part of a work-study group from China. Technically savvy, Will always helps Jim with computer questions and encouraged him to join an online community.

Training the Wellness Committee

Your committee members will be performing an important role. They will become spokespersons, spreading the word about wellness throughout your organization. You want to make sure you're all on the same page when getting the message out. This may mean devoting some time to your committee meetings to train your representatives. Give them talking points. Make sure they understand the program's vision and goals and can communicate it effectively to their peers. As you move forward and develop program literature, keep your committee members well-stocked with materials they can hand out.

Case Study Part 5: Recruiting Top Management Support

Regardless of the size of your company, it is likely that your employee population covers the spectrum from healthy to very unhealthy. Jim has noticed this trend within his organization. In the same way that their health status differs, people's motivation to participate in behavior change differs. Jim found that out very quickly when he started talking to his colleagues. But he also discovered that it is not only the interests of the employees that you need to identify.

What is management's position on wellness? Although Jim got an initial buy-in to move ahead from Lori, the corporate vice president of Human Resources, he has received little feedback or interest from other managers regarding his progress. He had a conversation with his supervisor that left him a little perplexed. He's not sure that his boss embraced the concept of a wellness initiative.

Good catch, Jim! Without a "champion" on the senior leadership team, the initiative probably won't succeed.

Jim confirms that Lori will be the spokesperson for the wellness committee. She also reaches out to John, a part owner of the company, who at age 70 continues to take an

Role of Senior Management

The role of senior management is crucial to the success of a wellness program.[lvi] If senior management does not consider wellness an important company issue, other workers are likely to follow their lead and ignore program offerings. This is one reason why the participation of a senior manager on a wellness committee can prove helpful, particularly if this individual participates in the activities offered. Top-level participation on the committee signals that wellness is considered important and that the recommendations of the wellness committee are going to be taken seriously. Also, the participation of senior management can serve as an impetus for other employees to step forward.

There are some other questions to consider when approaching senior management beyond their willingness to participate in a wellness committee. These include:

- Is the manager willing to personally participate in the worksite wellness program? We have all experienced how important it is to have company leaders to “walk the talk.” Nothing exemplifies this support as much as personal participation. And, personal participation sets the organizational tone that employee health is taken seriously.

- Is there a particular activity or element of a wellness program that is of particular interest—to them personally or to the company? Making it easy for senior managers to participate is important and including the activity of interest to them or the organization as a whole will prove important to the program’s success. For example, the senior manager might be interested in participating in a health risk assessment along with measures of his or her body mass index. If so, this should be a program element.

- Will he or she encourage others to participate? Hanging posters in the hallway that support a culture that is not reinforced by senior leadership are doomed to fail. On the other hand, a senior manager who is willing to make a presentation at the kick-off of a wellness program coupled with sending e-mails to employees explaining the program and its benefits can go a long way in gaining broad participation.

There are additional questions that need to be answered by senior management to gain employee participation. Starting with the kinds of worksite wellness programs that the company is able or willing to support:

- Will management dedicate space for wellness activities such as an exercise class?
- Is management willing to buy exercise equipment for onsite use? Alternatively, will it work to negotiate reduced gym membership fees for employees?
- Will management fund “Lunch and Learn” meetings?
- Pay for smoking cessation?
- Shoulder the costs of biometric screening?

The answers to these questions will help you set expectations before taking your next step: surveying the workforce.

Surveying Employee Interest

Conducting a simple worksite employee survey is an excellent way to start getting answers about the overall interest level and specific types of program activities likely to appeal to your workforce. This will be one of the first tasks for the wellness committee to undertake.

Case Study Part 6: An Initial Survey of Employee Interest

Jim's wellness committee circulates an initial survey questionnaire, simply asking whether employees would be interested and including a few examples of what might be offered. The results that they receive are very similar to studies that have been conducted at other organizations. The data show that at any given time, only 3 percent of employees are currently "open" or ready to begin a wellness program. Another 6 to 7 percent are open to it, but need more of a nudge. The other 90-odd percent are divided into three nearly equal categories:

- *Not really thinking about it right now.*
- *Not really interested but could be if it was presented to them in the right manner.*
- *They KNOW they are not interested in getting started.*

So it looks like Jim will be able to engage up to 10 percent of his population base with a little nudging. But there are some additional actions that he can take to increase that percentage by selling the health benefits of the

In the next frame, you'll find a sample letter to employees inviting input on a proposed worksite wellness initiative. The letter was created for the Tompkins County, New York, Wellness Program, already underway with funding from the CDC.

Sample Survey Letter and Questionnaire

Dear Employees:

We are in the process of developing a worksite wellness program. The idea is to work in a setting that will support the values of choosing a healthy lifestyle.

The first step was to form a Wellness Committee. The committee will initiate the program and oversee its continuation over time. The committee was formed and has met three times.

At its first monthly meeting the Wellness Committee drafted a mission statement, which was then adopted at its next meeting. The statement reads as follows:

> Our organization seeks to establish and maintain a workplace where environmental and social changes compatible with a healthy lifestyle are encouraged and supported.

Next on the agenda is to gather input from as many employees as possible. Drawing ideas and involvement from all of our coworkers gives committee members, your representatives, the best opportunity to facilitate a successful program.

Thank you very much in advance for helping us launch our worksite wellness program. This is a great opportunity for all of us to come together.

The Wellness Committee

P.S. Whether you complete your survey online or by filling out a paper copy, please submit it no later than [date]. Thanks!

Developing Broad Appeal: Incentives and Communication

We've discussed how important it is to have upper management involvement in the program to ensure that commitment starts from the top down. Once leadership has bought into the value of the wellness concept as it relates to employee health and financial return they will want to make sure the program is solidly designed so that it engages otherwise uninterested employees.

A key consideration in the design of a wellness program is the demographic mix in your workforce. There are currently four generations of men and women present in today's workforce—the Silent Generation, Baby Boomers, Generation X, and Generation Y (the Millennials)—with a culturally diverse mix as well. Ideally, your wellness committee has representatives from all the segments of your population. The design of program activities should reflect the needs and interests of the various groups.

It is also important to consider the gender and ethnic composition of your workforce. In regard to gender, for example, men in your workforce may be seeking organized team sports. The women may prefer organized exercise activities that tend to cater to them, such as gender-segregated gyms or jazz dance classes. Once again, remember that different cultures may have preferences regarding exercise. For example, soccer was a team sport played far more prevalently in Europe and South America before it becomes popular in the United States. And, some cultures have dress codes that tend to discourage certain types of exercise.

One way to test and gauge the level of interest is to conduct a second survey, this time listing and describing proposed activities. Alternatively, if an initial survey has not been conducted, questions about these potential activities can be included.

Case Study Part 7: Completing the Wellness Committee

Rhonda is the newest member of the Walking Club. She was invited along by Jim when the group was formed, but she was hesitant because she didn't like the idea of "exercising" with men. She belongs to a "Curves" facility for that very reason. It would be uncomfortable for her to use exercise equipment in front of men. However, Jim won her over when she realized that walking was hardly like "working out," and she has never missed a session in the past three months.

Rhonda is 58 and passionate about everything she tackles. When Jim approached her about serving on the wellness committee she was very receptive. As an accountant, she has already begun to think of issues such as how to measure the company's return on investment for the program and the role of financial and non-financial incentives to gain employee participation.

Link Program to Health Issues at Your Company

A wellness program needs the support of senior management to be successful. This support will not come unless a program makes sense from the company standpoint. Linking the activities of a wellness program to the types of health issues that are driving up company health costs is a key step in securing senior management support.

If you are spearheading a company's exploration of whether or not to pursue a wellness program one way to begin is by working with the Human Resources Department and your company's health plan to analyze claims information. While it is inappropriate to look at each employee's health information, either authorized company personnel or representatives from your health plan should be able to provide an overall analysis of this claims data.

Do not be surprised if the data show that chronic diseases are major contributors to health care costs. These are major contributors to the costs of the overall American health care system. Keep in mind that the top four causes of death according to the Centers for Disease Control and Prevention (CDC) are heart disease, cancer, stroke, and chronic lower respiratory disease. Diabetes is also playing an increasing role in acerbating America's health issues. Consider activities for your wellness program that lower the risks of these diseases.

Table 3 Wellness Activities that Lower Chronic Disease Health Risks

Disease	Heart disease	Cancer	Stroke	Chronic lower respiratory disease	Diabetes
Activity	Organized exercise program	Screenings Smoking cessation	Stress reduction class	Smoking cessation	Weight loss

Case Study Part 8: Testing Program Ideas

The Second Survey

Rhonda is very task-oriented and one of the first things she does as a committee member is developing a second survey seeking employee feedback on a broad range of potential activities that have already been cleared with senior management.

Rhonda works with Will to tabulate the results. They share them with the other members of the wellness committee and receive approval from senior management to move ahead with a program that includes the following activities:

- Free health risk assessment (HRA)
- Smoking cessation class
- Company-sponsored exercise class onsite
- Company-sponsored healthy cooking class off-site at a community college

Lori has authorized a small reduction in health insurance premiums for participants.

The Role of Incentives

There is a lot of research indicating that wellness program incentives increase participation and build motivation by offering rewards to employees for taking steps in the direction of healthier lifestyles.[lvii] While most agree about the value of incentives, there is a great deal of debate about exactly what those incentives should be.

Incentives can take many forms. They can range from full coverage of the cost of smoking cessation or weight reduction programs to reduced drug costs for those who participate in programs to better manage their chronic diseases. Other incentives include reduced health insurance premiums for those who reach goals, such as specified BMI or blood pressure levels. And in an era of limited company budgets, it's important to keep in mind that incentives can be both financial and non-financial.

One school of thought is that the more difficult the action the greater the reward or incentive needs to be to effect a change in employee behavior.[lviii] For example, the distribution of a t-shirt upon participation is unlikely to cause an employee to stop smoking. However, offering to cover the full cost of a smoking cessation program along with a waiver of co-pays for related medications is more likely to gain attention and motivate an employee to stop the habit. Similarly, an incentive of a 5 percent reduction in an employee's annual health care premium is likely to prove more effective in motivating employees to monitor their blood pressure levels and keep them within specified ranges than simply offering a free pedometer.

The Point Incentive System

One way to motivate employees to participate in a wellness program is to reward them for taking steps to improve their health. You can do this by offering a point system connected with prizes—in some cases a choice of prizes. Here is how it might work:

1) Identify steps employees might take to maintain and improve their health.
2) Notify employees of these steps along with the points they will earn if they complete them.
3) Once they have completed the steps and earned points they either automatically receive a pre-established award or have a choice of awards from which they can select.

> ***Example:*** ABC Company offers those who choose to participate in its wellness program 50 points for completing a health risk assessment (HRA) and taking an annual physical exam. It also offers 100 points for signing up for online weight coaching and 10 points for every 25 miles logged on a pedometer. Dan decides to participate in ABC's wellness program. Dan takes the following steps:

Action	Points
Completes HRA	50
Completes annual exam	100
Logs in 250 miles on the pedometer	100
Total Points	**250**

Dan decides to redeem his points and has a choice of receiving a name-brand sweatsuit or a baseball exercise game for his Wii.

Think this is too complicated for your firm. Reconsider your conclusion even if you are a small company. Your health insurance plan may be able to help you implement such a system.[lix]

Be aware there are some legal limitations when it comes to incentives. Remember incentives can be powerful tools in getting broad-based employee participation both initially and continuously.

Table 4 Sampling of Financial and Nonfinancial Incentives

FINANCIAL	NONFINANCIAL
• Waiver of co-pays on selected generic prescription drugs	• Free wellness team t-shirts for initial participation in a wellness program
• A reduced premium for achieving specific health goals	• Complimentary water bottles for renewal of participation in the wellness program
• Cash rewards for taking specific actions that promote health	• Distribution of pedometers for agreeing to participate in wellness walking group
• Payment of fees for smoking cessation program provided use stops for a minimum of six months	• Points for taking specific actions redeemable for small prizes

Another way to look at incentives is to divide them into three cost levels—low, moderate, and high(er).

Table 5 Incentives for Three Cost Levels

LOW COST	MODERATE COST	HIGHER COST
• Certificates	• Tickets to live performances	• Premium reductions
• Free fruit and vegetables	• Waist packs	• Waiver of co-pays
• Movie passes	• Subscriptions to health-related magazines	• Waiver of deductibles
• Recognition in the staff newsletter	• Books on health topics	• Cash
• Coffee mugs	• Exercise videos and DVDs	• Trips to health events
• Commendation from management	• Exercise games for Wii and other gaming devices	• Gifts from award brochures (based on earned points)
• Make kitchen equipment (e.g. refrigerator, microwave) available for the preparation of healthy lunches	• On-site cooking classes featuring the preparation of healthy food	• Bonus personal/vacation days
• Flexible start, lunch, and stop hours for physical exercise during the day	• Fall-weight sweatshirts and sweat pants for runners	• High-end prizes: flat-screen TVs, program participant lottery
• Walk and talk meetings	• Five-pound weight sets	• Personal trainer sessions
• Install bike racks in safe and accessible locations	• Pedometers with tech linkage to track data	• Free gym membership

Communicating with Employees about the Wellness Program

To gain participation in a wellness program your workforce needs to hear that it has been established and learn what it has to offer. Communications can go a long way in keeping employees engaged. Consider a company-wide meeting or a series of meetings to launch the program. These are the type of face-to-face events that appeal to many employees. If the budget permits, provide small incentives to those who attend and agree to sign up, like pedometers or water bottles with the company logo. You may also want to set the tone by providing a healthy snack such as fruit. These meetings can generate energy for the program not only at its initial launch date but periodically. Consider, for example, holding such meetings to announce winners of team contests or to celebrate the program's anniversary date. And consider asking a senior executive to lead part of the presentation. Nothing says a company is serious about its wellness program as much as a senior executive's presence and the announcement of personal participation.

Don’t forget the role of other media tools. Newsletters, containing health information along with a list of company-sponsored wellness activities, can serve as a reminder to employees of what is available and why it is important to their health to participate.

Electronic media also should play a big role in gaining and keeping participation going in your wellness program. Electronic newsletters and personalized e-mails to participants are one way to start. Consider a wellness program blog. Work with a senior executive to create a Twitter account dealing with health and wellness. You may also find social media a useful tool—particularly with your younger employees.

Case Study Part 9: Planning the Launch

Now that the wellness program is taking shape, Lori approaches Roger, the company’s CEO about making a presentation at a meeting announcing the launch of the program. Roger agrees and tells Lori that he is at long last going to try to give up smoking and be part of the cessation class.

Was it a good decision for Lori to invite the CEO to speak at the kick-off meeting? *Why or Why not?*

Branding the Wellness Program

Creating a separate and recognizable identity for your wellness program can facilitate initial employee participation and perhaps, more importantly, ongoing engagement. Keep in mind that the ultimate success of a wellness program is measured not just by the number of employees who attend an open meeting but by the number of employees who adopt a healthier approach to life leading to decreased incidences of absences, presenteeism, and debilitating chronic disease.

Branding a wellness program creates a sense of identity and recognition. Branding can begin with the use of communications with a simple banner and name such as ABCo HealthyLIFE. Employees will know when they see flyers around the office or e-mails that include the brand name in the header that the message contains information that may prove helpful to their achievement of better health. A consistently used wellness program brand on all pertinent communications sends a subtle message to employees that a company’s commitment to a culture of health is here to stay. Generic communication, on the other hand, can prove to be a prescription for unread flyers, deleted e-mails, and general employee apathy because they fail to appreciate what is being offered.

A branding initiative can also be used as a tool in and of itself to gain employee interest in wellness activities. One option to consider is a contest to name the wellness program. This typically involves four steps:

- Step 1 – Announcement of a contest to name the company’s wellness program
- Step 2 – Wellness committee review of the ideas submitted
- Step 3 – Selection of a program name by the wellness committee

- Step 4 – Announcement of the selected name for the wellness program along with congratulations to the individual(s) who submitted the winning name[lx]

Ongoing Communications with Wellness Program Participants

Use a combination of media both hardcopy and electronic. Hardcopy materials are used less frequently today. For this reason they are apt to gain a recipient's attention, even from those who are tech savvy but don't have time to go through all their e-mail. Consider using a mix of electronic media, including online newsletters and e-mail. You may also wish to sponsor a blog and create a social network focused on wellness program issues and events.

Case Study Part 10: Creating the Wellness Brand

During her meeting with Roger, Lori also alerts him that her reading indicates that branding the wellness program would be another way to gain employee attention. Roger agrees with Lori and together they plan to announce a *Name the Wellness Program Contest* at the kick-off meeting. To incentivize participation, Roger suggests that a prize of theatre tickets for two and post-theatre dinner be awarded to the individual or individuals who come up with the winning name.

Roger and Lori also discuss the desirability of a program logo. They agree that the best approach here is to have the wellness committee discuss ideas and internally agree on two or three alternative images that then could be submitted for a vote to all those who sign up for program activities during the first three months of its operation.

Would more employee engagement have been gained by simply asking an outside firm to create the name of the company's wellness program? *What do you think?*

Case Study Part 11: Program Launch and Branding Contest

Before the launch date announcing the program, the wellness committee meets to review Lori's discussions with Roger and his suggestion for a contest to name the program. The members are in full agreement that this is a good idea. Rhonda suggests that some employees may not be able to attend the meeting so it's important to announce the program launch and the contest in a variety of ways. The committee agrees that this is important, too. The Committee makes a list of ways to do this, including distribution of flyers in the lunchroom and a series of coordinated e-mails explaining the program, how employees can sign up, and why wellness is important to them.

Jim says he will write a draft of the e-mails for everyone to review. It is decided that Lori, as head of HR, will take responsibility for the review of their content. It is also agreed that Lori will approach Roger about sending out an e-mail announcing the meeting and the launch. The committee agrees that this is a good way to gain attention and employee attendance at the launch meeting. Will indicates that he will see to it that the agreed-upon e-mail messages are sent out following the meeting.

Hal and Joe volunteer to make sure the flyers are copied and distributed in the company mailroom. Joe also agrees to make sure flyers are posted on the bulletin boards located in the public spaces throughout the company. Melissa volunteers to translate the flyer into Spanish so that employees for whom English is a second language have an alternative way of digesting program information. John agrees to make personal calls to some of his friends throughout the organization to make sure they are aware of the program and some of the activities that might be of interest to them.

The wellness committee also agrees to meet the week following the announcement of the naming contest to review results and begin work on the development of at least two logos that can be put to a vote of wellness program participants.

Think About It: Do you think the wellness program will be more successful because of the participation of the wellness committee? *Spend a few minutes off-line to write down your thoughts.*

Summary

Now that you've examined tools and techniques for launching a wellness program and learned how age, gender, and cultural backgrounds may influence choices and health concerns of potential participants, you're ready to move on in the progression toward wellness, prevention, and value-based care. Thanks to Jim, Lori, and all the other case study actors who illustrated the role of the wellness committee, the importance of involving members throughout the organization, and the need for upper management support, you should have a better idea about what it takes to produce a program that appeals to an employee population.

Return on Investment (ROI)

Introduction

Wellness programs, whether they are simple or complex, involve the expenditure of funds by a company on behalf of its workers. In today's challenging economic environment employers are increasingly asking whether these dollars are simply a nice perk or an investment in their business. The purpose of this lesson is to help you determine whether the dollars spent on a wellness program are indeed an investment that can reap measurable returns in terms of dollars, better employee engagement, and ultimately increased productivity. This measurement starts with a formula called return on investment—frequently referred to simply as ROI.

Objectives:

After completing this lesson and the accompanying exercises, you will be able to:

- define ROI, know how it differs from standard cost control mechanisms, and understand what is included in the calculations
- identify the steps for gathering data and recognize alternatives that may need to be considered
- comprehend the processes for comparing outcomes for wellness participants versus nonparticipants, timeline factors, and how to improve ROI by focusing on the optimal lifestyle metric, some simple rules for changing unhealthy behaviors
- incorporate tools like the wellness dashboard to monitor progress and track trends

What Is Return on Investment (ROI)?

Return on investment (ROI) is a term associated with business studies and finances. It refers to a measure used to determine whether a business has employed resources in a way that yields profit or loss. ROI is a ratio that measures the value of assets employed in a project against the dollars yielded. The business dictionary defines ROI as the "earning power of assets measured as the ratio of the net income to the average capital employed in a firm or project."[lxi]

> ***Example:*** Health Seekers, a small company, establishes a wellness program for its workers at the cost of $10,000. Its Chief Financial Officer (CFO) determines that the program has lowered the firm's health care costs by $30,000 realizing an ROI of 3 to 1. In other words, for every $1 invested in the wellness program, Health Seekers has gained a $3 return.

ROI can be positive or negative. When a company's investment in a wellness program achieves returns greater than the costs associated with the program, it realizes a positive return on its investment. In some situations, the costs associated with a project are more than the dollars earned back by a company. In this case, the company has realized a negative ROI.

> ***Example:*** Widget, a mid-sized firm, invests in a business property at the cost of $100,000. Later, Widget's Chief Financial Officer (CFO) determines that these

dollars have returned $80,000—less than the initial investment. The widget has realized a negative ROI of .8 to 1. In other words for every $1 put into the project, Widget has received back just 80 cents.

Why Not Rely on Standard Cost Control Mechanisms?

Some employers and their advisors are likely to be initially skeptical about establishing a wellness program. Some will remain so despite the introduction to the evidence provided by ROI modeling. They may continue to rely solely on standard cost control mechanisms in the design of their employee health care programs. These design tools are likely to include higher co-pays, deductibles, and increased use of tiered networks with negotiated pricing.[lxii] While these tools have historically helped to control costs they focus primarily on the out-of-pocket price of the "health care product" delivered and fail to address the growing underlying demand—particularly where the care sought is medically needed and not an option.

On the other hand, wellness programs seek to improve and/or maintain employee health. This, in turn, helps to drive down the need for medical services by the employee population. While increased out-of-pocket costs have been shown to control costs, particularly during the strictly managed care era of the early 1990s, some studies have found co-pays and deductibles to be barriers to patients following instructions for care and medicine that help maintain individual health at relatively little cost while avoiding the more serious complications of leaving the disease untreated.[lxiii]

> ***Example**:* Blackstone Services opts not to initiate a wellness program in light of a struggling economy. Instead, it increases the co-pays its employees must pay on both generic and name-brand drugs. Alice, a lower-paid worker at Blackstone, suffers from high blood pressure exacerbated by her husband's unemployment. The higher co-pays present a financial barrier to Alice regarding fulfilling her medication. Rather than take the recommended daily dose of the prescribed medicine, Alice decides to reduce her use to every third day. Several months later, Alice suffers a cardiovascular event and has to be hospitalized compromising her future health and incurring substantial health care costs for Blackstone's self-funded health plan.

What Is Included When Measuring Wellness Program ROI?

ROI calculations for wellness programs involve more than simple dollar input for dollar yielded calculations. These calculations typically take into account more than the amount of money spent on establishing and maintaining the program and pure dollar cost savings in the form of lower health care expenditures. Depending on the nature of the firm's business, other measurement factors that are considered in wellness program ROI often include:

- Employee sick days (absenteeism)
- Employee self-reported days present but sick and underperforming (presenteeism)
- Number of long-term disabilities
- Number of workers' compensation claims
- Number of employees suffering from chronic conditions

- Number of participants in the wellness program
- Total weight losses of participants
- BMI levels of participants as aggregated
- Blood pressure levels of participants as aggregated
- Cholesterol levels of participants as aggregated

Two of these data measurement points should be of particular interest to employers and advisors helping to design ROI measures for wellness programs. These are absenteeism and presenteeism—factors which most experts say cost employers substantial sums of money and are indicators of overall productivity. In other words, the lower the days logged-in as absences and time lost to presenteeism, the higher the workplace productivity.

Absenteeism – Employee absences from the job caused by illness, injury, and other factors. Absenteeism is usually associated with unscheduled time away from work.

> ***Example:*** ABC company offers its employees the opportunity to have on-site free flu shots. Allen opts not to have the shot because he mistakenly believes there is a cost and he is short of funds. The following week Allen comes down with the flu and needs to stay home for two days.

The United States Bureau of Labor Statistics has estimated that American businesses lose an average of 2.8 million workdays each year due to unplanned absences. In dollar terms, these absences have been estimated to cost between $55 and $74 billion dollars.[lxiv]

Absenteeism impacts workplace productivity in several ways. Workers who report to the job site must frequently cover the work of those not there. Momentum on work projects underway is also often lost.

Presenteeism – The problem of workers being on the job but, because of medical conditions, not fully functioning. The health problems that result in presenteeism include chronic conditions such as depression, back pain, arthritis, heart disease, and high blood pressure. Presenteeism results in substandard performance on the job.

> ***Example:*** Sally reports to work suffering from a migraine headache. Her migraine causes her problems in looking at her computer screen and processing orders that are transmitted via the web.

The term “presenteeism” has been attributed to Professor Cary Cooper, a psychologist specializing in organizational management at Manchester University, England.[lxv]

Data Gathering: A Key Step in Measuring ROI

Data collection is a key step in measuring the ROI of a company wellness program. Without it, an employer will not be able to determine what has come before the initiation of a wellness program, where its wellness has been, where it is headed, or if it is valued by employees. A good place to start is with claims. Employers who self-insure and administer health plans are likely to have records of expenditures for claims submitted by employees for several years past. Employers who partially or fully insure their health care can work with their third-party administrators and health plans to gather claims data.

Claims are a good place to start when gathering data for ROI analysis.

Claims data from past years provide a data source to see whether a company's health care costs have been rising and if so how much they have risen on a historical basis. If their workforce has proved to be relatively healthy, their company-specific medical inflation rate may be lower than the recent 7.8 percent historical average in the United States cited by actuarial commentators.[lxvi] On the other hand, they may discover that their claims outlay have been rising at a faster rate than those of the nation as a whole.

Using claims data from before and after the initiation of a wellness program is one way to see if pure dollar savings have been realized.

Claims Outlay Comparison

Claims Year Before Initiation of Wellness Plan – Claims Year After Wellness Plan + Cost of Wellness Plan = Net Savings

Example: Whitestone, a small firm, examines its claims data and sees that medical claims submitted by its employees in Year 1 amounted to $150,000. Whitestone establishes a wellness program at a cost of $20,000. In Year 2, submitted claims amount to $90,000. Whitestone has realized cost savings of $40,000 [$150,000 – $90,000 + $20,000 = $110,000 ($150,000 – $110,000) = $40,000].

In this regard, it is important to keep in mind, that year-over-year savings—while good for the bottom line—are not the same as ROI ratios. Further steps are needed to arrive at ROI.

Measuring ROI: Considering the "What If" Alternatives

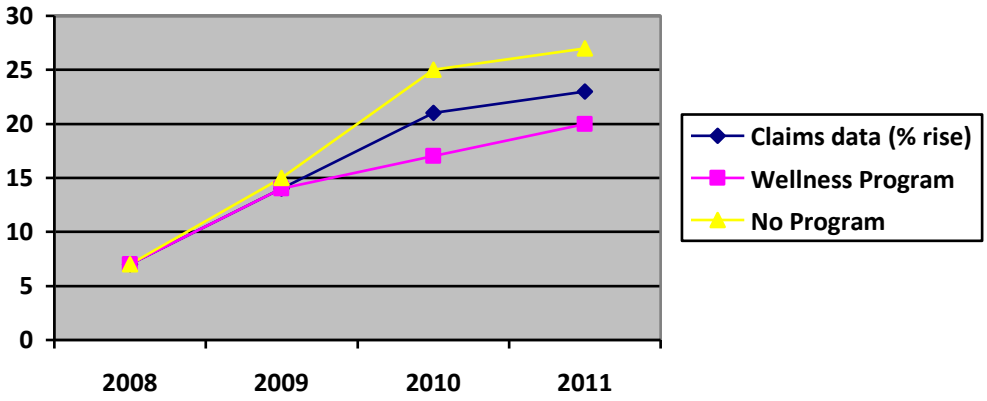
Most commentators believe it is important to consider not only the actual data in calculating ROI, such as past claims but also consider alternatives that provide points of comparison. Here are some points to consider:

- No program – What happens if a wellness program is not established?
- Low intervention level – What happens if a minimal level wellness program is established?
- High[er] intervention level – What happens if a more comprehensive wellness program is established?

No Program Alternative

If a wellness program is not established, what will happen to a firm's health care costs? Will they fall, stay the same, or rise? Given the recent history of employer health care costs, in most instances, these costs will rise. The issue then becomes by how much. One place to go is back into the employer's claims data to determine its particular trends. Have health care costs risen at the national average? Have they experienced a lower average rise over the past several years because they operate in a low cost of living region? Have the demographics of an employer's particular workforce caused claims costs to have risen in excess of the national average over the last several years? The answers to these questions will provide a benchmark against which the success of a wellness program can be judged—if it is indeed set-up. The value of this "what-if" can be further massaged by actuarial calculations taking into account the projected number of program participants and nonparticipants.

Figure 1 Employer Health Care Costs: Establishing Benchmarks



The Alliance for Wellness ROI, an inter-company cooperative formed to standardize and share wellness measurements, suggests using the following formula to determine ROI once health care costs are calculated using the "No Program" alternative and a wellness program has been established.[lxvii]

ROI = [A-B-C]/C

ROI = Return on Investment

A = Projection of Claims Without a Wellness Program

B = Actual Claims Amount With the Program

C = Expenditures for Wellness Program

Low and High[er] Intervention Levels

There are many possible components of an employer-sponsored wellness program. As we have seen, they can be relatively low level consisting of perhaps a company-sponsored sports team coupled with periodic talks by local experts on health issues such as the risks presented by smoking. Perhaps the employer is just starting a wellness program and wishes to begin with a low-key approach.

Other employers may take a more activist approach in handling their wellness program. Perhaps they have had a small program for a few years and now want to see what would happen if they expand it to include other services and activities. The employers involved may wish to model the likely outcomes against what would happen if they did nothing or just remain as is. In these situations, professional wellness advisors are likely sources of help. For example, some wellness advisory firms offer computer models that can generate results relatively quickly.

Sample Components of Low and High[er] Wellness Program Interventions

Low Intervention Program Components	High[er] Intervention Program Components
Employee Assistance Program (EAP)	Employee Assistance Program (EAP)
Health Risk Appraisal (HRA)	Health Risk Appraisal (HRA)
Smoking Cessation Program	BMI Screening
	Smoking Cessation Program
	Reduced Gym Club Memberships
	Walking [Counting Steps] Contest
	Wellness Education
	On-site Clinic
	Disease Management for Diabetes

Measuring Success: Participants vs. Non-Participants

As programs become established companies may wish to measure the success of their efforts against the health care costs of those who have chosen not to participate. In other words, how do the health care dollars spent on participants compare to nonparticipants. A successful program should demonstrate lower per-employee health care spending for participants after several years. In addition to pure dollar outlays other measures of success should be considered.

Sample Measures of Wellness Program Success

Measure	Why It Should Be Measured
Sick days	Reduced absences avoid disruptions of the workflow.
Self-reported days of presenteeism	Reduced days of presenteeism equates to increased productivity.
Number of employees on short-term disability	The reduction indicates better employee health and fewer disruptions of the workflow.
Number of employees on long-term disability	Reduction indicates fewer disruptions of the workflow. If a disease management program is in place, an indicator of success is keeping those chronically ill on the job.
Number of workers' compensation claims	Indicates adherence to workplace safety and if an exercise program is in place possible indicator of stress-induced injuries.
The aggregate number of pounds lost or gained	Lost pounds is an indicator of workers participating in lifestyle changes regarding diet and exercise.
Number of workers with chronic conditions	Increase likely indicators of poor lifestyle choices. Decrease likely indicator that workers at risk are taking steps to delay or avoid the onset of disease.
Number of wellness program participants	A large number of participants is an indicator of broad acceptance of the wellness program and its components.
Aggregated BMI level	Rise is an indicator of increased weight and a higher risk of the onset of disease within the workforce. The decrease is an indicator of positive health status and outcomes.
Aggregated blood pressure level	Rise is an indicator of an increased risk of cardiovascular disease. The decrease is an indicator of participants with heart disease adhering to medication and others engaging in activities to delay or avoid the onset of disease.
Aggregated cholesterol level	Rise is an indicator of an increased risk of cardiovascular disease. The decrease is an indicator of participants with heart disease adhering to medication and others engaging in activities to delay or avoid the onset of disease.

ROI: Consider the Time Frame to Be Measured

Wellness programs are best viewed as a long-term investment by a company in its employees—the human capital aspect of its business. In most situations, it is unrealistic to expect positive ROI results in one year. On the other hand, to gain and maintain support for a wellness program a time frame needs to be set at the onset of when positive results should be expected. Part of the determination of the appropriate time frame for a firm's wellness program will depend on the expected turnover of its workforce. Companies that employ individuals over a long period have greater leeway in setting a time frame of several years. In these situations, a period of three to five years may be appropriate.

If this period is considered too long, the firm may wish to consider phasing in parts of a comprehensive wellness program over several years. For example, focusing on smoking cessation in year one followed by an exercise and weight reduction in year two for diabetics. Since the dollars expended upfront is lower, this should help to yield positive ROI for aspects of the program put into place early on before more comprehensive aspects are added.

As we discussed earlier in the course, companies, where employee tenure is limited to one or two years, are unlikely to be candidates for comprehensive wellness programs because there is simply insufficient time to gain positive ROI. Simple initiatives focused on prevention such as office-sponsored flu shots may be more appropriate and quickly yield positive results in terms of employee attendance during peak influenza season.

ROI Timelines – Program Focus and Payback Periods

Focus on Select Disease Management Programs – Individuals suffering from diseases such as diabetes often incur sizeable health care costs. A disease management program for these individuals can result in substantial health care savings and show tangible results in just several years.

Focus on Programs Requiring Relatively Low Upfront Investments – Wellness programs focused on prevention, walking, and employee education by community health professionals can result in improved health care costs and positive ROI in the early years because the upfront costs are relatively low compared to the potential paybacks in terms of lower absenteeism, increased productivity, and early disease detection.

Improving ROI: Focusing on Simple Lifestyle Factors

Wellness program design decisions can become overwhelming for employers and their employees. For example, should a large employer build an on-site gym? Should a smaller employer include discounted gym memberships in its wellness program? Should a participation incentive be offered or should a penalty for smokers be considered?

At the same time, employees can become discouraged and confused by the diverse advice—

sometimes conflicting—offered on what they should do to maintain health. For example, some may have heard that butter should be avoided. Others may have heard that ingredients in margarine have the potential to increase the risk of cancer. Some commentators recommend fish while others warn of mercury poisoning.

One way of cutting through the clutter of options for both employers and employees is to focus on four factors that have strong relationships to the incidence of disease, emotional health, healthcare costs, workplace productivity, and ultimately health care costs:

- tobacco use
- diet choices
- physical activity
- level of alcohol consumption

Research has shown that several elements determine our overall health. Our genetic make-up and the predispositions that came with it play a 30 percent role in determining our health. Our social circumstances play a 15 percent role, while our exposure to environmental factors plays a 5 percent role in determining our health. The type of health care we receive plays just a 10 percent role in determining our health. The major determinant of our health—the other 40 percent—is our lifestyle behavior.[lxviii] Poor lifestyle behavioral choices are key factors leading to the deaths of many Americans.[lxix]

Do we smoke? Do we overeat, consume the wrong foods, or make wise food choices? Do we sit in front of the television, spending hours gaming on the computer, or do we exercise? Are we binge drinkers or do we consume alcoholic beverages in moderation? These are key questions we should be asking ourselves. Their answers provide insight into our current and future health as well as the likely path of our health care costs, including the potential opportunities for the success or failure of a company's wellness program.

Employers cannot change a person's genetics and have a limited role to play in the social circumstances in which workers live. Nor can employers fully control the environmental factors to which employees are exposed. Employer-sponsored wellness programs can focus on employee lifestyle choices in a way that is positive for employee health outcomes and at the same time improve ROI by lowering health care expenditures and ultimately improving worker productivity.

Wellness experts, including Nico Pronk, have christened the positive aspects of these behaviors as the Optimal Lifestyle Metric (OLM), which can be boiled down into simple rules for employees to follow as they participate in an employer's wellness program.[lxx]

Optimal Lifestyle Metric (OLM) Ground Rules

1. Do not smoke or use other tobacco products.
2. Be physically active.
3. Watch your diet—strive to eat five fruits and vegetables each day.
4. Drink alcohol in moderation.

Improving ROI via OLM Focus

Why are these lifestyle behaviors important? Think about this. Tobacco use has been cited for many years as a factor in lung-related cancer deaths. Secondhand smoke has come to be seen as a health hazard and cause of respiratory problems such as asthma. Lack of physical activity is one reason Americans are becoming overweight and those even moderately obese face increased risk of cardiovascular problems. Poor diet choices are another factor leading to the American obesity epidemic and a larger number of young people troubled with complications of diabetes. And, alcohol abuse has been cited in the deaths of college students following binge drinking.

It is estimated that only 10 to 15 percent of the American workforce follow all four of the OLM ground rules.[lxxi] Given the strong correlation to good health, a focus on the lifestyle metrics could offer a substantial opportunity for wellness programs to reap both the direct financial and indirect benefits of a healthy and more productive workforce by aiming at least a portion of their wellness initiatives at one or more of these rules.[lxxii]

OLM – Improving ROI While Making Wellness Easy

Following one optimal lifestyle metric is better than none…two is better than one…try to add just one to make three…and then one more to make four.

Some employers may have the financial means and capability of establishing wellness programs that focus on all four OLM factors. Other employers may choose to focus on just one of these elements such as tobacco use. Each of these metrics offers employees an opportunity to improve their health. And as we will see in later modules, each of these metrics can improve the ROI of an employer's wellness program.

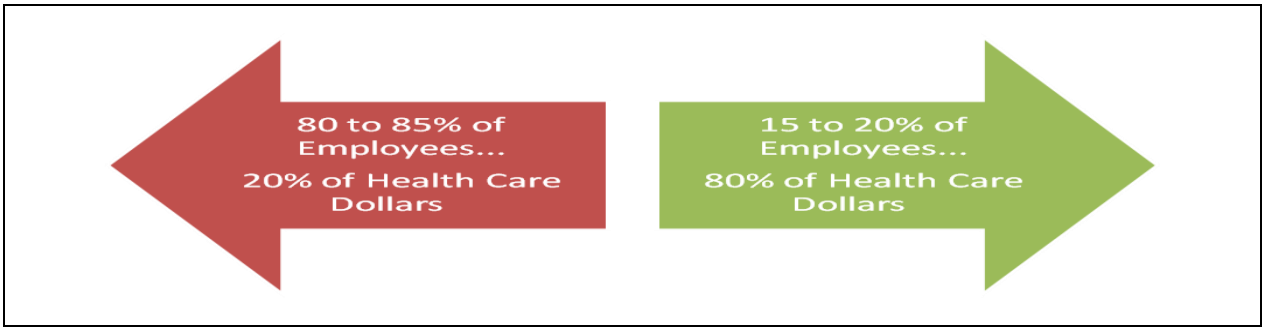
While employee health can be improved by two or more of the OLM metrics, one is better than none. An employer's wellness program may cover the cost of smoking cessation but be unable to provide an on-site gym or discounted memberships. In many cases, however, for just a small outlay or reliance on community services, an employer can provide employees with education through its wellness program on the importance of all of these factors in impacting their health.

Optimal Lifestyle Metrics – Sample Wellness Program Offerings

Metric	Sample Wellness Program Offering
Tobacco use	Smoking cessation
Physical activity	On-site physical activity – exercise dance class
Diet	A weekly bowl of seasonal fresh fruit in the cafeteria
Alcohol	Alcohol-free worksite celebrations

Employee Populations: Where to Focus for the Highest Yield

An employer's workforce can typically be divided into three overall segments: low risk, medium risk, and high risk for health care purposes. Studies have shown that 85 percent of employees fall into what would be considered low and medium risk categories. These employees account for roughly 15 to 20 percent of a company's health care dollars. In contrast, employees in the high-risk category are estimated to represent between 80 to 85 percent of an employer's health care dollars.[lxxiii]



Category	Low Risk	Medium Risk	High Risk	High Risk	High Risk
Evidence of disease	None	Some at risk of developing disease – often chronic condition	Acute episodic illness	Chronically ill	Catastrophic
Examples of	HRA BMI screening	Lifestyle education to effect	Primary care physician visit;	Disease management	Case management

care/wellness program intervention		behavioral change	prescription		
		Discounted gym membership	Referral to specialist	Education and coaching stressing importance of medication adherence	Rehab management
Disease example(s)		Pre-diabetes; high blood pressure	Flu	Diabetes; heart disease	Stroke; terminal cancer

Reasons to Focus on the 15 to 20 Percent

Many efforts (as will be discussed in later modules on disease management and specific programs) focus on the 15 to 20 percent of the employee population diagnosed and suffering from chronic diseases such as diabetes. There are strong reasons to concentrate on this segment because studies have shown that a substantial portion of health care dollars is related to chronic diseases.[lxxiv] If these chronic conditions can be controlled not only are the lives of employees improved but at the same time, the need for expensive procedures and multiple medications can often be reduced. This is also the portion of the employee population where change will yield some of the most visible results of a successful wellness program in terms of maintained health and corresponding lower health care expenditures.

Example: Will has worked for many years at Farmco, a small food processing firm with a workforce of 100. Will has recently been diagnosed with Type 2 diabetes after losing consciousness during work hours. Will's doctor has prescribed a common medication, available in generic form, to control diabetes. Left uncontrolled, Will's chronic condition could lead to frequent hospitalizations and potential amputation(s). These complications are both emotionally devastating and very costly.

Farmco has recently inaugurated a wellness program that includes a no co-pay policy for generic drugs as well as a patient coaching and disease management program for those suffering from chronic illness. This program is likely to help employees, such as Will, avoid or delay the most serious consequences of their chronic disease. This investment in a wellness program is likely to save the firm thousands, if not hundreds of thousands, in health care dollars by helping employees like Will manage and control diabetes and other chronic diseases.

Reasons Not to Forget the 80 to 85 Percent

What about the majority of employees—the other 80 to 85 percent that is estimated to consume just 15 to 20 percent of health care dollars? It is important not to ignore them. Wellness programs need not be too elaborate here. The objective is to keep this group healthy and for those at medium risk to delay the onset of chronic disease.

Wellness efforts can focus, for example, on such simple and cost-effective steps such as educating employees about the preventive benefits included as part of their health care plans. Before the reform, many plans included a package of preventive benefits at low or little cost. Now the passage of the Affordable Care Act incorporates no-cost preventive care into the majority of health care plans. Studies have shown that co-pays and deductibles can be barriers to health care—particularly for those earning limited incomes or facing mounting family financial pressures, such as the layoff of a spouse.[lxxv]

By alerting employees to these included preventive services, serious illnesses can be detected early and treated by less invasive means. For example, providing a colonoscopy for a middle-aged worker might detect a pre-cancerous polyp calling for simple removal and monitoring. Left untreated the polyp could result in the need for removal of part of the intestine—highly traumatic for the employee and a major health care expense for the employer's plan.

While the immediate results of wellness efforts with the majority are unlikely to show health or bottom-line results as dramatic as those focused on the minority, over time they will improve ROI by helping a company's workforce avoid illnesses that are physically devastating, emotionally challenging, and very costly in terms of health care dollars.

Sample Single Wellness Initiative ROI Formula for Smoking Cessation

$$\frac{\text{Number of Individuals Who Stopped Smoking} \times \text{Estimated \$ of Lost Productivity*}}{\text{(Investment in Smoking Cessation Program)}}$$

*Conference Board of Canada (2006) estimated the cost of smoking to be $3,376 per year per smoker in decreased productivity and absenteeism.[lxxvi]

Other Cost-Effective Ways to Improve ROI

Dr. Steven Aldana has written extensively about wellness programs. His work includes suggestions for implementing programs with positive ROI to meet the needs of today's challenging economic environment.[lxxvii] These suggestions include:

- Tapping into the preventive benefits offered by insurance plans

- Implementing worksite policies and environmental changes that promote wellness at a relatively low-cost
- Designing a revenue-neutral wellness program
- Making use of free community resources

Tapping into Preventive Benefits

The Affordable Care Act now requires most insured plans to provide free preventive coverage. Many employers and employees are unaware of the full scope of these services and their value often amounts to between $300 to $500 dollars. Arranging an on-site presentation by a carrier's representative is a low-cost way of educating employees as to the services available to them.

Implementing Worksite Policies and Environmental Changes that Promote Wellness

Is your lunchroom vending machine undermining employee health? Many vending machine options still include high-calorie sodas loaded with sugar. These types of beverages can play a role in employee weight gain—a factor that can lead to heart disease and diabetes. Is your worksite smoke-free? Some employers have taken steps to disallow smoking on the entire corporate campus—not just internal office space.[lxxviii] Do employees have a way to exercise during working hours? Many employers cannot afford to offer on-site gym facilities but perhaps they can install a simple walking path around their building sites and encourage the formation of before hours or lunchtime walking groups.

Designing a Revenue Neutral Wellness Program

In some circumstances, it may be possible to create a revenue-neutral wellness program through increased single and family employee contribution levels. For example, an employer might increase the annual employee-pay contribution by $50 for single coverage and $100 dollars for family coverage to create a source of dollars to fund a wellness program. These funds could in whole or part be returned to employees if they agree to participate in a variety of wellness activities such as completion of a health risk assessment (HRA), with completion of family medical history as optional. Such participation must be open to all employees with accommodations and opt-outs available for employees unable to participate due to factors such as disability, to comply with legal requirements.

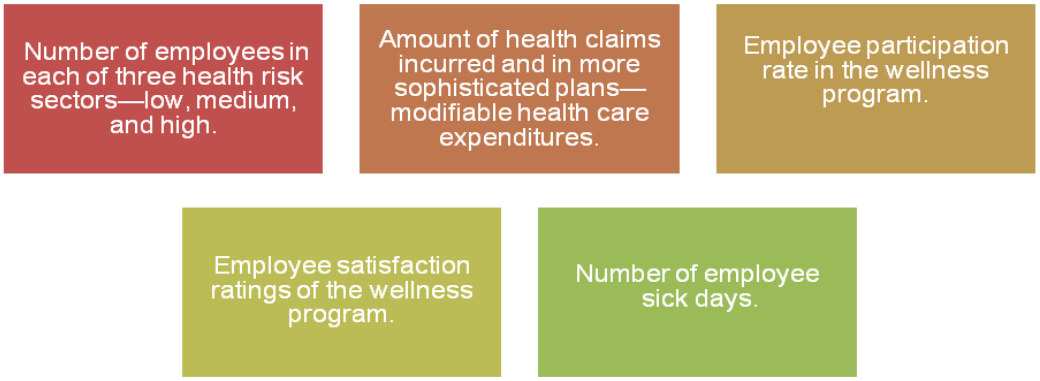
Making Use of Community Resources

Employers and their advisors can often look to community resources as a way to provide valuable but low-cost wellness benefits. Associations focused on the eradication of certain ailments such as heart, cancer, and diabetes often has programs that can be brought into the employment setting. Many associations have fundraising efforts that involve walks that can support employer-sponsored exercise initiatives. Not only are employees offered the opportunity to exercise through walks but money is raised for causes that support health and wellbeing. Local county health services may have professionals on staff willing to offer free presentations that can serve to educate employees on lifestyle issues and other health concerns.

One further word, make sure the message about your employer's wellness efforts gets out to the workforce. Use multiple communications to remind employees of what's available and be sure to communicate in such a way that they know what's in your wellness program for them. Tell them about the benefits of better health such as increased energy—often a positive message is better received than one that focuses only on the dangers of certain lifestyle choices or their disease implications.

Keeping Track of Progress: Constructing a Dashboard to Monitor ROI

It is important to keep track of whether or not your wellness program is producing results for your organization, and it is important to communicate these results to senior management and others responsible for the continued funding of the program and health benefits. One way of keeping track of results and presenting them in a digestible format is to construct a wellness dashboard. Typically, this will be a one or two-page report that provides a snapshot of wellness data:



If possible this information should be presented in a graphic format that makes it easy to spot trends indicating program success or areas that need attention.[lxxix]

Number of Employees in Various Risk Categories

Over time, depending on the demographics of an employee population, it is expected that the percentage of employees in the high-risk category will be declining. If, however, the firm employs a highly skilled professional workforce that is aging, this number could be rising. The trend could alert upper management that steps need to be implemented or reinforced in regard to disease management and other care management techniques to help avoid catastrophic health situations such as stroke from occurring.[lxxx]

A collateral benefit of such wellness data is that it could be used to alert upper management of the need to implement succession planning.

Health Claims [Medical and Prescription Drugs]

The number and amount of health claims should ideally trend downward for a workforce providing its relative size remains stable. Periodically monitoring claims data through a dashboard provides a quick alert if there is a spike—for instance, an ongoing epidemic that might be otherwise hidden in relatively stable attendance figures—and signal management of the possibility of reduced productivity due to presenteeism.

Modifiable Medical Health Claim Expenditures [Medical and Prescription Drugs]

Some companies, often with the help of their wellness advisors, may be able to use claims data in a more sophisticated manner by looking at the percentage of claims due to factors that can be modified through wellness programs. For example, a trend showing increasing prescription costs might spur further investigation into aggregated data indicating that many employees are relying on brand name medications. In turn, this could open the opportunity to educate workers about generic drugs that could save them money, as well as reduce employer health care outlays. This information might also be used to educate workers about the benefits of an exercise and diet program that could reduce the levels and perhaps the need for such medications.

Employee Participation in Wellness Program

A wellness program cannot demonstrate positive ROI nor can it impact health care cost trends unless employees participate. Therefore, a wellness data dashboard should track the percentage of employees participating in the activities and services it offers. Ideally, this metric should rise year after year until it indicates that the majority of employees are participating in wellness activities. This metric may, however, decrease from year-to-year indicating the need to investigate ways to refresh the wellness program offerings, such as an interoffice contest with the winning team receiving a free bonus day to regenerate participation and enthusiasm.

In addition to looking so hard at employee participation, you may also want to consider the inclusion of a metric measuring the intensity of employee participation. For example, in a weight loss program that includes telephonic coaching, how many sessions were attended by each participant? If the majority of employees spoke to the coach and discussed their status during each scheduled session, that would be a sign of strong employee participation. On the other hand, if most employees in a weight loss program were failing to keep their scheduled telephonic appointments, that would be a warning sign that new program approaches should be investigated.

Employee Satisfaction Survey Results

Closely related to the level of employee participation is employee satisfaction with the wellness program. Periodically, internal or external staff charged with the administration of the program should survey participants to monitor whether or not they are satisfied. If employees are highly satisfied, and the current components of the program are being well received, this outcome is likely to have a positive impact on the health care cost curve. If participant survey responses are mediocre to poor, this would be an indicator that there is a need to reevaluate aspects of the program.

Non-Participant Surveys: Dashboard Offshoot

Wellness program administrators may also wish to survey nonparticipants to gain insights as to why they are not enrolled in the wellness program and what activities, incentives, and/or disincentives might encourage their participation. Whether this data should be summarized and included in the dashboard will depend on a company's needs and reporting preferences.

Employee Sick Days

One often-cited factor impacting productivity is the number of sick days taken by workers. A sign of increased productivity within a workforce is a drop in the aggregate number of sick days. Conversely, an increase in the number of sick days is an indicator of decreased productivity and the need to reevaluate the wellness program and perhaps reemphasize benefits—such as free preventive care for seasonable illnesses such as influenza.

In some cases, the employee sick day number will be expressed as an unadjusted figure. In other situations, employers may prefer to monitor this as a per-employee average, particularly where the number of workforce members varies during tracking time frames.

In summary, while the exact composition of a wellness dashboard may vary from company to company, its construction provides program administrators and senior management with a tool for easier tracking of progress or identifying needs for wellness program adjustments.

Tapping Into Technology: ROI Calculators

Technology can help companies with their wellness program ROI calculations. Today there are technology tools available that will provide, for example, estimates of what will happen if a company does nothing, the results if risks are lowered by 1 percent over 10 years, and the results if risks are lowered by 10 percent over 10 years. These programs can also help companies determine the breakeven points between wellness spending and health care cost-saving returns.[lxxxi]

The calculators do require companies to gather data including the firm's total health care costs for at least the past year (12 months); the total number of employees covered by its health plan; and an estimate of how much its health care costs have risen or fallen over a past period — desirably, five years. Other pieces of information helpful in using these programs include, if available, the number of employees who smoke and the number of employees who are considered obese.

These technology tools may or may not be appropriate for a particular organization. Smaller firms initiating wellness programs may not have the data available to fully utilize these tools. Larger firms with established wellness programs and resources available to gather data may find the technology useful or prefer to rely on their internal calculations.

Summary

In today's challenging economic environment employers are seeking a competitive edge. Wellness programs can be part of this edge by lowering health care outlay trends and increasing worker productivity. This lesson has sought to alert you to some of the basics needed to measure ROI. It is by no means a comprehensive study of this subject. More sophisticated models, for example, may employ advanced mathematical tools such as regression to the mean. Just remember, ROI metrics can aid companies and their advisors to make the case for why such programs should be implemented, maintained, and in many cases expanded.

Legal Issues, Part I: HIPAA and the ACA

Introduction

Wellness programs offer many benefits to participants but they have also raised concerns about issues related to nondiscrimination and privacy. We will discuss how the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA) address these issues. As part of that coverage, we will briefly touch upon the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Objectives:

After completing this lesson and the accompanying exercises, you will be able to:

- recognize how the HIPAA Nondiscrimination Rules, as modified by the ACA, apply to wellness programs
- determine when a wellness program is outside the scope of HIPAA/ACA
- apply exceptions to the general HIPAA/ACA provisions related to groups plans, premium differentials, and wellness incentives
- understand the impact of HIPAA Privacy and Security Rules and the HITECH Act regarding the collection and use of personal health information

HIPAA: An Overview

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress in 1996 to:

- provide consumers with greater access to health insurance
- protect the privacy and security of their health care data
- promote standardization and efficiency in the health care industry

HIPAA seeks to increase access to health care through a series of provisions requiring guaranteed issue, guaranteed renewability, and portability for group plans. These provisions include strong mandates against discrimination in eligibility and benefits based on health history and current health status. HIPAA seeks to address data privacy and security of an individual's protected health information (PHI) and promote standardization and efficiency in the health care industry, through its administrative simplification provisions.

HIPAA Nondiscrimination Rules and Wellness Programs

HIPAA impacts wellness programs through its nondiscrimination provisions. It prohibits group plans from discriminating against individuals on the basis of health factors in regard to eligibility and benefits.

Eligibility and Benefits: HIPAA Prohibitions

Eligibility Cannot discriminate in regard to:	**Benefits** Cannot discriminate in regard to:
Enrollment	Premiums
Effective date of coverage	Contributions
Waiting periods	Deductibles
	Co-pays
	Coinsurance
	Covered expenses

The health factors protected from discrimination under HIPAA are fairly broad.

HIPAA Protected Health Factors Under Nondiscrimination Rules

Health status	Genetic information
Physical or mental condition	Medical history
Receipt of health care	Disability
Claims experience	Evidence of insurability (including factors such as dangerous occupation/activity)

Employers currently maintaining or considering wellness programs and their advisors need to be aware of these factors. A properly designed wellness program can either avoid being subject to HIPAA entirely or be subject to HIPAA and fall within its safe harbor rules. Improperly designed wellness programs risk violation of these HIPAA rules and penalties.

Separate Plans: Avoiding HIPAA Rules

HIPAA nondiscrimination rules only apply to group health plans. If a wellness program is not part of a group health plan or is not itself a group health plan, it does not fall under the HIPAA nondiscrimination rules.

Example: Company ABC offers $100 gift certificate to employees who do not use tobacco products. This program is not a group health plan and would not be subject to the HIPAA/ACA wellness rules.

Tests to Determine Whether HIPAA Rules Apply

In recent years as wellness programs have grown in popularity, the government has been increasingly asked about the scope of HIPAA. When does HIPAA apply? When is a wellness program considered a separate plan and outside the scope of HIPAA? On February 14, 2008, the Department of Labor (DOL) issued Field Assistance Bulletin Number 2008-02 to guide on this topic. The Bulletin contains a wellness checklist that asks four questions:

1. Is the first day of the current (group health) plan year after July 1, 2007?
2. Does the plan have a wellness program?
3. Is the wellness program part of a group health plan?
4. Does the program discriminate based on a health factor?

The answers to these four questions determine whether or not HIPAA will apply. Let's now spend some time on each of the questions in further detail.

Question 1 – Is the first day of the current plan year after July 1, 2007? ☐ Yes ☐ No

This question is aimed at reminding companies and their advisors that HIPAA wellness program rules only apply to group health plan years beginning on or after July 1, 2007.

Question 2 – Does the plan have a wellness program? ☐ Yes ☐ No

The DOL bulletin recognizes that wellness programs take many different forms and may be called by other names. Generally speaking, if the plan covers things such as disease management, smoking cessation, or a diagnostic testing program for early detection of health problems it will be considered a wellness program. Thus, firms taking an active role in the management of their employees' health are likely to check "Yes".

Question 3 – Is the wellness program part of a group health plan? ☐ Yes ☐ No

This is a key question for many firms. Perhaps a better way of thinking about this question is to rephrase it as follows: Does the wellness program's incentive relate to the health plan? If the answer is "No" then HIPAA likely would not apply. For example, an employer institutes a simple wellness program that offers every employee a $50 coupon to join a local gym. The employees' decisions to join or not to join have no impact on their health insurance premiums. Thus, this program is not part of a group plan. Another example is an employer that institutes a policy that any employee who smokes will be fired. Here, the group health plan is not acting, so the Employee Retirement Income Security Act (ERISA) and HIPAA rules would not apply to the policy. Other federal and state laws may apply such as Americans with Disabilities Act, and state laws prohibiting discrimination against employees who participate in lawful activities.

On the other hand, if the employer's wellness program offers employees a 15 percent discount on health insurance premiums if they accumulate 1,000 participation points at a local gym, this is a sign that the program is linked to the group health plan. Thus, another factor is checked indicating that HIPAA should apply.

A wellness program may itself be a group health plan. This will be the case if the employer sponsors an arrangement that provides medical services. For example, employer-sponsored stand-alone biometric screening programs and flu shot programs may be considered group health plans, even if those programs are not a part of the major medical plan sponsored by the employer.

Question 4 – Does the program discriminate based on a health factor? ☐ Yes ☐ No

In general, a plan discriminates based on a health factor if it provides an incentive to individuals who meet a standard related to a health factor. Incentives could be in the form of a reward or a penalty. The incentive could include items of cash value such as discounted premiums, lower co-pays, or the absence of a surcharge and in-kind rewards. The incentive also could be acquiring eligibility to enroll in the health plan. The health factor for purposes of this question includes the eight HIPAA-protected health factors.

It is also important to note that for purposes of HIPAA mere participatory programs generally do not result in discrimination based on a health factor.

YES and NO Examples

"Yes" Example(s) ***Standard-Based***	**"No" Example(s)** ***Participation-Based***
Achieve specific cholesterol level(s)	Sign-up for a gym membership
Achieve weight at the recommended level(s)	Attend smoking cessation class
Achieve a blood pressure level(s)	Complete health risk assessment (HRA) [without questions on family medical history]

If any of these four questions are answered "No," the program is not subject to the rules under HIPAA for wellness programs. Participatory programs are considered to comply with the HIPAA nondiscrimination requirements without having to satisfy any additional standards if participation in the program is made available to all similarly situated individuals, regardless of health status.

> ***Example:*** Mainline, Inc. establishes a wellness program that is participation based. Incentives are offered to its workers for completing a 10 question health risk assessment. Employee answers are fed into a computer system that identifies risk factors and sends education materials to the employee's home address. It answers the four questions as follows:
>
> 1. Is the first day of the current (group health) plan year after July 1, 2007? YES
> 2. Does the plan have a wellness program? YES
> 3. Is the wellness program part of a group health plan? YES
> 4. Does the program discriminate based on a health factor? NO

The plan does not maintain a program subject to HIPAA group health plan wellness program rules, but this program must be available to all similarly situated individuals.

Example: Same facts, except those plan participants who achieve a cholesterol level under 200 receive a 10 percent premium reduction. This changes the answer to the fourth question:

Does the program discriminate based on a health factor? YES

The plan does maintain a program subject to HIPAA group health plan wellness program rules.

Caution: Satisfying the HIPAA and ACA wellness program rules is not the end of the inquiry!

Whether the HIPAA and ACA wellness program rules apply or not, and even if the program satisfies those rules, the program still must be lawful under other laws such as Genetic Information Nondiscrimination Act (GINA)**;**
Americans with Disabilities Act (ADA)**;** state laws (often referred to as lifestyle laws)**;**
Internal Revenue Code (IRC)**;** HIPAA Privacy Rules; Title VII and the Age Discrimination in Employment Act (ADEA). For example, certain EEO laws prohibit unintentional discrimination (i.e., an employer's use of neutral policies or practices that have a "disparate impact" on employees in legally-protected groups). Employee representatives have raised concerns that outcome-based wellness programs, in particular, could have an unlawful "disparate impact" by making health insurance coverage disproportionately more expensive for some legally-protected groups such as individuals with disabilities, racial minorities, women and older workers. While it remains to be seen whether wellness programs will produce a "disparate impact" that violates federal, state or local law, employers should be mindful of the potential for such claims and discuss with legal counsel steps to guard against such exposures.

Wellness Programs Established Under Group Health Plans

Many wellness programs are established as part of employer-sponsored group health plans and offer incentives (rewards) to employees who meet specified health standards, such as cholesterol levels below a threshold. In these situations, the HIPAA wellness program rules must be considered.

HIPAA wellness program rules are outlined in regulations made final in 2006. The Affordable Care Act (ACA), enacted in 2009, codified the HIPAA wellness program rules into statute with some significant changes. In 2013, the Departments of Treasury, Labor, and Health and Human Services finalized regulations implementing the ACA's wellness program provisions. Thus, when

discussing the wellness program rules herein, we are discussing the HIPAA rules, as modified by the ACA.

General Rule

Premium differentials or other plan-related financial and other incentives applied to individuals and based on health factors generally violate HIPAA nondiscrimination rules.

Safe Harbor Exceptions to the General Rule

There are two exceptions to the general nondiscrimination HIPAA provisions:

- First Exception (Wellness Programs) – Program with incentives, including premium differentials, that satisfy the HIPAA/ACA wellness program rules are permitted. But, there still may be other laws to consider to ensure the program is compliant.

- Second Exception (Benign Discrimination) – Incentive, including premium differentials, are permitted in situations where there is discrimination that favors individuals suffering from an adverse health factor. For example, wavier of co-pays for diabetics enrolled in a disease management plan of care.

Four Questions Answered Yes…Don't Despair

A wellness program can still qualify under the HIPAA/ACA rules if it fits within either the "Wellness Program" exception or the "Benign Discrimination" exception.

Wellness Program Exception: A Closer Look

As noted, the ACA and its implementing regulations codify most of the requirements in the HIPAA wellness program rules, but with some significant changes. The ACA wellness regulations are effective for plan years beginning on and after January 1, 2014.

The rules identify a few different forms of wellness programs that need to be considered. A participatory program is one form of the wellness program. "Health-contingent" wellness programs are another form. Under that category, an individual generally is required to satisfy a standard related to a health factor to obtain a reward (or require an individual to undertake more than a similarly situated individual based on a health factor to obtain the same reward). There are two subcategories of health-contingent wellness program: (1) activity-only wellness programs; and (ii) outcome-based wellness programs.

- Activity-only programs require an individual to perform or complete an activity related to a health factor to obtain a reward but do not require the individual to attain or maintain a specific health outcome. Examples of these include walking, diet or exercise programs.

- Outcome-based programs require an individual to attain or maintain a specific health outcome to obtain a reward. Outcome-based programs typically are structured in two-tiers. In tier one, the program applies a measurement, test, or screening to the individual. If satisfied, the individual earns a reward. If not, the individual moves to tier two which requires the individual to take additional steps to earn the same reward, such as meeting a health coach, taking a health/fitness course, complying with a walking or exercise program, or complying with a health care provider's plan of care.

Caution: Distinguishing Between Participatory Programs and Activity-Only Programs Can Be Challenging

A requirement to join a fitness center to receive a reward, with nothing more, will be a participatory program. If the requirement is to participate in an exercise program at the fitness center to get the reward, the program will likely be considered activity-only, even if the program does not require that participants achieve any outcomes while participating in the exercise program. Likewise, a requirement to attend a monthly nutrition seminar would be considered participatory. A requirement to participate in a dieting program to receive the reward likely would be considered activity-only. This is because a person's health factor may make it more difficult to participate in the program, as compared to other participants.

Each of these types of programs has different requirements under the ACA regulations. For health-contingent programs, the requirements are:

- **Annual qualification requirement (same for activity-only and outcome-based)**

  The program must allow individuals eligible for the program to qualify for the reward under the program at least once a year.

- **Incentive limit (same for activity-only and outcome-based)**

  The amount of incentive (reward/surcharge) may not exceed 30% of the premium for the employee-only tier of coverage or 30% of the total costs of the coverage in which an employee and any dependents are enrolled. [lxxxii] If the program is designed to prevent or reduce tobacco use, the amount of the incentive may not exceed 50% of the total cost of coverage (regardless of whether it is employee-only coverage, or employee and dependents coverage).

The cap applies to all wellness programs offered. So, for those plans that offer multiple incentives for meeting different standards, those incentives have to be aggregated to determine if the incentive limit has been reached. Note, that because participatory programs are not subject to these rules, incentives for those programs are not aggregated for purposes of the HIPAA/ACA incentive cap. But, again, that will not be the case when analyzing the ADA/GINA maximums.

Example: Mary participates in GenerousCo's wellness program. The program offers her a 10 percent reduction in premium if she reaches a cholesterol target—a health factor. Also, the program offers Mary another 10 percent reduction in premium if she monitors and achieves a blood pressure target—another health factor.

Result: Although the program offers two incentives for achieving health standards the dollar amount incentive when combined is 20 percent and within the permissible limitations.

Example: Same facts as the first example except a 20 percent reduction in premium is offered for meeting the cholesterol target and another 20 percent is offered for achievement of the target blood pressure level.

Result: The combined incentives equal 40 percent and exceed the limit currently permissible – 30 percent.

The wellness program may offer additional incentives if they are not tied to these health factors. In other words, discounts for other elements of the wellness program do not enter into the current 30 percent limit equation - participatory programs.

Example: Same facts as the first example except that in addition to the 10 percent incentives offered for achieving specified cholesterol and blood pressure levels, the program offers a 15 percent reduction in premiums to those who complete a health risk assessment (HRA).

Result: Despite total rewards (35 percent = (10 + 10 + 15)) constituting more than the currently permissible level of 30 percent, the rewards are deemed acceptable. The 15 percent reward for the participatory HRA is not part of the incentive limit calculation under the HIPAA/ACA rules. This is because completion of the HRA is required to earn the reward and this does NOT require Mary to meet a health standard.

Example: Company ABC's health plan has a total premium (ER and EE portion) for the employee-only tier of coverage of $6,000. It wellness program has 3 components: (i) participatory online assessment - $500 annual reward; (ii) outcome-based biometric screening program - $600 annual reward; and (iii) tobacco prevention program - $2,000 annual reward.

Result: The program does not exceed the incentive maximum under the HIPAA/ACA rules. The reward limit is 50% of the annual premium or $3,000 per year. The total annual reward ($3,100) does not exceed the 50% limit. Again, rewards for participatory programs (here, $500) are not included in the calculation. Thus, the total reward for purposes of the reward limit is $2,600. Also, because the total incentive for biometric screening and tobacco prevention program ($2,600) is less than 50 percent incentive limit ($3,000), and the total incentive for biometric screening program ($600) is less than the 30 percent incentive limit ($1,800), the reward limit requirement is satisfied.

IMPORTANT: This analysis may be impacted by incentive limited imposed under the final EEOC regulations under the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act

- **Program description requirement (same for activity-only and outcome-based)**

Plan materials describing the program must disclose the existence of a reasonable alternative standard or the possibility of a waiver – the regulations provide the following as sample language for such a notice:

"Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status."

- **Reasonably designed requirement**

For both activity-only and outcome-based programs, the programs must (i) provide a reasonable chance of improving health or preventing disease, (ii) not be overly burdensome, (iii) not be a subterfuge for health factor discrimination, and (iv) not be highly suspect in the method chosen. These determinations are made on a facts and circumstances basis. For outcome-based programs to meet this requirement, they also must provide a reasonable alternative to any individual who does not meet an initial standard based on a measurement, test, or screening that is related to a health factor.

- **Uniform availability requirement**

  To meet this requirement, activity-only programs must provide a reasonable alternative standard or waiver for individuals who have difficulty meeting the standard due to a medical condition, or because it is medically inadvisable to do so. Outcome-based programs must provide a reasonable alternative to any individual who does not meet the initial standard.

  The ACA regulations provide flexibility concerning the kinds of alternatives that a program can make available for a program participant to still earn a reward. There are some key principles to consider when designing and applying these alternatives for activity-only and outcome-based programs:

  - The regulations contemplate that for standards relating to health factors that involve addiction (e.g., tobacco, food) multiple attempts at meeting alternatives would be made available.
  - For education program alternatives, the wellness program must pay for and provide the education program or assist the individual in finding the educational program.
  - For diet program alternatives, the wellness program must pay for the diet program or membership fee, but not the cost of food.
  - Time commitments required to meet the alternative must be reasonable.
  - Personal physician's recommendations must be taken into account if a physician determines the wellness standard is medically inappropriate.

  Other questions arise concerning designing reasonable alternatives:

  - *What if the reasonable alternative to an activity-only standard is another activity-only standard?*

    In this case, the program must go through the same analysis as it did for the initial activity-only standard. This means that it may need to make a second reasonable alternative available.

  - *What if the reasonable alternative to an outcome-based standard is another outcome-based standard?*

    The program must go through the same analysis as it did for the initial outcome-based standard. If the alternative is a different level of the same standard, the program must provide additional time to comply, taking into account the individual's circumstances. Also, the program must allow the

individual to comply with his physician's recommendations as a second alternative to meeting the plan's reasonable alternative, but only if the physician "joins in the request." Individuals can inject their physician's recommendations at any time, and physicians can adjust recommendations any time, as long as medically appropriate.

- *Does an employer or wellness program administrator have to automatically grant an employee an alternative standard or a waiver?* The answer depends. In the case of activity-only is programs, the answer is “No.” The employer or wellness program administrator can ask the employee to verify the need for the alternative standard. For outcome-based programs must make the alternative available.

- *Must the wellness program create a standardized approach in crafting the alternative?*

  The answer is “No.” A wellness program can provide a standardized broad-based alternative or provide an individualized approach. It is helpful to have some alternatives in mind when the program is being rolled out.

Benign Discrimination: A Second Safe Harbor Exception

A safe harbor from the nondiscrimination requirements under HIPAA is also provided for wellness programs that practice what is termed benign discrimination. Benign discrimination occurs when an incentive is offered only to individuals suffering from specific adverse health factors. In other words, the incentive is offered only to individuals suffering from diseases such as diabetes, heart disease, or cancer. It is not available to other participants in the wellness program.

Example: Copayments are waived on specialized drugs related to treatment for participants diagnosed with cancer.

Result: Fits within the safe harbor even though not available to cancer-free participants.

Example: Participants in the wellness program who suffer from diabetes are offered $300 toward their gym membership dues if they complete specified blood tests twice annually.

Result: Fits within the safe harbor. Lowers overall health costs due to increased likelihood of compliance with the recommended treatment.

Impact of HIPAA Privacy and Security Rules

HIPAA administrative simplification provisions include privacy and security rules designed to protect an individual's health information, including participants in certain employer-sponsored wellness programs. HIPAA establishes a firewall between an employee's individual health information gathered as part of a wellness program and the employer unless the employer as a plan sponsor is using the information for plan administration purposes and meets several other requirements.

As a general rule, it is permissible for an employer and/or its wellness administrator to obtain health aggregated information about its workforce but not health information about its employees. Employers that satisfy the plan sponsor requirements under the HIPAA privacy and security rules and are more actively engaged in the operation of their wellness programs, need to, among other things, maintain health data in secure files separate and apart from the more general records normally maintained by human resource departments.

Other employers take a more hands-off approach when it comes to their wellness programs by retaining third-party specialists to manage their offerings and handle the records. In such instances, where the wellness program is part of, or itself, a group health plan, employers need to be sure third party service providers (such as outside wellness program managers) have agreed to the terms of a HIPAA-compliant business associate agreement. These agreements must require, among other things, that the business associate will maintain secure records and adhere to HIPAA's privacy and security rules.

Why are the HIPAA privacy rules important? From a participation standpoint, which is critical to the success of most wellness programs, the rules provide a comfort zone that encourages employees to honestly answer questions about lifestyle habits and health status, thus promoting broad participation. Very few individuals would like their employer to be aware, for example, that they had three to four drinks per evening and suffered a potential alcohol problem. Furthermore, should such information become public very few individuals would welcome their co-workers knowing that they were potential alcoholics. For further example, very few workers would like for their employers or co-workers to be aware that they tested positive for a sexually transmitted disease.

Exercise Care When Handling Health Risk Assessments (HRAs)

The information provided in HRAs is the type of data protected by HIPAA's privacy and security provisions. Employers can expect in most circumstances to be provided with or have access to aggregated data which enables them to better target wellness benefits and programs. Small firms where the identities of individual workers can be easily discerned may need to rely on third-party specialists that aggregate data from other firms of similar size and engaged in similar businesses. They may also have more stringent policies and training to be sure information is not accessed or used for an improper purpose.

HITECH Act

Employers and their wellness advisors need to monitor the implications of the **Health Information Technology for Economic and Clinical Health Act**—commonly referred to as the **HITECH Act**. Its provisions place increased responsibilities on the third-party companies who frequently establish and manage wellness programs on behalf of employers.

Under HIPAA these third-party companies are considered **business associates**. As business associates, they must take several steps to safeguard protected health information, including without limitation: conduct security risk assessments, adopt written policies regarding privacy and security, and train their workforce members regarding these rules and the importance of complying with them. Should a security breach occur, these third-party companies, as business associates, must follow a series of rules designed to notify the individuals impacted. One of the changes made by HITECH is that these entities are no longer subject to these requirements as a matter of the contract (the business associate agreement), they are now directly liable for violations of many of the HIPAA privacy and security regulatory requirements that plans have to satisfy.

HITECH Security Breach Notification Rules: A Quick Summary

What is a security breach? Subject to certain limited exceptions, a security breach occurs when there is access, acquisition, use, or disclosure of unsecured protected health information.

What must be done if there is a breach? Individuals whose information has been compromised by the breach must be notified. This notification must take place without unreasonable delay, but no later than 60 days following the discovery of the breach. Also, the Department of Health and Human Services (HHS) [or in some cases the Federal Trade Commission (FTC)] must be notified as well as the media.

Are there any exceptions? There are exceptions, such as if the PHI could not be retained by the individual who acquired it. Also, the notification may not be required if it can be shown after consideration of several factors that there was a low probability of compromise.

The bottom line is to handle wellness participant health information very carefully—respecting the privacy of individuals and the need to maintain strict security over access to their health information.

Summary

Rules under the nondiscrimination provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act impact wellness programs established as part of group health plans. Many of these programs offer incentives (financial or otherwise) to employees who participate in certain activities or meet specified health standards, such as cholesterol levels below a threshold. In these situations, the HIPAA/ACA rules would apply. To protect participants in the programs from impermissible discrimination based on a health factor, the programs must have certain protections in place, including a cap on the amount that could be provided as an incentive to participate and alternatives to meeting some of the program requirements. Also, HIPAA privacy and security rules protect the information that is collected,

used, and maintained in the administration of these programs. Under the HITECH Act, third-party companies, considered business associates, are held directly liable for violations of HIPAA privacy and security breaches. Finally, even if the wellness program satisfies the HIPAA and ACA requirements, they must still be examined to ensure compliance with other laws, such as the ADA and GINA.

Legal Issues, Part II: GINA, ADA, and ERISA

Introduction

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically its nondiscrimination provisions outlined in regulations, is the first law employers and their advisors must consider in their analysis for dealing with the legal requirements surrounding the establishment of a wellness program. Those regulations were codified in the Affordable Care Act (ACA) which made some significant changes to the HIPAA rules. Other laws must be considered as well. Those laws include the:

- Americans with Disabilities Act of 1990 (ADA)
- Genetic Information Nondiscrimination Act of 2008 (GINA)
- Employee Retirement Income Security Act of 1974 (ERISA)[lxxxiii]

In 2016, the Equal Opportunity Employment Commission (EEOC) finalized regulations under the ADA[lxxxiv] and GINA[lxxxv] to address certain aspects of employer-sponsored wellness programs. The EEOC's rulemaking is particularly concerned with the voluntariness of disability-related inquiries and medical examinations by employers, and inducements relating to employees' spouses or other family members to disclose current or past medical conditions on health risk assessments (HRAs). The Commission is also attempting to align its reading of the ADA and GINA with the regulation of wellness programs under the ACA and HIPAA. The final ADA and GINA regulations were issued along with FAQs concerning ADA[lxxxvi] and FAQs concerning GINA[lxxxvii].

Employers must consider whether states in which they conduct business have enacted laws (sometimes referred to as lifestyle laws) providing protections for individuals with nontraditional lifestyles and the implications of these laws upon employment practices. Additionally, state insurance laws may also affect the nature and scope of the wellness programs employers can adopt.

Objectives:

After completing this lesson and the accompanying exercises, you will be able to:

- determine which legal requirements enacted under GINA, ADA, and ERISA need to be considered when planning workplace wellness programs
- clarify when genetic information can be collected and how a health risk assessment (HRA) can be used
- understand the impact of the ADA's reasonable accommodation requirements and the limitations on incentives to engage in disability-related inquiries and medical examinations

- ensure that your program considers applicable state laws

Genetic Information Nondiscrimination Act: A Closer Look

On May 21, 2008, then-President George W. Bush signed the **Genetic Information Nondiscrimination Act (GINA)** into law. GINA was enacted by Congress in recognition of the many achievements in the field of human genetics, the increased use of genetic information in treating disease, and the fear of misuse of genetic information.[lxxxviii]

The benefits brought about through the decoding of the human genome are clear. They include the ability to offer predictive testing as to the likely occurrence of diseases. Such knowledge can facilitate the ability of individuals to take actions and adopt lifestyles that lower the risk of the actual onset of diseases. They also include the potential to increase the effectiveness of medicine for those suffering from disease by tailoring treatment to work in concert with their genetic makeup.

These achievements are laudable and welcome. At the same time, the public has feared that such information might be used against them as they seek employment or medical coverage. Congress enacted GINA to address these concerns by prohibiting discrimination based on genetic information[1] and restricting acquisition and disclosure of such information. This Congressional action was taken so that individuals would not fear adverse employment or health coverage-related consequences for undergoing genetic testing or participating in research studies that examine genetic information.

Statutory Framework: Title I and Title II

The statutory framework of GINA consists of two major parts of concern to those in the field of wellness:

- Title I focused on preventing discrimination in health coverage; and
- Title II focused on preventing discrimination in the employment setting.

GINA Title I sets forth rules relating to genetic nondiscrimination in health coverage. The regulatory requirements are administered jointly by the U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury. The provisions of Title I prohibit genetic discrimination in group health insurance plans, individual products, and Medicare supplement (Medigap) markets. Title I rules prohibit premiums from being set based on genetic information,[2] prohibit determining eligibility for insurance coverage or benefits based on genetic information, and place limits on the ability of health insurance plans to request or require an individual to undergo genetic testing. The collection of an individual's genetic information is also restricted.

The GINA statute directed HHS to revise the HIPAA privacy regulations, which establish requirements for uses and disclosures of protected health information. In response, HHS issued final regulations clarifying that genetic information is "protected health information" and health

[1] The EEOC defines "genetic information" as information about an individual's genetic tests and the genetic tests of an individual's family members, as well as information about the manifestation of a disease or disorder in an individual's family members (i.e. family medical history). www.eeoc.gov/laws/types/genetic.cfm.

[2] Premiums can be based on the manifestation of a disease or disorder of an individual enrolled in a plan, even if the disease or condition is deemed to be related to genetics.

insurance plans that are covered under the HIPAA privacy regulations are prohibited from using or disclosing genetic information for underwriting purposes, which include eligibility determinations, premium computations, applications of any preexisting condition exclusions, and any other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

Not Permitted by GINA Title I

- Cannot collect genetic information for underwriting purposes.
- Cannot collect genetic information prior to or in connection with health plan enrollment.
- Cannot vary premiums or contributions for entire group based on genetic information of an individual within the group.

GINA Title II is also of importance for those engaged in the development, promotion, or administration of wellness programs. It restricts employers and other entities covered by its rules from requesting, requiring, purchasing, using or disclosing genetic information except in limited circumstances.

Not Permitted by GINA Title II

- Protects job applicants, current and former employees, labor union members, apprentices, and trainees from discrimination based on their genetic information.
- Strictly limits employers and others from disclosing genetic information.
- Restricts covered entities, such as employers and third-party wellness administrators, from using, requesting, requiring, or purchasing genetic information.

Simply stated, Title II was enacted to protect job applicants, current and former employees, labor union members, apprentices, and trainees from discrimination based on their genetic information. The Equal Employment Opportunity Commission (EEOC) is the agency charged with its interpretation and administration. In other words, EEOC issues the rules and provides the guidelines that apply to GINA Title II.

Information for Purposes of Medical Treatment: Permissible Under GINA

It is possible to elicit some genetic information within GINA rules and guidelines. One such situation involves the collection and use of genetic information to determine the medical necessity of treatment and the best possible approaches to such treatment. An insurer can request and collect genetic information to determine the medical necessity of treatments in narrow circumstances such as the treatment of breast cancer.

> ***Example:*** Sally suspects she may be at risk of breast cancer, a serious illness that led to the death of her mother. She is advised by her physician to be tested for the presence of a genetic trait highly correlated to the risk of developing breast cancer. Tests indicate the presence of the gene and Sally is exhibiting symptoms of having the disease. Thus, a medical course of treatment is recommended. Sally contacts her health insurance company to understand her benefits. The insurance plan providing her health coverage may request the test results to have evidence of the medical appropriateness of the recommended treatment.

Eliciting Family Medical History: Key Issues for Wellness Programs

An individual's family medical history can be an important predictor of the type of diseases for which they have a genetic propensity. Is it likely that an individual will develop a disease such as diabetes, cancer, or possibly obesity because a parent or other close relative suffered from or is currently afflicted by the specified disease or condition? Many wellness programs wish to have this type of information so that they can help participants avoid or mitigate the onset of disease and take steps to control it once manifested.

Under the provisions of GINA, family medical history is considered genetic information. Note also that a spouse is considered a family member under GINA. If a health risk assessment (HRA) contains questions regarding the family medical history or other genetic information of the person taking the HRA, it is requesting genetic information. If the HRA is requesting health information of the individual taking the HRA, that information might be considered family medical history with respect to another individual and, therefore, genetic information. Under this view, for example, when employees and their spouses participate in HRAs under the employees' employers' wellness program, the information collected from the spouse in the HRA may be genetic information with respect to the employee. Whether or not these questions violate GINA depends upon several factors, including whether or not an incentive is being provided to the individual to complete the HRA and submit the genetic information.

Are the questions relating to family medical history and other genetic information *permitted on an HRA*?

Many of those who administer wellness programs have concluded that incentives need to be offered to motivate an employee to complete an HRA. Some types of incentives may include a prize, a reduction in premium payments, or a cash payout (e.g., $100). These incentives pose a significant question: Is a health insurance plan, an employer, or other entity covered by GINA requesting genetic information in violation of the law and regulations by offering an individual an incentive in exchange for his or her genetic information? The answer is *maybe yes* and *maybe no* depending upon how the information is sought and the format of the questionnaire itself.

If an incentive is offered for completion of an HRA, is this a request for genetic information in violation of GINA?

Fortunately, regulations have helped clarify how family medical information and other genetic information may be obtained through the use of an HRA, as well as under what circumstances spouses may participate in HRAs.

HRAs: Following GINA Guidelines

Title I and II GINA regulations help to clarify when and how health risk assessments (HRAs) can be used as part of a wellness program.[lxxxix] Generally, several guidelines establish what is permissible:

- Completion of an HRA must be completely voluntary by an individual or employee.
- HRAs that request genetic information should be given to an individual only after he or she is enrolled in a health insurance plan or product, rather than before enrollment.
- An HRA can request genetic information as long as no financial or other incentive is provided to an individual.
- A financial inducement for an individual or employee to complete an HRA can be offered as part of a wellness program if there is no request for genetic information concerning the Americans with Disabilities Act (ADA).
- An HRA may contain questions relating to family medical history or other genetic information provided its instructions are clear that the financial inducement is available whether questions relating to family medical history or other genetic information are answered. For example, there may be two parts to an HRA—one

part that asks questions unrelated to genetic information and a second part that does ask about genetic information. An individual would receive the incentive if only part one or if both parts one and two were completed. If the HRA contains questions relating to family medical history or other genetic information, the instructions must make clear which questions request this type of information.

Example Permissible HRA: ABC Employer offers $100 to employees who complete an HRA. The HRA contains 100 questions, the last 20 of them concerning family medical history and other genetic information. For example, the last 20 questions might include inquiries such as “Did your father have heart disease?,” or “Do you have a family history of colon cancer?” The instructions are written to be easily understood by ABC’s employees. These instructions inform employees that the $100 will be paid whether or not they answer the last 20 questions which deal with a family medical history and other genetic information.

Result: HRA is permissible under GINA.

Example Impermissible HRA: ABC Employer offers $100 to employees who complete an HRA. The HRA contains 100 questions. Mixed within these questions are inquiries concerning family medical history and other genetic information. The instructions simply direct employees to answer all the questions. The instructions do not make clear which questions relate to family medical history nor do the instructions make clear to the individual which questions may be unanswered without forfeiting the $100 inducement.

Result: HRA is impermissible under GINA.

Many wellness programs providers and employers have simply removed questions from HRAs seeking genetic information, rather than following the approach in the first example. Given the uniqueness of each health insurance plan’s wellness program and design, the specific facts of whether and how genetic information may be requested should be analyzed to ensure compliance with the GINA laws and regulations.

Spousal and Dependent Participation in HRAs

EEOC Title II GINA regulations confirm that employers may offer limited inducements for employees’ spouses to provide information about the spouse’s manifestation of disease or disorder as part of an HRA. The rules concerning the inducements become effective for plan years beginning on and after January 1, 2017.[xc] The regulations do not permit the collection of genetic information about a spouse or information about the manifestation of diseases or disorders in, or genetic information about, an employee’s children.

The regulations concerning spousal participation in HRA are not limited only to those HRAs that are offered in connection with the employer’s group health plan. Instead, the rules apply to all wellness programs that provide incentives in exchange for an employee's spouse providing

information about his or her manifested disease or disorders, whether or not the program is part of a group health plan. The final rule applies to all employer-sponsored wellness programs that request genetic information including wellness programs that are: offered only to spouses of employees enrolled in an employer-sponsored group health plan; offered to spouses of all employees regardless of whether the employee or spouse is enrolled in such a plan; or offered as a benefit of employment to spouses of employees of employers who do not sponsor a group health plan or group health insurance.

An employer-sponsored wellness program does not request genetic information when it asks the spouse of an employee whether he or she uses tobacco or ceased using tobacco upon completion of a wellness program or when it requires a spouse to take a blood test to determine nicotine levels. Likewise, questions about height, weight, and exercise regimes of spouses are not requests for genetic information under GINA.

For an employer to maintain a wellness program with an HRA for spouses the:

- **program must be "reasonably designed"**

  The program must have a reasonable chance of improving the health of, or preventing disease in, participating individuals, and must not be overly burdensome, a subterfuge for violating Title II of GINA or other laws prohibiting employment discrimination, or highly suspect in the method chosen to promote health or prevent disease. For example, in general, a program will not be considered to be reasonably designed if the employer denies an employee an inducement for the participation of either the employee or the spouse in an employer-sponsored wellness program because the employee's spouse has blood pressure, a cholesterol level, or a blood glucose level that the employer considers too high.

- **employer must obtain prior, knowing, voluntary and written authorization**

  In 2010, the EEOC recognized several exceptions to the general rule that employers were not permitted to collect genetic information. One of those exceptions was the voluntary provision of genetic services. The EEOC is essentially applying that exception here to permit spouses to participate in HRAs, which includes a requirement that the spouse must provide prior knowing, voluntary, and written authorization, and that authorization must describe among other things the confidentiality protections and restrictions on the disclosure of genetic information.

  With regard to GINA's confidentiality protections and restrictions, it is worth noting that the EEOC did not call for additional confidentiality and security procedures for safeguarding genetic information in its 2016 final Title II regulations. The agency acknowledged that GINA and implementing regulations already had sufficient protections. These protections include, for example, requirements that (i) genetic information needs to be maintained in medical files (including where the information exists in electronic forms or files) that are separate from personnel files; (ii) authorization is needed for certain disclosures; (iii) individually identifiable genetic information may only be provided to the individual receiving the services and the licensed health care professionals or board-certified genetic counselors involved in providing those services; and (iv) information is only available for purposes of the health or genetic services and is not disclosed to the employer except in aggregate terms.

- **incentives may not exceed the regulatory cap**

The maximum incentive that can be made available by the employer to an employee for the employee's participation in a wellness program (including other programs offered by the employer and subject to GINA) is 30 percent of the cost of self-only coverage. This maximum generally follows the incentive cap established under the ACA. The EEOC wanted the incentive cap for spouses to not be more than the maximum incentive for employees. Thus, the maximum inducement for a spouse to provide information about his or her manifestation of disease or disorder will also be 30 percent of the total cost of (employee) self-only coverage.

Under the EEOC's rules, employers may not use plan eligibility as an incentive for the spouse to provide information about the manifestation of disease or disorder. The rules expressly provide that employers will violate Title II of GINA if they deny access to health insurance or any package of health insurance benefits to an employee and/or his or her family members, or retaliate against an employee, based on a spouse's refusal to provide information about his or her manifestation of disease or disorder to an employer-sponsored wellness program.

Disease Management: GINA Compliance Following HRA Footsteps

More sophisticated wellness programs often offer disease management (DM) component as a way to improve employee well-being and lower overall health care costs. As seen elsewhere in this course, DM programs usually offer an education component about the specified disease and a series of recommended actions to prevent or limit its progress. Family history and other genetic information provided through the aggregation of HRA data can help identify areas of current and potential health concerns within employee populations. Thus, programs can be designed that address these needs including offering those at risk the opportunity to participate in DM programs. These programs also should ensure that they do not run afoul of the GINA provisions.

Example: ABC Limited establishes a wellness program. An HRA is distributed to individuals and while no financial incentive is offered for completing the HRA, an individual can be identified as being eligible for participation in a disease management program for diabetes based on genetic information.

Result: The HRA questions would likely be impermissible under GINA, absent satisfying other requirements under GINA.

Americans with Disabilities Act: A Closer Look

In devising their wellness programs, employers and their advisors should consider the potential impact of the Americans with Disabilities Act (ADA) upon plan designs. In general, the ADA prohibits discrimination against a qualified individual based on a disability. The ADA is fairly broad in its scope and covers employee hiring, advancement, discharge, compensation, and job procedures. The ADA also applies to other terms, conditions, and privileges of employment.[xci] The act was amended in 2008 to further broaden its scope and make it easier for individuals to seek protection under its terms.

The ADA, as its name implies, protects the disabled. Who is considered disabled? Once again, the scope of the act is fairly broad. A person with a disability means any person who has a physical or mental impairment which substantially limits one or more major life activities. These

major life activities include but are not limited to walking, seeing, hearing, and speaking. A disabled individual for purposes of the ADA also includes an individual with a record of such a limitation or one who is regarded as having such impairment. Examples of the types of disabilities covered by the legislation include cancer, cerebral palsy, and diabetes. Loss of limbs, speech impediments, muscular dystrophy, visual impairments, and specific learning disabilities also fall under the types of disabilities covered by the ADA.

The ADA includes two provisions that merit particular attention by those involved in the planning and design of wellness programs. These provisions are (1) the reasonable accommodation requirement and (2) the prohibition on disability-related inquiries and medical examinations.

The provisions of the ADA, like those of the Genetic Information Nondiscrimination Act (GINA), are administered and interpreted by the U.S. Office of the Equal Employment Opportunity Commission (EEOC). Its rulings, both public and private, have influenced and continue to influence the design of wellness programs regarding the ADA requirement for reasonable accommodations and prohibition of disability-related inquiries and medical examinations.

ADA Reasonable Accommodation Requirement

Some wellness programs offer awards for participating in certain activities, such as an organized exercise program, or the attainment of certain health goals, such as weight reduction. These goals are designed to be obtainable by most people in the work population. Unfortunately, these goals are sometimes unobtainable by those suffering from a disability. In these situations, the wellness program should be prepared to offer reasonable accommodations to disabled employees. Typically, this involves working with an employee to develop a reasonable alternative that satisfies the goals of both the individual and the goals of the wellness program.[xcii]

> ***Example:*** Rock Creek Hardware establishes a wellness program that offers reduced gym fees for those who participate in an organized exercise program that includes running and jumping. Melanie suffers from a health condition that limits her ability to perform these activities. Melanie and Rock Creek's wellness program manager work together to locate an exercise program centered on water aerobics. This accommodation will allow Melanie to participate in an organized exercise program that will meet the goals of Rock Creek's wellness program but also take into account Melanie's disability and physical limitations.

In many cases, the wellness program is part of, or itself, a group health plan, subject to HIPAA and the ACA. In that case, certain program requirements to earn incentives also may be more difficult for disabled persons. For health-contingent programs, the HIPAA/ACA regulations require that plan sponsors make "reasonable alternatives" available. According to the EEOC,

> *Providing a reasonable alternative standard and notice to the employee of the availability of a reasonable alternative under HIPAA and the Affordable Care Act as part of a health-contingent program would generally fulfill a covered entity's obligation to provide a reasonable accommodation under the ADA.*

It is important to note that the reasonable alternative requirement under HIPAA and the ACA applies only to health-contingent programs, and not participatory programs. But, the ADA does not make this distinction. Accordingly, a person who has difficulty completing an on-line HRA

because of a vision impairment would be entitled to a reasonable accommodation under the ADA, even if a reasonable alternative would not be required under HIPAA or the ACA.

ADA Rules on Disability-Related Inquiries

The provisions of the ADA prohibit all disability-related inquiries before an offer of employment. As a general rule, the ADA allows disability-related inquiries and medical examinations *after* a conditional offer of employment only if they are job-related and consistent with business necessity. They also are permitted in connection with voluntary wellness programs, with voluntary meaning that the employee may not be rewarded or punished for not taking part in the inquiry or examination. Otherwise, such inquiries and examinations are prohibited. This aspect of the ADA is important because it offers protection to all employees whether or not they are disabled.

What is a disability-related inquiry? A disability-related inquiry is a question or series of questions likely to elicit information about a disability. In terms of wellness programs, the prohibition must be considered when crafting questions asked on a health risk assessment (HRA) and whether or not answering the HRA is mandatory.

Here are examples of non-disability related inquiries that are less likely to be subject to ADA restrictions:

- Do you see a doctor for routine care?
- Do you take a daily vitamin supplement?
- Do you exercise weekly?
- Do you have a health care directive?
- How many servings of fruit and vegetables do you eat each day?

Disability-Related Inquiries and Medical Examinations: The Permissible Exception

The EEOC has issued guidance permitting disability-related inquiries and medical examinations provided they are answered voluntarily. This exception is important because it provides a window for HRAs that provide meaningful information and add to the effectiveness of wellness programs. It is considerable foresight, for example, not to include a wellness program designed to manage high blood pressure for a younger workforce if there is no information that this is a widespread need.

When is participation in a wellness program voluntary? In general, a wellness program is considered voluntary if employees are neither required to participate nor penalized when they do not participate.

Here are examples of disability-related inquiries. Make sure these are voluntarily answered:

- How often do you feel depressed?
- Do you suffer from asthma?
- Have you been diagnosed with cancer?
- Do you monitor your blood sugar level regularly?

- How many prescription drugs are you taking?

Permissible exceptions:

> ***Example:*** Addington Computer Services offers employer-sponsored health coverage to its employees. As part of its benefits package, Addington also offers employees the opportunity to participate in a wellness program offering discounted monthly gym rates. The amount of the insurance premium paid by Addington is the same whether or not employees participate in the wellness program. This is permissible under the ADA – the employer is not making a disability-related inquiry or medical examination, and employees are not being treated differently because of a disability or regarded as disabled.
>
> ***Example:*** Employees are offered the opportunity at a company-sponsored health fair to take a series of simple medical tests designed to measure their blood pressure and body mass index (BMI). Whether or not they take these tests has absolutely no impact on the insurance premiums they pay, and there is no other incentive relating to whether or not individuals take the test. Once again this is permissible under the ADA.

Sometimes a wellness program is designed in such a way as to be considered involuntary. The EEOC considered such situations in a series of Informal Discussion Letters.[xciii] There, an employer established a health reimbursement arrangement in conjunction with a wellness program for its employees. The wellness program included a health risk assessment (HRA) questionnaire. The employer predicated its contribution to the health reimbursement arrangement on an employee's completion of the HRA. If an employee completed the HRA, his or her account was credited by the employer. On the other hand, if the employee failed to complete the HRA no contribution was made on his or her behalf. The EEOC deemed that design to be impermissible under the provisions of the ADA – it was determined to be neither voluntary nor within the parameters of business necessity.

Since that time the EEOC has modified its position, now permitting employers to provide incentives under certain conditions to employees to take part in certain disability-related inquiries or medical examinations without violating the ADA.

ADA Conditions for Providing Incentives for Employees to Respond to Disability-Related Inquiries and Medical Examinations

EEOC ADA regulations confirm that employers may offer limited inducements for employees to respond to disability-related inquiries and medical examinations. The rules concerning the inducements and confidentiality notice become effective for plan years beginning on and after January 1, 2017.[xciv] The final regulations make clear that employers may not require employees to participate in the program as a condition for health plan eligibility. This is in response to a recent federal district court decision allowing such a plan design. Employers also cannot prevent outright access to a benefit based on participation in a disability-related inquiry or medical examination.

Just as with the GINA regulations, the ADA final rules concerning disability-related inquiries and medical examinations concerning wellness programs are not limited only to those programs that

are offered in connection with the employer's group health plan. Instead, the rules apply to all wellness programs that provide incentives to respond to disability-related inquiries and submit to a medical examination.

For an employer to incentive wellness programs with disability-related inquiries or medical examinations the:

- **program must be "reasonably designed"**

  The EEOC maintained this requirement from the proposed regulations which provide that a program cannot require an overly burdensome amount of time for participation, involve unreasonably intrusive procedures, be a subterfuge for violating the ADA or other laws prohibiting employment discrimination, or require employees to incur significant costs for medical examinations.

  In the proposed regulations, the EEOC stated that it would be unreasonable for a program to ask employees to provide medical information in an HRA without providing any feedback about risk factors. In the final regulations, it modified that position noting that such a program may still be reasonable so long as it uses aggregate information to design programs or treat any specific conditions.

- **confidentiality notice may be needed**

  For wellness programs subject to the EEOC's final regulations, an employer must provide clear notice to employees regarding what medical information will be obtained, how it will be used, who will receive it, and the restrictions on disclosure. This is to ensure voluntariness. The company could use an existing notice or a program description to deliver the same information. The EEOC soon will be providing a sample notice for this purpose.

- **incentive may not exceed the regulatory cap**

  For programs that involve disability-related inquiries or medical examinations, a 30-percent limit applies – whether or not the program is part of a group health plan. Thus, programs that do not include disability-related inquiries or medical examinations, such as attending nutrition, weight loss, or smoking cessation classes, and walking programs, are not subject to this limitation. EEOC also confirmed that there are no exceptions for de minimus or in-kind inducements.

  The percentage limitation is based on the total cost for self-only coverage – including both the employer and employee portions of the contribution toward the applicable premium. EEOC did not base the maximum on other tiers of coverage (e.g., employee and spouse, family) because the ADA's prohibitions on discrimination – including its restrictions on disability-related inquiries and medical examinations – apply only to applicants and employees, not their spouses and other dependents. Similar inquiries for spouses and other dependents raise issues under GINA.

There are four ways to calculate the limitation on the rewards, including for wellness programs that are not part of a health plan:

- When program participation depends on health plan enrollment: incentive of up to 30 percent of the total cost of self-only coverage under that health plan is permitted.
- When program participation does not depend on health plan enrollment but the employer maintains a group health plan: incentive of up to 30 percent of the total cost of self-only coverage under that plan.
- When program participation does not depend on health plan enrollment but the employer maintains more than on group health plan: incentive up to 30 percent of the total cost of the lowest-cost self-only coverage under plans offered by the employer.
- When the employer maintains no group health plan: the incentive maximum is based on the cost of the second-lowest-cost Silver Plan for a 40-year-old non-smoker available through the state or federal health care Exchange in the location that the employer identifies as its principal place of business.

The EEOC also requires that employers only receive and disclose employee medical information in connection with a covered program in aggregate form, except as is necessary to administer the plan or as otherwise permitted under the ADA. The agency notes that for programs that are subject to the HIPAA privacy and security regulations, these confidentiality requirements can likely be satisfied if the employer complies with the HIPAA rules. The EEOC advises that individuals who handle medical information that is part of an employee health program should not be responsible for making decisions related to employment, such as hiring, termination, or discipline. Employers typically avoid this concern by using third-party vendors but should take steps to make sure that the vendor has appropriate privacy policies for ensuring the confidentiality of medical information.

Employee Retirement Income Security Act: A Closer Look

The majority of working-age Americans obtain health insurance coverage as part of their total compensation package through employer-sponsored group health plans. Generally speaking, these plans must comply with the provisions of the Employee Retirement Income Security Act of 1974 (ERISA) which imposes strict standards regarding fairness and financial soundness. ERISA does not require any employer to establish a retirement or health plan. It only requires that those who do establish plans must meet certain minimum standards.

Some employers may wish to avoid dealing with ERISA requirements when it comes to their wellness programs. Other employers are less concerned about ERISA compliance and perhaps more concerned with limiting health cost increases associated with their plans.

The rules surrounding ERISA are fairly complex and employers are best advised to seek legal counsel specialized in the employee benefits area if they have questions. As a rule, a wellness program that is part of a group health plan is subject to ERISA. An employer-sponsored, stand-

alone wellness program that provides medical services could itself be subject to ERISA as an employee welfare benefit plan. In layperson's terms, if a wellness program provides benefits that have a medical element, such as nicotine patches as part of a smoking cessation program, it will probably be considered a plan subject to ERISA.

Wellness programs subject to ERISA need to take into account not only its nondiscrimination rules but also its reporting requirements such as the need to file Form 5500[xcv] (if there are over 100 participants) and the furnishing of a Summary Plan Description.[xcvi] One of the benefits of plans subject to ERISA is the preemption doctrine. Under that doctrine, in general, state laws that relate to employee benefit plans are preempted by ERISA, except to the extent such laws regulate insurance. Thus, in the case of a wellness program subject to ERISA, state laws such as the state discrimination lifestyle laws would not apply to the program.

State Lifestyle Discrimination Laws

Many states protect employees against discrimination for engaging, while away from work, in lawful activities or using lawful products even if these activities or products are unhealthy. These laws (referred to as **state lifestyle discrimination laws**) can come into play where an employer seeks to promote employee health by providing disincentives to engaging in these activities or use the products. Tobacco use has been a focal point of legal actions relying on these laws as more employers have sought to lower their health care costs by reducing the number of smokers in their workforce.

In most jurisdictions, employers can ban smoking in the workplace. When an employer attempts to control the activities of employees outside the job site, the picture becomes more controversial and can raise many legal issues. For example, an employer who may wish to ban smoking among members of its workforce may find itself in litigation because this would adversely impact the employment of smokers in the company's workforce. The employer likely would be on stronger legal footing by incentivizing non-tobacco use under a wellness program subject to ERISA.

State lifestyle laws can also complicate the hiring process. In some states it may be possible to refuse to hire smokers; in other jurisdictions, a smoker who is not hired may be able to claim discrimination or file an action under the ADA as a disabled person suffering from nicotine addiction. The bottom line, before instituting bans on legal behaviors and activities off the job, checks with legal counsel to know where your state stands and any applicable federal laws or regulations that may apply.

Summary

Now that you have had a closer look at legal requirements enacted under GINA, ADA, and ERISA, we trust you have acquired basic knowledge of rules and regulations to guide in the design and installation of your workplace wellness programs. Our discussion was intended to clarify some specifics, for example, on the collection of genetic information and how, when, and what was appropriate for employers to use in health risk assessments. We also discussed the reasonable accommodation requirements and the prohibition on disability-related inquiries before employment to make you aware of these ADA provisions. Also, we touched on state lifestyle laws that may come into play when an employer attempts to promote employee health by banning certain activities and products in the workplace. In cases where rules are complex, employers are best advised to seek legal counsel or the advice of benefits specialists if they have questions.

Prevention, Wellness, and Consumer-Driven Health Plans in a Post-Reform World

Introduction and Overview

Health care costs have risen dramatically in recent years, and employers and insurance carriers have struggled to find ways to contain them. In a survey asking employers about the greatest challenges they face in maintaining affordable health coverage for employees, "employees' poor health habits" was mentioned most often (by 67 percent of employers), and "underuse of preventive services" was third (41 percent).[xcvii]

Health conditions that are often preventable, such as heart disease, cancer, and diabetes, are responsible for seven of ten deaths among Americans and account for 75 percent of the nation's health spending. But Americans use preventive health care services at only about half the recommended rate.[xcviii] And many have unhealthy lifestyles. A recent survey found that employees know how to get healthy but aren't necessarily taking action. Asked how well they do with getting exercise, just 22 percent said "great." Interestingly, 75 percent said workers who practice healthy behaviors should pay less for their health coverage.[xcix]

This situation has led to the introduction of incentives to encourage healthier behaviors by employees and health plan enrollees. Often referred to as "wellness programs," these incentive programs take many different forms, from promoting preventive care use and providing a gym at the workplace to linking health care benefits or discounts to certain healthy lifestyles. For example, in Arkansas state employees who exercise more frequently or eat healthier foods can earn up to three extra days off from work each year.[c] These healthy lifestyle programs can include requirements for no tobacco use and certain cholesterol, blood pressure, or body mass index (BMI) measurements. For example, Scotts Miracle-Gro, a lawn care company, has a policy that any smoking by employees, whether on or off the job, would result in termination of employment.[ci]

Approximately 30 years after the first health maintenance organizations, a new concept was introduced that encourages more involvement of employees in their health and their health care spending. The "consumer-driven" or "consumer-directed" model attempts to align financial incentives and consequences by making individuals more financially responsible for their care so that they will generally have more of a personal interest in maintaining good health. The theory suggests that these individuals will also be more involved in taking steps to improve their health, helping prevent the costs associated with chronic illnesses.

Consumer-driven health plans paired with health savings accounts (HSAs) and health reimbursement arrangements (HRAs) are generally used to provide the financial incentives for maintaining one's health, especially when the individual is rewarded by being able to keep the money he or she does not spend. Many companies are combining these plans with wellness and prevention programs to support employees in taking steps for healthier lifestyles.

The Affordable Care Act (ACA), often referred to as health care reform includes several provisions designed to encourage Americans to maintain their health. These provisions:

- require coverage of clinical preventive care services under health insurance plans
- regulate employer-sponsored wellness programs that provide financial incentives to employees to improve or maintain their health

- allow insurance companies to charge individuals who use tobacco products a higher premium than non-users

Coverage of Preventive Services

Before ACA, federal law did not require employer group health plans and private health insurance carriers to cover preventive services. But as of September 23, 2010, all health plans (except for those with grandfathered status, which are exempt) must cover certain preventive services without any cost-sharing. Specifically, these rules apply:

- Coverage of clinical preventive services recommended by the U.S. Preventive Services Task Force (USPSTF)[cii] and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) is required.[ciii]
- Most or all cost-sharing associated with the use of effective clinical preventive services and immunizations is prohibited.

The types of preventive services health plans must cover depend on the insured's age but generally include the following:

- routine vaccinations
- well-baby and well-child visits
- blood pressure, diabetes, and cholesterol tests
- other screenings and diagnostic tests
- counseling from a health care provider on such topics as quitting smoking, losing weight, eating better, treating depression, and reducing alcohol use

Preventive Services for Children

The regulations require that plans cover the following preventive services for children:

- Well-baby and well-child visits up to age 21. These visits must include a comprehensive array of preventive health services, including:
  - physical exam, including height, weight, and body mass index measurements
  - vision and hearing screening
  - oral health risk assessments
  - assessments to identify any developmental problems
  - other screenings and diagnostic tests
  - counseling and guidance from the doctor about the child's healthy development.

- Screenings for newborns, including screenings for hemoglobinopathies, sickle cell anemia, phenylketonuria (PKU), congenital hypothyroidism, and hearing problems, as well as gonorrhea preventive medication for the eyes of all newborns.

- Screenings and counseling for children of all ages to prevent, detect, and treat childhood problems.
  - obesity
  - high blood pressure
  - dyslipidemia, for children at higher risk of lipid disorders

- hematocrit or hemoglobin disorders
- anemia
- iron supplements for children ages six to twelve months at risk for anemia
- lead screening for children at risk of exposure
- tuberculin testing for children at higher risk of tuberculosis
- developmental screening for children under age three and surveillance throughout childhood
- dental cavities
- oral health risk assessment for young children
- fluoride chemoprevention supplements for children without fluoride in their water source
- vision
- behavioral assessments
- autism, for children at 18 and 24 months
- depression, for adolescents at higher risk
- alcohol and drug use
- cervical dysplasia, for sexually active females
- sexually transmitted infections, for adolescents at higher risk
- HIV, for adolescents at higher risk

- Immunizations for the following illnesses (doses, recommended ages, and recommended populations vary): diphtheria, tetanus, pertussis, Haemophilus influenza type b, hepatitis A, hepatitis B, human papillomavirus, influenza, measles, mumps, rubella, meningococcus, pneumococcus, poliovirus, rotavirus, and varicella.

Preventive Services for Pregnant Women

The regulations require that plans cover the following services for pregnant women:

- screening for conditions that can harm pregnant women or their babies, including anemia, hepatitis B, Rh incompatibility (including follow-up testing for women at higher risk), bacteriuria, urinary tract and other infections, tobacco and alcohol use, and syphilis

- special, pregnancy-tailored counseling from a doctor to help pregnant women quit smoking and avoid alcohol use

- counseling to support breast-feeding and help nursing mothers

Preventive Services for Adults

Plans must cover the following preventive services for adults:

- Screenings for:

- abdominal aortic aneurysm (one-time screening for men of specified ages who have ever smoked)
- alcohol misuse (and counseling)
- high blood pressure
- high cholesterol, for adults of certain ages or at higher risk
- colorectal cancer, for adults over 50
- depression
- Type 2 diabetes, for adults with high blood pressure
- obesity, including counseling
- diet counseling for adults at higher risk for chronic disease
- aspirin use for men and women of certain ages
- tobacco use, including cessation interventions for tobacco users
- sexually transmitted infections, including counseling for adults at higher risk
- HIV, for all adults at higher risk
- syphilis, for all adults at higher risk

- Immunizations for the following illnesses (doses, recommended ages, and recommended populations vary): hepatitis A, hepatitis B, herpes zoster, human papillomavirus, influenza, measles, mumps, rubella, meningococcus, pneumococcus, tetanus, diphtheria, pertussis, and varicella

Additional Services for Women

Preventive services for women must be covered by health plans, including:

- BRCA counseling about genetic testing for women at higher risk
- breast cancer mammography screenings every one to two years for women over 40
- breast cancer chemoprevention counseling for women at higher risk
- cervical cancer screening for sexually active women
- chlamydia infection screening for younger women and other women at higher risk
- folic acid supplements for women who may become pregnant
- gonorrhea screening for all women at higher risk
- osteoporosis screening for women over age 60 depending on risk factors
- tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- syphilis screening for all pregnant women or other women at increased risk

Other Preventive Services

Other services may be added when the final regulations are released. Employer plans and private insurance plans may cover additional preventive services at their discretion, even if they are not recommended services.

Cost Sharing

Health plans may impose cost-sharing for some preventive services if:

- they are delivered by out-of-network providers
- they are not mandatory services but additional services that the plan chooses to cover

It is not yet clear whether employer group health plans and health insurance plans may utilize "value-based insurance designs" that apply cost-sharing or other financial incentives to encourage the use of services that have clinical benefits exceeding their costs while discouraging the use of services when the expected clinical benefits do not justify the costs. The HHS Secretary is permitted to develop guidelines to allow plans to apply value-based designs to preventive services, but these have not yet been issued.

Workplace Wellness

As employers and insurers have struggled with rising health care costs, there has been significant interest in reducing these costs by incentivizing healthy behaviors through wellness programs. As we have seen, these programs take many forms, from providing a gym at the workplace to linking health care benefits or discounts to certain healthy lifestyles. Wellness programs can include education, weight management programs, smoking cessation programs, health risk assessments, health screenings, stress management, personal coaching, and a variety of related programs.

However, an employer-provided wellness program raises potential discrimination issues since, if the employer obtains information about a health condition, there could be an impact not only on the provision of insurance but also on employment.

HIPAA Nondiscrimination Rules

Wellness programs offered by employers may be subject to several federal laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA created certain nondiscrimination requirements, one of which prohibits employers and health insurance carriers offering group health plans from denying coverage based on health-related factors, such as:

- health status (physical or mental)
- claims experience
- receipt of health care services
- medical history
- genetic information
- evidence of insurability
- disability

HIPAA also prohibits group health plans from charging individuals a higher premium or contribution-based any of these health-related factors compared to other individuals who are "similarly situated." However, HIPAA regulations "do not prevent a group health plan and a health insurance issuer from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention (i.e., wellness programs)."[civ]

HIPAA regulations divide wellness programs into two categories. The first either does not offer rewards or provides rewards based solely on participation, *not* on the meeting of goals or standards related to behavior or health status. Such wellness programs are considered not discriminatory if they are made available to all similarly situated individuals. A reward can take the form of:

- a discount or rebate on a premium or contribution
- a waiver of all or part of a cost-sharing payment (deductible, copayment, or coinsurance)
- the absence of a surcharge
- the value of a benefit that would otherwise not be provided under the plan (such as a prize)

Example: Company A offers all full-time employees $500 towards the cost of a fitness center membership. Company B gives a $10 gift card to any employee who attends a monthly health education seminar. Company C reimburses all full-time employees for the cost of smoking cessation programs, whether or not they quit smoking.

The second type of wellness program under HIPAA provides a reward based on an individual meeting a certain standard relating to a health factor (such as quitting smoking or keeping body mass index below 30). This type of program must meet these requirements:

- 20 percent limit

  The reward cannot exceed 20 percent of the cost of employee coverage under the health plan. If dependents (such as spouses or children) participate in the wellness program, the reward cannot exceed 20 percent of the total cost (employer plus employee share) of the family coverage in which an employee and any dependents are enrolled. The 20 percent limit was designed to prevent a reward or penalty being so large that it had the effect of denying coverage or creating a heavy financial penalty on individuals who do not satisfy an initial wellness program standard.

- Program purpose

  The program must be “reasonably designed to promote health or prevent disease.” A program satisfies this standard “if it has a reasonable chance of improving the health of or preventing disease in participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease.”[cv] The preamble to the final regulations states that there does not need to be a scientific record that the method used in the program promotes wellness.

- Annual basis

  The program must allow eligible individuals to qualify for the reward at least once per year.

- Availability

  The reward must be available to all similarly situated individuals. Programs must also offer a "reasonable alternative standard" (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom it is "unreasonably difficult" because of a medical condition to satisfy the otherwise applicable standard or it is "medically inadvisable" to attempt to satisfy the otherwise applicable standard. While the regulations provide no guidance as to what constitutes "unreasonably difficult" or "medically inadvisable," the plan may seek verification (such as a statement from an individual's physician). In all materials describing the terms of the program, the availability of a reasonable alternative standard (or the possibility of a waiver of the otherwise applicable standard) must be disclosed.

Changes Made by ACA

ACA codifies the previous wellness program regulations under HIPAA and establishes reporting requirements for plans and insurance carriers that implement wellness and health promotion activities. ACA also established federal grant programs to assist employers in establishing and evaluating workplace wellness programs. And perhaps the biggest change made by ACA is permitting larger rewards for employees who meet specified health standards. ACA raises the cap on the allowed value of rewards from 20 to 30 percent of the cost of coverage. Furthermore, the law gives discretion to the Secretaries of HHS, Labor, and the Treasury to increase this cap on reward value up to 50 percent.

ACA requires the HHS Secretary to develop reporting requirements for employer group health plans and health insurance carriers regarding their "wellness and health promotion activities." These activities may include personalized wellness and prevention services "that are coordinated, maintained, or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness, or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic, or web-based intervention efforts for each of the program's participants."[cvi] These activities could include wellness and prevention programs such as smoking cessation, weight management, and healthy lifestyle support. Health plans will be required to annually submit to their enrollees (and the Secretary) a report on whether their programs and benefits meet criteria established by the Secretary.

Tax Treatment of Wellness Benefits

An employer's costs in creating or administering a wellness program may generally be deducted from its taxable income as a business expense. However, the value of a wellness benefit may be taxable to an employee depending on the circumstances. Amounts received by employees under an employer-provided group health plan are excluded from employees' gross income, but only if they are provided for medical care. While "medical care" includes health insurance premiums paid by employers, the IRS has issued regulations indicating that benefits that only promote general health do not qualify as "medical care" for these purposes. Some workplace wellness benefits (such as high blood pressure screenings or vaccinations) would likely qualify as medical care because they serve a diagnostic or preventive function. But other types of benefits (such as discounts on commercial gym memberships) might not qualify. The value of nonqualified benefits must be included in the employee's gross income even if they were provided in the context of an employer-provided health plan.

One way for employers to avoid including the value of wellness program incentives in employees' gross income is to make contributions to employees' health savings accounts (HSAs) and health reimbursement accounts (HRAs) instead of offering cash benefits. The IRS allows companies that offer wellness programs to make contributions to employees' HSAs based on their participation in a wellness program. If an employer offers to make these contributions, it must offer comparable amounts in cash to employees that choose not to participate. The cash is taxable as income.

Example: Canyon Company wants to encourage every employee to complete a health risk assessment as part of its wellness program. For employees who participate in an HSA, the company offers a $100 HSA contribution, and this money is excluded from their wages and not taxed. For employees without an HSA, the company offers $100 cash, but this money is taxable as wages.

Employers making HSA contributions as a way to provide financial incentives must remember to take into account the rules governing employer contributions to employees' HSAs. Failure to satisfy the comparability rules can subject an employer to an excise tax. Similarly, there are tax penalties that apply if an employer does not meet the nondiscrimination rules.

Wellness Programs and CDHP Eligibility

In general, employees enrolled in consumer-driven health plans coupled with a health care flexible spending account (FSA) or an HRA do not have to worry about their participation in the wellness program creating any eligibility problems. However, to be eligible for an HSA an individual must be enrolled in a qualified high-deductible health plan and not enrolled in another medical benefit plan. Therefore, eligibility for an HSA can be compromised if an individual participates in a wellness program that provides "significant benefits in the nature of medical care or treatment."[cvii]

What does the IRS consider "significant benefits"? The IRS has stated that employers can provide the following services without providing "significant benefits" to employees:[cviii]

- physicals and immunizations
- injecting antigens provided by employees (such as performing allergy injections)
- a variety of aspirin and other nonprescription pain relievers
- treatment for injuries caused by accidents on site

Higher Premiums for Tobacco Users

Under ACA, as of January 1, 2014, all health insurance plans (both group plans and individual policies and including grandfathered plans) will be prohibited from charging individuals different premiums based on health factors. One exception will be allowed: A tobacco user can be charged up to 50 percent more than a non-user for identical coverage. (Health plans will also be allowed to vary premiums by age, locality, and family size).

Also, lower-income Americans who qualify for premium subsidies (those with income below 400 percent of the federal poverty level) will not receive greater subsidies because they are paying higher premiums as tobacco users. These people will pay more out of their own pockets for coverage than non-users. These rules will likely encourage some people to stop using tobacco, and this should stimulate demand for smoking cessation programs to be included in wellness programs. Screening for tobacco use during physician office visits for preventive care services will also be important.

It appears that the return on employer investment in smoking cessation programs is large, with studies estimating that an employer could save $5,000 to $6,000 each year in medical costs and productivity. And employers see the worth of these programs—in one survey 96 percent say that it would be beneficial to have such a program. Nonetheless, only 20 percent of employers in the survey offered programs with all four of the criteria recommended by the CDC.[cix]

Summary

The Affordable Care Act (ACA) affects wellness programs in three main ways:

- ACA requires health insurance plans (except grandfathered plans) to cover an extensive list of preventive health care services. No cost-sharing may be charged for preventive services unless they are provided out of the network or are not on the required list.
- ACA modifies the regulation of wellness programs to allow higher rewards, and it establishes grants and reporting requirements for programs.
- ACA will (as of 2014) prohibit any health insurance plan from charging a higher premium based on health factors except for tobacco use.

Healthy Aging: Shifting the Paradigm from Treating Disease to Aging Well

Introduction

Aging—we do it every day. Some of us do it gracefully and embrace the process. Some exert great energy to keep it from happening. And others give it no thought at all and are surprised when it sneaks upon them with a jolt (as when they need to replace a knee or are diagnosed with Type 2 diabetes). Like it or not, aging is an ongoing process every day we breathe.

Today the United States (and indeed much of the industrialized world) is being forced to confront the issues of aging, as an increasing portion of its citizens become eligible for social services and benefits associated with the senior years. In the U.S. the key programs include Medicare and Social Security. Our national discussion has been brought about in great part by the intersection of two dynamics—the approach of the Baby Boom generation to retirement and a government deficit on a dangerous trajectory.

Decisions made during the ensuing political debate are likely to impact companies and their workers. Higher taxes, increased fees for Medicare, and changes in Social Security eligibility are all possible outcomes. One thing is certain—employers and their workers can be part of the solution by taking steps today to maintain and improve health through wellness programs.

Objectives:

After reading and reviewing this lesson and completing the accompanying exercises, you will be able to:

- understand the nation's financial challenges concerning funding Social Security and Medicare as Baby Boomers become eligible for benefits
- recognize possible solutions to the funding crisis, including the role of wellness programs in taming the Medicare cost curve
- define theories about healthy aging, such as the compression of morbidity, and know why it may be possible to postpone infirmities associated with chronic diseases
- broaden your knowledge about the steps individuals can take to pursue active life expectancy
- determine what health care reform will mean for Medicare, seniors, and wellness

Financial Challenges of an Aging Population

Determining how we reached this point can be better understood by taking a closer look at the American population and Medicare. Today, the population can be divided into five generations and an upcoming sixth, commonly referred to by these names:

- the GI Generation
- the Silent Generation
- the Baby Boom Generation
- Generation X
- Generation Y (or Millennials)
- the upcoming Generation Z

A Generational Primer

The GI Generation - These individuals grew up during the Great Depression of the 1930s. Many of its members served in World War II and were involved in large and successful public undertakings in the post-war period, such as the construction of the interstate highway system and the space program, so it is often called “the Greatest Generation.” Many of this generation have died, decreasing the size of the group, and those remaining are entering the ranks of what has been termed the “old-old”—those in their mid-eighties and beyond.

The Silent Generation - This age cohort is relatively small, as its members were born during the Great Depression or World War II when birth rates were low. Sometimes called “the Lucky Few,” these people entered the workforce during the post-war economic boom and later experienced the cultural upheavals of the 1960s and 1970s.

The Baby Boom Generation - Members of this generation were born in the years after World War II when birth rates soared, and they are the largest age group in the American population, estimated at 78 million. It is sometimes split into two subsets, those born from 1946 through 1954 and those born from 1955 through 1964, to reflect slightly different experiences in early adulthood. Many male members of the earlier group served in the Vietnam War, and female members experienced the beginnings of the movement for gender equality. Later Baby Boomers saw the end of the war and the draft and entered a workplace that was starting to adjust to demands for diversity and gender equality. Older Baby Boomers are at or near traditional retirement ages, and this is being taken into account in efforts to reform entitlement programs.

Generation X - Gen Xers were born in the later 1960s and the 1970s. The cohort is smaller than both the preceding Baby Boom Generation and the following Generation Y. While there was economic stagnation in the 1970s, by the time these people entered the workforce in the 1980s and 1990s the economy had rebounded. Members of this generation are actively engaged in the debate on the deficit and are likely to be impacted by the decisions made to bring it under control.

Generation Y - Members of this generation were born in the 1980s and 1990s, the decades leading up to the Millennium, and so are also called the Millennials. They grew up during a period of relative prosperity but are now entering the workforce during more turbulent economic times. Members of Generation Y, while not as actively engaged in the deficit debate as Gen Xers and with less access to the levels of power, will also be impacted by the decisions made.

Generation Z - The children now being born and raised are sometimes called Generation Z. Some commentators mark the end of the Millennial generation and the beginning of Generation Z at the terrorist attacks of 2001, while others place it in 2005.

Currently, members of the GI and Silent generations are old enough to qualify for a wide range of social services and benefits, including Social Security retirement benefits and Medicare health benefits. The nation can pay for these benefits for these two age groups in part because of the Reagan era changes that broadened the tax base for funding them and in part because of

the decreasing numbers of the GI Generation and the relative smallness of the Silent Generation.

However, this situation is about to change with the oncoming tsunami of roughly 78 million Baby Boomers becoming eligible for Social Security and Medicare. An in-depth discussion of Social Security is outside the scope of this course, but briefly, many experts feel its finances are an easier problem to solve. Solutions discussed include raising the eligibility age (perhaps to 70) and reducing benefits (perhaps through a change in the adjustment for inflation). Medicare is considered a more difficult problem because of the continual rise of medical costs. And it is here that wellness programs offer one solution. But before we look at the role of wellness in taming the Medicare cost curve, let us examine the basics of Medicare funding.

The Cost of Poor Lifestyle Choices

Data compiled by the U.S. Centers for Disease Control and Prevention (CDC) indicate that approximately 75 percent of the nation's health care costs stem from chronic diseases—many of which are preventable because they are often the result of personal lifestyle choices.[cx]

Let the Statistics Do the Talking

Over one million Americans die prematurely each year because of unhealthy lifestyles including tobacco use, obesity, lack of exercise, and alcohol abuse. The importance of taking steps to curb the rising incidence of chronic diseases and looking for new ways to treat them is particularly important given the entry of the Baby Boom Generation into their senior years. It is estimated that 35 million of them already suffer from at least one chronic health condition.[cxi]

Medicare: What It Is and How It Is Funded

Medicare is a federal health care benefits program for people 65 or older (as well as those with severe long-term disabilities and a few others). It was signed into law by President Lyndon Johnson in 1965 as part of amendments to the existing Social Security Act. The program guarantees a standard set of benefits to those eligible to participate regardless of their health status.

Traditionally Medicare consisted of two parts (together referred to as Original Medicare). Medicare Part A (Hospital Insurance) covers inpatient hospital care, hospice care, and if certain restrictive conditions are met skilled nursing facility care for a limited time. Medicare Part B (Supplementary Medical Insurance) covers medical services and products provided by physicians and other health care practitioners and hospital outpatient care. If restrictive conditions are met, home health care may be covered for a limited time under either Part A or Part B.

More recently the Medicare Advantage (MA) program (Medicare Part C) was created. It gives Medicare beneficiaries the option of receiving Part A and Part B coverage, as well as some other benefits, from Medicare-approved private-sector health insurance plans instead of directly from the government. And in 2006 a prescription drug benefit program, Medicare Part D, became available. Medicare beneficiaries choose whether to participate in Part D and those who do pay an additional monthly premium. Part D benefits are provided by Medicare-approved private-sector prescription drug plans (PDPs) and by most MA plans.

Medicare Part A is financed primarily by a payroll tax levied under the Federal Insurance Contributions Act (FICA). The rate is 2.9 percent, half of which (1.45 percent) is paid by the worker and the other half by the employer. The self-employed pay the whole 2.9 percent themselves. Revenue from this tax is credited to the Hospital Insurance Trust Fund, which pays Part A benefits and administrative costs and makes other authorized expenditures.[cxii] Only a few people pay a premium for Part A—essentially those who did not pay the payroll tax while they were working.

Medicare Part B is funded differently. While enrollment in Part A is basically automatic, individuals choose whether to enroll in Part B and must pay a premium for it. Most people—those with annual income at or below $85,000 (individual) or $170,000 (couple)—pay the standard premium ($115.40 in 2011), while those with greater income pay higher amounts based on their income.[cxiii] Premiums cover about one-quarter of the program's outlays, with general revenues making up the rest. Medicare Part D works similarly—enrollees who choose to enroll pay premiums, which cover roughly one-quarter of costs.[cxiv] Medicare Advantage plans receive payment from the federal government for providing Medicare coverage, and they also charge their enrollees premiums for Part B and Part D coverage and other benefits.

Medicare beneficiaries generally must make significant cost-sharing payments. Part A, Part B, and Part D all have deductibles and coinsurance or copayments. Medicare Advantage plans have their cost-sharing structures, which may differ from Original Medicare.

The Affordable Care Act (ACA) will increase the Medicare payroll tax for high-income individuals beginning in 2013. Those with annual employment earnings above $200,000 (individual) or $250,000 (couple) will pay a higher Medicare employment tax rate on their earnings above that level (2.35 percent instead of the usual 1.45 percent). The employer contribution (1.45 percent) will not be increased. These thresholds will not be adjusted for inflation, so over time, more people will be liable for this increased rate. There will also be a 3.8 percent Medicare tax on unearned income (investment income such as interest, dividends, and capital gains) of high-worth individuals, estates, and trusts. For individuals, this tax will apply to net investment income or to modified adjusted gross income (MAGI) in excess of $200,000 (individual) or $250,000 (couples), whichever is less.

The Wide Net of the Medicare Payroll Tax

We have seen how workers and their employers partially finance Medicare through payroll taxes. It is important to note that this 2.9 percent FICA tax has a wide base. It is levied on an individual's entire salary and other compensation earned in connection with employment. There is no salary cap. The more one earns, the more that one pays (and under ACA, if income rises above a certain level, a higher rate is paid). This differs from the Social Security tax, which is imposed only on compensation up to an annual cap ($106,800 in 2011, adjusted annually).

A Pay-As-You-Go System

Medicare, like Social Security, was designed as a pay-as-you-go system. In other words, the dollars workers pay into the system today fund the benefits provided to workers who are now retired. This design works successfully when many workers are supporting a few retirees. But as longevity has increased, the number of Medicare beneficiaries has risen, and as a result, the ratio of workers paying into the system to the people drawing benefits from it is shrinking.

Currently, approximately 3.5 workers are supporting each Medicare beneficiary, but by 2030 there will be just 2.3 (as the program is now structured).[cxv]

The Pyramid Teeters

Medicare and Social Security are financially structured as pyramids. A small number of beneficiaries at the pyramid's pinnacle are supported by a larger number of workers at its base. But this pyramid is currently changing its shape. The number of workers is decreasing in relationship to the number of beneficiaries—the bottom of the pyramid is getting smaller and the top is getting larger, making the structure less stable.

The Tsunami Comes into Sight

The early edge of the Baby Boom has just begun to reach the Medicare system. The entry of approximately 78 million people over the next 20 years could overwhelm the program. A record 2.8 million individuals will qualify for Medicare in 2011, and this figure is set to rise to approximately 4.2 million by 2020. And it is projected that by 2030 Medicare will grow to cover 80 million people, compared to roughly 47 million today.[cxvi]

Because of these demographic changes and the steady rise of health care costs, society's ability to adequately fund Medicare is eroding. Possible solutions to this impending problem include the following:

- **Reducing federal subsidies**
  The government would pay less than the current 75 percent of costs, meaning that beneficiaries would pay higher premiums.

- **Adopting a premium support (voucher) system**
  The government would provide a fixed amount of money to each elderly person, which he or she would use to buy health coverage. This amount would not cover the entire cost of coverage, and seniors would have to pay a substantial portion themselves.

- **Increasing cost-sharing**
  Medicare deductibles, coinsurance, and copayments would be raised, increasing out-of-pocket costs to beneficiaries.

- **Encouraging a shift to consumer-directed health plans**
  This would enable younger workers to prefund higher retirement Medicare costs.

Healthy Living to the Rescue: The Compression of Morbidity

Much of what we have covered thus far about Medicare is disheartening—from the spiraling health care costs to a public sector program seemingly out of control. What if there were a way to change the trajectory of those costs that would benefit the Medicare cost structure, the private sector health system, and the individual participant?

Dr. James Fries and his followers believe there is an answer. The Fries' theory, known as **compression of morbidity**, posits that if the age when an individual first experiences chronic infirmity can be postponed more rapidly than the age of death, then an individual's lifetime illness can be compressed into a shorter period nearer to the age of death. In other words, if they are watchful of their health, individuals can experience more years of active living and fewer years of impaired and debilitated from chronic diseases, such as heart disease or diabetes.

Think about two points on a typical human lifespan—the first point being the time when a person becomes chronically ill, and the second point representing the time at which the person dies. Let us assume that the usual distance between those two points is 20 years. In the beginning, the chronic disease causes relatively minor distress. As time goes on, however, the scope of the disability increases requiring increased use of medical care. Let us further assume that instead of the chronic illness becoming apparent 20 years before death, it manifests itself just five years before death. This would minimize the number of years the individual suffers from a chronic disease. It also is likely to translate into less need for care and lower medical outlays. Simply put, by avoiding long-term periods of sickness (morbidity), we can reduce health care costs and improve the lives of individuals at the same time.[cxvii]

The theory of healthy aging was proposed by Dr. Fries in 1979 during a sabbatical year at the Center for Advanced Studies and Behavior Sciences.[cxviii] Subsequent studies have confirmed its validity. The best known early study followed a group of alumni from the University of Pennsylvania for 20 years. Researchers found that the cumulative lifetime disability was four times greater in those who smoked, were obese, and/or failed to exercise compared to those who did not smoke, were lean, and followed a course of exercise. The onset of a chronic disability was postponed by nearly eight years in the lowest-risk third of the study group compared to individuals who fell into the highest risk category.[cxix]

A second longitudinal study supported these results. It involved members of a runners club and compared their health experiences with other members of their community. On average, the participants were 59 years old, around the age of leading-edge Boomers today. This study found that the runners developed disability at a rate of only one-forth that of the community participants serving as the control group. The runners were able to postpone the onset of disability by more than 22 years over their more sedentary counterparts in the control group.[cxx]

To re-emphasize, the compression of morbidity rests on two pillars. First, by following a course of healthy living that includes attention to diet, exercise, and other preventive measures, an individual can delay the onset of chronic disease. Second, the increases in longevity due to this pattern of healthier living would be comparatively modest. Yet the potential financial savings brought about by healthy aging are enormous—for individual families and company plans covering seniors, as well as government-sponsored programs such as Medicare. The following case study provides a comparative view.

Case Study – A Tale of Two Approaches to Living

Sally and Mary are neighbors and senior citizens aged 70. Assume both will live to age 90. Sally takes long walks with her dog every day although she has a minor case of arthritis. This exercise keeps Sally fairly limber and allows her to live independently and participate in other activities she enjoys. At aged 88, Sally begins to notice that walking is becoming increasingly difficult and that she is experiencing other health difficulties requiring her to take daily prescription medications for heart disease. At the time of her death, Sally has experienced just three years of severely diminished physical capabilities. Although the care she received was costly in those closing years, she had

enjoyed roughly 17 active years in the twilight phase of her life. The dollars spent on her care were far less than they would have been had the severe ravages of chronic disease manifested itself earlier.

Mary follows a different trajectory. She never liked walking or other forms of exercise and decided to rely on the car once she reached aged 70. Rather than garden or walk the dog herself, Mary decided to hire workers to do those chores. Just a few years later, at age 74, Mary began developing shortness of breath. A visit to the doctor confirmed that Mary was beginning to suffer from heart disease and elevated blood sugar. Mary was willing to take medication for her heart but found the recommended diet too limiting in the choices it offered. Two years later at 76, Mary had a confirmed case of Type 2 diabetes. At this point, Mary took her diet more seriously but refused to enroll in a fitness program specifically aimed at seniors. As time went by, Mary found it increasingly difficult to leave the house and participate in activities that she enjoyed such as shopping or going to the theatre. At age 84, Mary was rushed to the hospital as gangrene brought about by her diabetes spread from her foot forcing doctors to amputate her leg. By the time she died at age 90, Mary had spent roughly 16 years battling chronic illness. She and her family had spent thousands of dollars on her care as had the Medicare program.

Active Life Expectancy

A term frequently used to describe the compression of morbidity is **active life expectancy**. The National Institute on Aging refers to the concept in its mission to support healthy aging by preventing or delaying the onset of chronic disease and the ensuing debilities which can rob individuals of their ability to engage in the activities of daily living and an independent lifestyle.[cxxi]

Steps to Healthy Aging

There is an opportunity to encourage healthy aging through the implementation of wellness programs. Employers and wellness administrators can be part of this solution by sponsoring such initiatives. By taking advantage of wellness activities offered at work, employees can also help lower the health care cost trajectory and benefit from improved personal health. (Those not currently employed can be part of the solution, too, by consciously assuming responsibility for their health and well-being.) The National Institute on Aging recommends five steps individuals can take to pursue active life expectancy. These steps are:

- get moving
- pay attention to weight and body shape
- think about food choices
- participate in enjoyable activities
- take an active role in personal health care

Step 1 – Get Moving

Emerging scientific evidence suggests that people who exercise not only live longer, they live better. Balance exercises can help prevent falls. Strength exercises build muscle and reduce the risk of osteoporosis. Flexibility or stretching exercises can limber up the body and provide individuals with the greater freedom of movement needed for everyday activities.

Exercise can even be a tonic for those already suffering from chronic conditions. The Arthritis Foundation promotes tai chi as a way to relieve stiffness, allowing individuals suffering from

arthritis to remain active and avoid the weight gain that puts pressure on joints causing further deterioration. By remaining active, individuals can avoid atrophied muscles that can rob one of the ability to walk. Exercise also helps people with diabetes control their blood sugar levels, and it can play a role in lowering high blood pressure.

Dancing, walking, swimming, and bicycling are all forms of exercise that build up endurance and improve an individual's breathing function. Gardening involves the individual in a whole series of activities that combine strength and endurance, such as bending, stretching, lifting heavy bags of mulch, and walking a lot if one mows the lawn.

Desk Jockeys – Don't Despair

Have you spent much of your life behind a desk—at school and then at work? Have you put off exercise as you raised your family? Do you now find yourself facing the so-called golden years overweight and out-of-shape? Don't despair. People who begin exercise training later in life, whether it be at age 60 or 70, can also experience improved health including improved heart function.[cxxii]

Step 2 – Pay Attention to Weight and Body Shape

Most of us know that being overweight is not a good thing. There has certainly been enough media coverage on the dangers of unhealthy weight gain for the public to know that more than cosmetic issues are involved. As we will see in other lessons, being overweight or obese can lead to serious health risks for Type 2 diabetes, heart disease, and high blood pressure, to name a few weight-related conditions.

When it comes to weight gain, a "pear" shaped body (body fat deposited around one's hips and thighs) is generally considered less risky to health than an "apple" shaped body (large weight gain around the waist area). An "apple" shaped physique is considered a danger sign linked to increased risk of heart disease and possibly breast cancer.[cxxiii]

What Is Considered Overweight? Obese?

Individuals with a body mass index (BMI) of between 25 and 29.9 are generally considered to be overweight. Individuals with a BMI equal to or greater than 30 are generally considered to be obese.[cxxiv] To calculate BMI, the formula requires converting height to meters and weight to kilograms. BMI = height/weight squared. For example, someone who is 5 feet 5 inches tall (1.67 meters) and weighs 150 pounds (68 kilograms) has a BMI of 68/(1.67 x 1.67) = 24.4.

For an easy-to-use BMI calculator, go to http://bmi.emedtv.com/bmi-calculator/bmi-calculator.html.

Step 3 – Think About Food Choices

Remember the saying "You are what you eat"? It turns out to be true when it comes to one's health. Food can either support healthy aging or it can lead to health problems. Fruits, vegetables, fish, and nuts contain nutrients that can boost immunity against certain cancers and help protect the cardiovascular system. On the other hand, food groups containing saturated fat are prime suspects when it comes to increasing the risk of age-related disease.

As for unhealthy weight gain, food choice certainly plays a role. Participants in the Baltimore Longitudinal Study of Aging who maintained a diet of “meat and potatoes” experienced a greater annual increase in BMI compared to those who chose a regular diet of high-fiber cereal, reduced-fat dairy, along with heavy helpings of fruit.

Employers who want to provide employees with a source of guidance about healthy eating or learn more can visit www.MyPyramid.gov. Developed by the United States Department of Agriculture (USDA), the website offers personalized food plans and tools to help individuals assess their menu choices. It also offers current reports on dietary guidelines and recommendations in other areas, such as physical activity based on age, sex, current weight, and height.

Step 4 – Participate in Enjoyable Activities

Participating in activities one enjoys can be good for both mental and physical health. Again, the Baltimore Longitudinal Study on Aging provides promising guidance. According to its findings, people who are sociable, generous, and goal-oriented have higher levels of personal satisfaction and lower levels of depression than their counterparts who do not possess these attributes. Researchers also found that preserving brain power by reading, participating in board games, and playing a musical instrument are factors in reducing the risk for dementia.[cxxv] If one likes to dance, take a swirl around the dance door. If gardening is appealing, plant some tomatoes, putter in the yard, and grow food that is good to eat.

Today, many organized activities provide exercise for people of all ages. Many of the newer programs stress the importance of having fun. Zumba®, a combination of fitness and Latin dance moves, is becoming popular with Baby Boomers. Another sensory-based movement practice that leads to health, wellness and fitness is Nia® which combines Latin dance with tai chi and yoga. Wii-Fit Plus is also marketed as a program of fitness and fun for everyone. The game lets players set goals, chart their progress, and check BMI and Wii Fit Age. These are just a few of the options adults have for staying physically involved in activities they enjoy.

Step 5 – Take an Active Role in Personal Health Care

Individuals should not be passive when it comes to understanding what is personally healthy for them and what is not. While medical professionals are usually the best qualified to diagnose disease once manifested, there is a lot an individual can do to ward off disease. For example, stay informed by subscribing to a medical newsletter geared to laypeople such as those offered by both the Mayo Clinic[cxxvi] and Johns Hopkins.[cxxvii] Take advantage of the new preventive screening rules under private health plans and Medicare brought about by the recent health reform legislation. Receiving preventive health screenings is vital to healthy aging.

The Affordable Care Act: Recognizing the Value of Preventive Care

The Affordable Care Act (health care reform) is making it financially easier for seniors to follow the recommended rules when it comes to preventive care. As of January 1, 2011, Medicare beneficiaries can have a yearly wellness exam and receive many preventive services (such as screenings and inoculations) without paying copayments or coinsurance. These exams and screenings can often detect diseases in early stages, when treatment is often highly effective and less invasive.

ACA will also enhance access to preventive care for those under 65. As of 2014, it will require health insurance plans offered to individuals and small groups through the new health insurance exchanges, as well as plans sponsored by large employers, to cover wellness and preventive services (although already existing plans will be exempt). And exchange plans will not be allowed to charge cost-sharing for preventive care. As a result, many families will have free access to many inoculations, tests, and screenings, which may include the following (depending on age):[1]

- Blood pressure, diabetes, and cholesterol tests
- Many cancer screenings, including mammograms and colonoscopies
- Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression, and reducing alcohol use
- Routine vaccinations against diseases such as measles, polio, or meningitis
- Flu and pneumonia shots
- Counseling, screening, and vaccines to ensure healthy pregnancies
- Regular well-baby and well-child visits, from birth to age 21

Other Steps on the Path to Healthy Aging

In pursuit of a healthy aging lifestyle, individuals need to be aware of a few more red flags as highlighted in other sections of this course. For example, those who still smoke should stop. The correlation between smoking and increased risk of cancer has long been clear, as are other health risks associated with tobacco use. In addition to watching what one eats, individuals should be careful about what they drink, too, especially alcohol intake. While some studies show moderate drinking can be healthful (e.g., one or two glasses of wine a day), others conclude that excessive consumption of alcoholic beverages is destructive to one's health.

Also, there are other ways to perpetuate healthy aging. Continuing the pursuit of intellectual interests, cherishing social relationships, and maintaining a positive attitude top the list of recommendations.

- **Exercise the brain**

  Think of the brain as a muscle—work it out. While a failing body can be very sad, a failing brain can pose a far worse nightmare for many individuals and their families. The word "cognition" refers to the mental processes that we use to perceive, remember, and think. Many individuals face decreased cognitive abilities or at least perceived decreases in their mental abilities as they age. Part of this may be due to the vast amount of information that we have stored over a lifetime and the increased time it takes to access this mental library. The amount of lost cognitive function usually does not pose serious issues unless we develop a neurodegenerative disease such as Alzheimer's.

There are recommendations, however, that seniors can follow to stave off even moderate decline. Once again, the role of lifestyle comes into play. Older adults who are cognitively active are 2.6 times less likely to develop Alzheimer's disease and dementia than those who are not mentally active.[cxxviii] Other studies have confirmed these results.[cxxix]

Mental exercise like physical exercise can be fun and enjoyable. For example, playing cards can be good for your brain. Bridge can be an exceptionally stimulating card game to keep one mentally agile. For those who enjoy math, try Sudoku, a popular Japanese numbers game. Crossword puzzles are another engaging mental exercise.

For those who enjoy continued learning, enrolling in a course at a local community college or participating in educational seminars may be intellectually fulfilling. The technology was not part of the curriculum when most of today's GIs, Silents, and Boomers were in high school and college. Given the ubiquity of computers in the office and at home, now might be a good time to study this area and pick up new skills that can be put to everyday use. On the flip side, reading the newspaper is much more likely to stimulate the brain than passively watching the news on television.

Learning does not have to be about completely new subject matter. It can involve learning more about a topic in which one already has an interest. For instance, many individuals—both men and women—like to cook. Why not build upon what one already knows by enrolling in a cooking class.[cxxx] A final thought to keep in mind: Research has found that there is an interrelationship between physical exercise and a healthy brain. So it is important to include physical movement in the healthy brain exercise routine.[cxxxi]

- **Cultivate a network of friends and family**

Continued interaction with family, friends, and other individuals with whom we have shared interests for entertainment, leisure, and work (paid or voluntary) is central to the concept of healthy aging. It is one of the secrets of successful aging. Take another look at the activities people can do to stay mentally active. Keep the list in mind as we talk about the importance wellness has on older Americans staying socially engaged. Older people can accomplish two activities on the healthy aging scale at the same time by inviting a friend or family member to share in their activities.

Research shows that the social dimension is critical to longevity. A study of 4,725 age 55+ randomly selected residents of Alameda County in California found that those with the fewest close friends and social connections had mortality rates that were *two to three times higher* than those with high levels of social connectedness. Also, life expectancy tables show a difference of *nine years* between people with very poor social connections and those with solid ones. As we age, friendships and continued socializing create a feeling of belonging, a buffer against stress, and a sense of purpose in meeting the needs of others.[cxxxii]

Another innovation available to improve connectivity for aging Americans is the use of new social media. Social utility tools like Facebook and microblogs like Twitter help consumers make informed health decisions and keep us connected to an extended network of friends, family, celebrities, and events around the world. With more than five billion mobile phone users, 2.6 billion people on the Internet worldwide, and 2.5 billion text messages sent every day in the U.S. alone, today's information revolution connects people in ways that have never before been possible. And older Americans are as enthusiastic about using online tools as any other age-wave.

- **Maintain an optimistic attitude**

  All those self-help messages that encourage positive thinking were right! Maintaining a positive attitude may help improve the quality of one's life. According to Dr. Mark Lachs, the quality of life is connected to our circle of friends. He found that people with a strong and supportive social network also tend to have a more optimistic outlook.[cxxxiii]

Tools for Training the Trainers on Healthy Aging

Those responsible for the administration of a corporate wellness program should offer educational sessions to workers on the steps recommended for healthy aging. The employer benefits from healthy outcomes for workers who can fully engage in the job and achieve higher productivity.

NIH Senior Health provides a kit for trainers to help older adults find medical information. The kit offers a variety of lesson plans on different topics and for different levels of Internet expertise. The information found in the training kits can be useful for a broad cross-section of the workforce.[cxxxiv]

Organized Activities for Seasoned Adults

Silver&Fit and **Silver Sneakers** are two programs that aim to keep seasoned adults in their 60s, 70s, 80s, and beyond active physically, mentally, and socially. These programs are offered as part of many Medicare Advantage plans—often at no or low cost to the enrollee. Employees at or near the Medicare eligibility age of 65 may want to consider the benefits of these programs as they seek to maintain a healthy lifestyle.

Curves is another program wellness administrators may want to investigate for employees. Its program is focused on a 30-minute circuit workout designed for women. Candidates for this option are often health club novices who are uncomfortable in a co-ed environment of mirrors, muscles, and exercisers that look like models.

Health Care Reform: What It Means for Medicare, Seniors, and Wellness

The Affordable Care Act (ACA) contains many provisions designed to improve Medicare, including several that address the importance of preventive care and wellness.

Preventive Services

In terms of wellness, probably the most significant change ACA makes to Medicare is increasing access to a wide array of preventive care services and making them more affordable. In most cases, Medicare beneficiaries will no longer pay cost-sharing (such as a copayment or coinsurance) for preventive services. These changes became effective on January 1, 2011.

Preventive Services: Medicare's Definition

Preventive services are health care services intended to prevent or detect illness at an early stage when treatment is likely to work best. Examples include flu shots, Pap tests, and mammograms.[cxxxv]

Physical Exams

Medicare Part B now covers two types of physical exams: a Welcome to Medicare Exam after the beneficiary first enrolls and a Yearly Wellness Exam each year thereafter. The beneficiary pays nothing for these exams (provided the doctor accepts Medicare assignment; if she does not, there may be a limited charge).

The Welcome to Medicare Exam is a one-time review of the beneficiary's health. It includes education and counseling about preventive services and referrals for other care if needed. Medicare covers this exam if it takes place within the first 12 months of enrollment in Part B.

The Yearly Wellness Exam is now covered once every 12 months (after the first 12 months of enrollment and at least 12 months after the Welcome to Medicare Exam). It enables the beneficiary's doctor to get an overall picture of her health and how it may be changing. The doctor conducts a comprehensive health risk assessment, identifies existing or potential issues, and, if necessary, develops a personalized prevention plan and refers the patient for additional services.

Coverage of the Yearly Wellness Exam is one of the most significant improvements in Medicare coverage of wellness and prevention. In the past only about half of beneficiaries had annual exams, but many more are now expected to do so, with positive results for their health.

Other Preventive Services

ACA eliminates Medicare cost-sharing for many preventive services. For some services, the beneficiary pays nothing provided the health care provider accepts assignment. For others, while there is no cost-sharing for the test or preventive service itself, the beneficiary may still have to pay a physician or hospital copayment. Some preventive services are covered only for those considered at risk for certain conditions.

Medicare preventive services include:

- abdominal aortic aneurysm screening
- bone mass measurement
- cardiovascular screenings
- colorectal cancer screenings
- diabetes screenings
- diabetes self-management training
- flu shots
- glaucoma tests
- hepatitis B shots
- HIV screening
- mammograms
- medical nutrition therapy services
- Pap tests and pelvic exams
- pneumococcal shot
- prostate cancer screening
- smoking cessation counseling

Medicare Wellness Success

With enhanced access to exams, screenings, and other preventive services, and the elimination or reduction of cost-sharing for them, Medicare is taking important steps to help the elderly maintain their health so that their doctors can spend less time and resources treating acute conditions. Sounds like a good start, doesn't it? But the shift to wellness and prevention will occur only if Medicare beneficiaries embrace the new opportunities offered to them. Are they taking advantage of the changes?

Yes, they are. In March 2011 HHS reported that in less than two months after the new rules went into effect (January 1 to February 23, 2011), more than 150,000 Medicare beneficiaries had an annual wellness visit.[cxxxvi] It looks like the concept is catching on!

Medicare Part D

For many people, especially elderly people, drugs play an important role in managing chronic conditions and maintaining health. Until a few years ago, Medicare did not cover outpatient prescription drugs, but in 2006 a new prescription drug benefit program, Medicare Part D, became available. Medicare beneficiaries choose whether to participate in Part D and those who do pay an additional monthly premium. Part D benefits are provided by Medicare-approved private-sector prescription drug plans (PDPs) and by most Medicare Advantage plans.

A Medicare beneficiary enrolls in the PDP of her choice, receives benefits from that PDP, and pays her Part D premium directly to the PDP. Medicare beneficiaries usually have many PDPs to choose from, and PDPs vary in the benefit packages they offer. But all plans must provide a minimal level of benefits, and Medicare also specifies certain drugs that all PDPs must cover.

The benefits and cost-sharing of a PDP are typically structured as follows:

- **Annual deductible**
  The standard amount in 2011 is $310, but this may vary, and not all PDPs have a deductible.

- **Coinsurance and/or copayments**
  Coinsurance percentages are often 25 or 33 percent. Copayment amounts vary widely from plan to plan.

- **Coverage gap**
  Once the total amount both the beneficiary and the PDP have paid for drugs reaches a certain level (the initial coverage limit) ($2,840 in 2011), there is a coverage gap, during which, until 2011, the beneficiary paid all costs and the PDP paid nothing. The coverage gap is being slowly phased out.

- **Catastrophic coverage**
  If the amount the beneficiary has paid for drugs reaches a certain level (the out-of-pocket limit) ($4,550 in 2011), catastrophic coverage is triggered, and the coverage gap ends. From this point until the end of the year, the PDP pays nearly all costs, and the beneficiary pays only small copayment or coinsurance amounts.

Example: Kate pays the first $310 of prescription drug costs to satisfy her PDP's deductible. Then she pays 25 percent coinsurance. After several months, the amount she has paid (for the deductible and coinsurance) plus the amount the PDP has paid together total $2,840, the initial coverage limit (2011). The coverage gap begins, and Kate must pay most of the cost of her prescriptions for the rest of the year.

But suppose Kate's costs (deductible, coinsurance, and costs she pays herself after the initial coverage limit) reach $4,550, the out-of-pocket limit (2011). Catastrophic coverage is triggered, and from then until the end of the year, Kate pays only small coinsurance or copayment amounts, and the PDP covers the rest.

Different PDPs offer a wide variety of benefit packages, many of which go far beyond the minimal level required. Some PDPs have no deductible or a smaller deductible, and coinsurance percentages and copayments amounts differ. Many PDPs cover drugs not required by Medicare, and some cover certain drugs during the coverage gap. Of course, premiums vary by PDP and plan option, according to the benefits provided.

Health Care Reform

The Medicare Part D coverage gap is understandably unpopular, as beneficiaries must pay their own drug costs for a considerable time and may have to spend a few thousand dollars out of their own pockets. The Affordable Care Act addresses this problem, initially by offering partial relief and eventually by eliminating the gap.

- In 2010 beneficiaries in the coverage gap (those who had passed the $2,830 threshold for that year and were paying all of their drug costs) received a rebate check of $250 to help defray some costs.
- From 2011 through 2020, the percentage of drug costs beneficiaries pay during the coverage gap will be gradually reduced from 100 percent to 25 percent. This will lower cost-sharing to the standard percentage applicable before a person enters the coverage gap, so it in effect will eliminate the gap.

For generic drugs, the coinsurance percentages will be gradually lowered. For brand-name drugs, beneficiaries' costs will be reduced in two ways: First, as of 2011 manufacturers that want their products to be covered by Medicare Part D will be required to give a 50 percent discount to beneficiaries in the coverage gap. Second, beginning in 2013 the coinsurance percentage for the beneficiary's remaining cost will be gradually reduced.

Phasing-Out the Medicare Part D Coverage Gap
Percentage of Drug Costs Paid by a Beneficiary During the Gap
Brand-name costs take into account both the manufacturer's discount and coinsurance.

Calendar Year	Beneficiary Pays for Generic Drugs	Beneficiary Pays for Brand-Name Drugs
2010	100%*	100%*
2011	93%	50%
2012	86%	50%
2013	79%	47.5%
2014	72%	47.5%

2015	65%	45%
2016	58%	45%
2017	51%	40%
2018	44%	35%
2019	37%	30%
2020 and later	25%	25%

** minus $250 rebate*

Example: Judy takes a generic drug that costs $100. In 2010 she paid all costs during the coverage gap, but starting in 2011 she pays slightly less each year ($93 in 2011, $86 in 2012, and so on).

Example: David takes a brand-name drug that costs $100. Beginning in 2011, he pays only $50 during the coverage gap, since the manufacturer will offer a 50 percent discount. And starting in 2013, he will continue to receive the discount, and he will also pay slightly less of the remaining cost over time ($47.50 in 2013 and 2014, $45 in 2015, and so on).

Extra Help

Medicare beneficiaries with low income and few assets may qualify for a subsidy, called “extra help,” to them pay their Part D premiums, deductibles, and coinsurance or copayments. To be eligible, an individual must have annual income no greater than $16,335 and assets no greater than $12,640; the limits for married couples are $22,065 in income and $25,260 in assets (2011). (Some people with higher income may qualify.) Persons receiving Medicaid or Supplemental Security Income (SSI) payments automatically qualify for extra help (since they must be very poor to qualify for these programs). A person can apply for extra help at any time.

Those who qualify for extra help receive assistance paying their monthly premiums, and they pay no more than $2.50 for generic drugs and $6.30 for brand-name drugs (2011), regardless of the deductibles, coinsurance, and copayments of their plan, and even during the coverage gap.

ACA does not substantially change extra help, but it makes some small improvements. It will be easier for those receiving extra help to stay in the same PDP from one year to the next, the number of plan options available to them will be increased, and those who must switch plans will receive more information to help them make their choice.

Other Medicare Changes

Center for Medicare and Medicaid Innovation

ACA established the Center for Medicare and Medicaid Innovation (CMMI), which will support new models for Medicare.[cxxxvii] It will foster changes to payment and service delivery programs that will increase access to health care, promote efficiency and effectiveness, and boost patient satisfaction. It will explore evidence-based programs targeting improving senior health outcomes and identify those that are suitable for replication on a broader scale. It will support pilot projects that, if proven effective, can be scaled up in communities across the country. And it will analyze the role of technology such as electronic medical records or passive remote monitoring devices to help reduce costs and/or increase quality care outcomes.

Many supporters believe that CMMI will help promote prevention and chronic disease management programs, in both the public and private sectors. It is hoped that by supporting innovative research, the center will foster healthy aging, including more effective treatment of the diseases that currently affect and will affect the baby boomer generation.[cxxxviii]

Transition Care Management

ACA established the Community Care Transitions Program, which focuses on Medicare beneficiaries who leave the hospital but are at high risk of having to return and helps them avoid unnecessary readmissions. The program coordinates care between the hospital and home and helps connect patients to community-based and home care services that can help them stay at home. Existing models of transition care management will be examined to identify cost-effective best practices that could be more broadly adopted.

Medicare Advantage Plans

As explained earlier, Medicare beneficiaries have the option of enrolling in a private-sector Medicare Advantage (MA) plan, from which they receive Part A and B coverage and usually Part D and some other benefits. ACA includes provisions designed to reduce government expenditures on Medicare Advantage and make MA plans operate more efficiently.

- Government payments to MA plans will be reduced beginning in 2012. This could result in higher premiums or reduced benefits for plan members. MA plans will not be allowed to compensate for this reduction by charging higher cost-sharing than Original Medicare.
- On the other hand, MA plans that meet certain quality standards will receive bonuses (to be phased in from 2011 through 2013). Bonus payments will be made to plans receiving four or more stars out of a five-star rating system. A plan must use this money first to reduce costs, then to add prevention and wellness coverage, and if any money remains, to add coverage of such items as vision and dental care.

Other ACA provisions are designed to directly benefit MA enrollees.

- MA plans are not allowed to charge higher cost-sharing than Original Medicare for chemotherapy, renal dialysis, skilled nursing care, and certain other critical services.
- Beneficiaries will be provided with information about the quality ratings of MA plans based on the five-star system, to help them choose a high-quality plan.

Annual Enrollment Period

Medicare beneficiaries can enroll in an MA or Part D plan or change plans during the annual enrollment period (AEP). Previously the AEP was from November 15 through December 31, but because this falls during the busy holiday season, it was decided to move it forward. Starting in 2011 the AEP will be from October 15 through December 7. New coverage selected begins on January 1, as will any changes in costs and coverage that plans make. Beneficiaries are encouraged to begin reviewing and comparing their options in September so that they will be ready to make their decisions before December 7.

Also, those enrolled in an MA plan have an additional 46 days after the start of the calendar year during which they can disenroll from the plan and return to Original Medicare, giving them a bit more leeway in making sometimes complicated choices.

Living Better Longer: Some Closing Thoughts

What do Americans think about aging? According to an ABC News poll, quality of life is a major issue.[cxxxix] Not everyone wants to live to be 100. Declining health, being unable to care for oneself, and losing mental acuity top the public's list of fears. Nearly two-thirds of the adults polled by ABC did not think they could live to a ripe old age and still enjoy the good life.

While no one can predict precisely how long someone will live, research points to factors that indicate how well we might live as we age. The National Institute on Aging supports the theory of active life expectancy in its mission to prevent or delay the onset of chronic disease. The wellness message on healthy aging is a beacon of light. For those who choose to follow through, the movement dispels many of the fears we associate with the aging process. It puts consumers in charge of making conscious decisions about health and taking responsibility for the outcome.

Strong supporting joists for healthy aging are already in place. Many employers have adopted the concept of wellness and crafted worksite programs, making it easier for employees of all ages to pursue health and fitness goals. The benefits rebound, studies show, in lower health care costs, reduced absenteeism, and higher employee productivity and retention. The Affordable Care Act lends heft with its provisions for yearly wellness exams at no extra cost for Medicare beneficiaries and enhanced access to preventive care for those under 65.

Going forward, we can count on the Baby Boomers blazing new trails. For a lot of Boomers "aging in place" may mean remaining actively engaged in the workforce much longer than previous generations. Some may stay on the job by necessity, others by choice or to meet company needs for experienced workers. For whatever reason, it is proof that age is no longer an automatic entitlement to a gold watch or a ticket to forced retirement.

Summary

With a looming national deficit, it is none too soon to take wellness seriously no matter what our age, young or old. This lesson conveyed a powerful message about changing the paradigm from treating disease to aging well. Chronic diseases take a toll on our working population way too soon. The business community is stifled by rising employee health care costs. Living better longer strengthens us as individuals, improves our society, and ultimately helps American industries become more competitive here at home and in the global marketplace.

Value-Based Insurance Design (VBID)

Introduction

Value-based insurance design (VBID) programs are structured to encourage the use of pharmaceuticals and services that are most likely to improve or maintain health. One tool used to accomplish this is offering plan participants reduced out-of-pocket costs on selected medications and services typically targeted to better manage certain chronic conditions (e.g. diabetes, hypertension, and depression). At the same time, VBID programs discourage the unnecessary use of more discretionary services by shifting an increased portion of costs to the prospective patient.

Incorporating a VBID with a wellness program has the potential to enhance the clinical effectiveness of the high-value medical care sought and used by plan participants. A combined offering also provides employers the potential of decreasing the number of years necessary to reap the financial benefits of investing in these programs.

Objectives:

After completing this lesson and the accompanying exercises, you will be able to:

- describe the various aspects of value-based insurance design, including the combination of VBID with wellness programs
- understand basic VBID program objectives, design options, complementary strategies for enhanced value, and the implementation process
- know what to expect in short-term cost escalation and return on investment
- identify barriers to adoption of VBID and future pathways for expansion

Cost Sharing: Purpose and Implications

Individuals rely on the use of health insurance to shift the risk of the costs associated with illness. Health insurance allows those who become ill to afford the care they might not otherwise be able to purchase.[cxl] At the same, lowering the cost of care increases the potential for those insured to access or agree to take advantage of covered medical services that might otherwise be perceived as somewhat discretionary, such as duplicative tests. This excess consumption of medical services is commonly referred to as **moral hazard**.[cxli]

Cost-sharing in the form of deductibles and copayments is one response to the risk of moral hazard. These tools have served as a way to shift a portion of the rising health care costs from employers to employees to keep overall health care premium outlays within manageable levels and also to increase the consideration of costs when individuals are seeking health care services.

Traditionally, insurance programs have incorporated cost-sharing tools with a one-size-fits-all approach. All participants within a selected plan are responsible for the same copayments and deductibles regardless of their medical conditions. Consider these two examples:

> ***Example:*** XYZ plan specifies a $15 co-pay each time a prescription is filled. Mr. Smith, a worker in good health, occasionally needs a prescription filled twice a year. His annual outlay for prescription co-pays amounts to $30.

> ***Example:*** In contrast to Mr. Smith in the first example, Ms. Jones suffers from a chronic condition requiring her to have two prescriptions filled per month. Her monthly outlay is $30 and her annual outlay amounts to $360. Should she need a third prescription, Ms. Jones' monthly outlay would increase to $45 and her annual outlay amount to $540.

Copayments on medications and treatments associated with chronic conditions can represent a significant financial barrier for many individuals. Some insured workers may choose to leave prescriptions unfilled. Others may reduce the dosage taken by cutting pills in half or taking medication every other day versus the recommended daily dosage. In each of these cases, the potential effectiveness of the medication is reduced. At the same time, reduced medication can increase the odds of a more serious and costly illness.[cxlii]

A VBID plan seeks to take a more tailored approach based on individual medical conditions. For example, the use of certain pharmaceuticals may offer a highly effective low-cost method of treating a condition and maintaining an insured's health. To encourage adherence to the recommended treatment, the co-pay for such an individual might be lowered or in some instances waived. It takes into account recent research demonstrating that copayment reductions may generate increased adherence (use) of prescribed drugs.

A Closer Look at Design Options

Not all VBID plans are alike; there are variations. We will examine two basic design options:

- Blanket (non-targeted) design
- Population targeted design

We will also examine other design elements such as tiered copayments, coverage of specialty drugs, and incorporation of health management into the overall VBID program.

- **Blanket design**

  A VBID program using a blanket design takes a non-targeted approach to plan participants. All plan participants are eligible for the program's incentives if they are prescribed a particular drug or use a particular service.

- **Population targeted design**

  Under this type of VBID program, incentives are limited to specified individuals suffering from specific conditions. Typically, the conditions covered include diabetes, hypertension (high blood pressure), hyperlipidemia (high cholesterol), congestive heart failure, and asthma. These conditions are targeted for three key reasons. First, left untreated they can lead to serious complications that can badly compromise the individual sufferer's health. Second, left untreated the ensuing complications can involve the expenditure of substantial dollars that might otherwise have been avoided. Third, these conditions are usually easily identified through claims and other related data that are accessible.

- **Pharmaceutical design refinement**

  Whether a targeted or non-targeted blanket approach is taken, both typically involve incentives to encourage individuals to take their prescription drugs since adherence lowers the risk of costly complications such as stroke, heart attack, or diabetic coma. In addition to the lowering or waiver of copayments, some companies may wish to take a tiered approach. This could be structured so that the entire co-pay would be waived on the generic version of selected drugs while a reduced co-pay would be offered for brand name drugs.

- **Design considerations for specialty drug populations**

  Specialty drugs represent another area with the potential for design refinement in both targeted and non-targeted blanket plans. Specialty drugs are those frequently associated with the treatment of serious illness such as rheumatoid arthritis or cancer where failure to adhere to a recommended drug regiment can result in dire health consequences including death. The costs associated with these drugs are often very high, increasing the chance that they represent a financial barrier to following a recommended treatment plan. Some VBID programs may focus solely on those taking these types of medications since adherence is especially important to these populations in avoiding more costly medical complications. Other VBID programs may drastically reduce the copayments associated with these drugs while others may waive the copayment associated with them entirely.

- **Increased fees for selected services**

  VBID programs are not necessarily designed solely around decreased out-of-pocket fees. They may also incorporate higher fees for selected drugs or services that are believed to be

of lesser value or overused. For example, a VBID program may include lower co-pays for generic blood pressure prescriptions but higher out-of-pocket fees for magnetic resonance imaging (MRI) services. Another possible example might involve lower fees for office administered injections aimed at lessening knee pain caused by worn cartilage while increasing the out-of-pocket costs associated with a full knee replacement.

Complementary Strategies for Enhancing VBID Program Value

The value of a VBID program, as well as the likelihood of positive return on investment (ROI), can be enhanced by the adoption of complementary strategies that include:

- incorporating a wellness program into the design
- medical self-care and consumer strategies designed to encourage the insured to be a better steward of health, consumer of health care services, and partner with health care providers
- integrating pharmacy benefit management (PBM) services
- developing closer relationships with providers who understand and support VBID objectives

Incorporation of a Health Management Wellness Program into the Design

In designing their VBID program employers and their advisors may also wish to consider coupling copayment reductions with the participation in health management wellness programs. In other words, for an individual to qualify for a lowered copayment on the prescription drugs included in the program, he or she would first need to agree to participate in a health management program. Such programs typically include an educational component covering the impact of lifestyle choices including diet and exercise on health and their implications for certain diseases. Health management programs also often include components that focus on patient management of conditions such as diabetes and heart disease. If these components sound familiar, they should since they are often part of a company's wellness program demonstrating the mutual reinforcement offered by well designed VBID and wellness programs.

Integration of Pharmacy Benefit Management (PBM) Services

VBID programs often rely heavily on drug adherence in reaching their design goals. PBM services can help by maintaining records of prescription fulfillment. They can also help in the identification of appropriate generic substitutes for expensive brand name drugs. Also, PBM services can lower the upfront costs often experienced by VBID programs by offering tools such as the fulfillment of multiple month prescriptions. For example, 90-day supplies received through the mail not only tend to lower administrative costs but also can help with drug adherence—particularly in situations of rural locations with few pharmacies and in cases where the insured is

housebound. Automated messages from PBMs reminding patients to order medications also help in the management of chronic conditions.

Development of Closer Provider Relationships

One of the goals of selecting a VBID option is to encourage accountability for both the insured's behavior and the medical care that is received. Unfortunately, the traditional fee-for-service system often encourages the opposite because these plans facilitate the use of high-cost low-value services, which in turn drive up overall health care costs. To combat this trend, employers and their design advisors can seek to work with providers who understand and appreciate the goals of a VBID plan.

Health insurers with their networks of providers can help a VBID program reach these goals by ensuring that their provider ranks include those who adhere to evidence-based medicine and wellness practices. Once again, wellness programs which include disease management can help to reinforce the objectives of a VBID plan by working with individuals to manage their health conditions to avoid costly and unnecessary medical interventions. These two examples present tools employers can use to achieve VBID program objectives:

> ***Example:*** In looking at its employee population, High Manufacturing determines that many workers still smoke and heavily across all ages. High offers to cover the costs of over-the-counter nicotine replacement products, such as gum, patches, or lozenges, for employees who smoke, provided they sign up and participate in a stop-smoking health management program. For employees that sign up but fail to participate in program classes, the employer will require reimbursement for the OTC medications.[3]

> ***Example:*** An analysis of claims data indicates that many employees of Low Service Company suffer from diabetes. Low works with its advisors to develop a VBID program that offers to waive co-pays on generic drugs and lower co-pays on brand name drugs frequently taken by many diabetics. To be eligible for these lower out-of-pocket costs individuals must participate in a disease management program that includes education and ongoing routine tests to monitor their medical condition. Individuals who opt-out of the disease management program pay the normal copayments on their diabetes medications.

Table 1: Sample of Value-Based Insurance Design Tools

Tool	Type of VBID
Reduced co-pays for generic drugs available to all plan members for whom such drugs are prescribed.	Non-Targeted VBID
Reduced co-pays for brand name drugs available to all plan members for whom such drugs are prescribed.	Non-Targeted VBID
No co-pays for generic and reduced co-pays for selected drugs available to all plan members for whom such drugs are prescribed.	Non-Targeted VBID
Reduced co-pays for selected generic and brand name drugs with increased co-pays and deductibles for other services.	Non-Targeted VBID
Reduced co-pays for selected generic and brand name prescription drugs for those diagnosed as suffering from specified diseases.	Targeted VBID
No co-pays for generic and reduced co-pays for brand name drugs for those suffering from specified diseases who agree to participate in disease management programs.	Targeted VBID
Co-pays eliminated on specified generic drugs and gym membership fees reduced for those suffering from specified diseases who agree to participate in disease management and related wellness programs.	Targeted VBID + Wellness Program
Reduced premium costs for plan members who complete an annual health evaluation form and participate in a wellness program. Individuals taking prescribed medications to control diabetes or heart disease are offered lower co-pays.	Non-targeted VBID + Wellness Program

Consumer-Directed Health Plans vs. VBID Programs

General Description of Consumer-Directed Health Plans

Consumer-directed health plans (CDHP) (also referred to as consumer-driven plans) typically combine a high-deductible health plan offering lower premiums with a savings account into which funds may be deposited and accumulated on a tax-favored basis. These tax-favored accounts are similar to individual retirement accounts (IRAs) in that dollars accumulate and rollover yearly on a tax-free basis with the distinction that funds may be withdrawn in most circumstances solely for the payment of health care costs. These-tax favored accounts are usually set-up as **health reimbursement accounts (HRAs)**, **health savings accounts (HSAs)**, or a combination of the two. In some cases, they may also be linked to an employer's health care flexible savings account (FSA) program.

CDHP vs. VBID

A CDHP allows the participant-consumer to be involved in his or her health care purchasing decisions. This approach is designed to facilitate careful thought about whether a medical procedure or service is necessary and if so, how much should it cost. Where time permits the plan is also designed to promote quality and cost comparisons for particular types of care.

Some individuals are medically knowledgeable. On the other hand, many consumers are less knowledgeable about the medical conditions that afflict or could potentially afflict them. As a result, they may not always make wise choices when it comes to their health care. Individuals may choose their financial goals over health outlays because they are not fully aware of the serious consequences that they face regarding their health or the ravages that serious disease can ultimately wreak on their finances if they require expensive treatment that could have been avoided and/or lose their ability to be gainfully employed.

In contrast, VBID programs guide the participant-consumer toward recommended care regiments by offering incentives when actions designed to improve or maintain health are taken. The following scenarios examine possible outcomes:

> ***Example:*** Gordon participates in an employer-sponsored health plan that includes high-deductible medical coverage with a health savings account (HSA) into which his employer deposits $1,000. Gordon suffers from high blood pressure for which his doctor provides a prescription of daily medication. Rather than fill the prescription, Gordon decides to save the money in his HSA since he still feels relatively well. Gordon is unaware that he risks more serious and more costly cardiovascular illness by failing to take the medication.

> ***Example:*** Gordon participates in an employer-sponsored value-based insurance design health plan that waives co-pays for generic drugs. Gordon's doctor

prescribes a commonly taken generic drug to control his high blood pressure. To take advantage of this benefit, Gordon must fill his prescription.

Combined CDHP and VBID Programs

Combining a CDHP with a VBID component allows the individual to participate in a program that would provide medical guidance in the selection of appropriate care and in the way medical dollars are spent. The savings feature offered through the CDHP allows the participant to accumulate a source of funds to offset the cost of such care, which is not otherwise covered through her health insurance plan.

Example: Melissa suffers from diabetes. Her doctor prescribes several drugs. Melissa's employer has established a value-based insurance design plan that lowers the co-pays on both her generic and brand name prescription drugs. Despite the lowered co-pays, Melissa's out-of-pocket costs are still substantial to her income. Also, Melissa participates in a consumer-directed health plan offered by her employer to which both Melissa and her employer contribute dollars. These dollars provide a welcome source of funds to offset the cost of the co-pays and help Melissa maintain a recommended health regiment aimed at keeping her diabetes under control.

Health Savings Accounts (HSAs)

Health savings accounts (HSAs) came into existence with the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This act included Internal Revenue Section 223 governing their operation. The first HSAs were established in 2004.

An HSA is a tax-favored trust or custodial account similar to an individual retirement account (IRA). Dollars placed into an HSA are permitted to grow year over year without the burden of income taxation. An HSA may be designed to offer employees the ability to make contributions on a pre-tax basis—in many cases lowering their immediate income tax liability.

To be eligible to contribute to an HSA, an individual must be covered by a qualified high-deductible health plan. Such plans often offer lower premiums, but should illness occur, an employee is responsible for first-dollar coverage, meaning payment out-of-pocket until the deductible is met. The funds set aside in an HSA serve as a source of dollars to offset such costs.

Health Reimbursement Arrangements (HRAs)

A health reimbursement arrangement (HRA) is an optional account that permits an employer to provide funds to its employees to help them pay for their health care expenses. Although they are not required to do so, many employers sponsoring an HRA also require their employees to enroll in a high-deductible health plan (HDHP). Such plans typically offer lower premiums in return for enrollees assuming more of the financial risk of illness. HRAs can offer a source of dollars to meet these higher out-of-pocket expenses.

HRAs do come with restrictions. Dollars in an HRA can only be used to pay medical expenses. And, only employers can fund HRAs. Employee contributions are not permitted. Finally, many employers do not let unused HRA funds accumulate from one year to the next, so the money is usually “use or lose” every year.

High-Deductible Health Plan (HDHP)

As the name indicates, a high-deductible health plan (HDHP) has a considerably higher deductible than a traditional health plan. An HDHP is intended to provide coverage in situations of catastrophic loss. The high deductible typically makes these plans less expensive than a traditional plan, but it also creates the potential for large out-of-pocket expenditures by the insured. Health reimbursement arrangements (HRAs) and health savings accounts (HSAs) are frequently paired with HDHPs to provide sources of funding to help offset these potential high outlays for medical expenses.

Steps for Implementing a VBID Program

Implementing a VBID program requires planning and a roadmap. Many companies will follow the seven steps or a close variation of them:

- Analysis of employee population
- Design development
- Identification of necessary funding
- Location of internal and external resources
- Consideration of complementary tools
- Development of a communications strategy or education plan for employees
- Enlistment of support from senior management

Step 1 – Analyze the Employee Population

To determine whether a VBID program is appropriate and if so, its design, there must first be an understanding of the employee population. This analysis will consider several factors including the type of work performed, employee turnover, average age, and the prevalence of a chronic disease among workers and, if applicable, their dependents. Data regarding type of work, turnover, and average age should be available in records maintained within the company's human resources department. Information on the prevalence of chronic disease as well as the types of such illnesses can often be gathered from medical claims data.

Step 2 – Determine the Design

The first decision of design development involves the determination of whether the VBID program should be targeted or non-targeted. As has been previously discussed, a targeted program offers the potential for greater health care savings but involves substantially more mining of data, administrative support, and oversight. In contrast, a non-targeted plan is easier to implement and administer but generally offers a longer payback period to recoup costs and realize health care savings.

The second design development decision is the selection of the pharmaceuticals and/or medical services to be targeted for the VBID incentives. As stated previously, the pharmaceuticals frequently selected include those used by individuals suffering from diabetes, high blood pressure, high cholesterol, and asthma.

A third decision to be made if applicable is how to best link the VBID incentives with the company's wellness program. This can call for close coordination among different vendors. For example, the wellness program may include a disease management program for those suffering from high blood pressure offered by one vendor while the VBID program includes low copayments for hypertension drugs administered by another vendor/pharmacy benefit manager (PBM).

Step 3 – Identify the Necessary Funding Sources to Support the Selected Design

A company considering the implementation of a VBID program must also consider the likelihood of an upfront financial commitment. Lower or no co-pays for employees equate to increased dollar outlays at the company level. Providing employees with access to other services such as a health management program will also mean an increased financial commitment on the part of the company. It can take many years before the costs of a VBID program are fully offset and the financial gains realized through improved employee health outcomes.

Step 4 – Locate Internal and External Resources to Support the Selected Design

The implementation of a VBID program is likely to require locating both internal and external resources to support the selected design. This includes identification of knowledgeable internal personnel who can educate the workforce about the program, select and interact with outside vendors, and handle the on-site administrative issues that are likely to be attendant to the

program. Many of these personnel are likely to be the same individuals that interact with a company's wellness program. External resources may include a selection of an appropriate health plan, a pharmacy benefit manager, and a disease management firm.

The selection of a targeted program focused on those with specific diseases may require additional internal and external resources to support the extra data gathering and tracking components of the program as well as the additional external resources to support the likely ancillary components of lifestyle education and disease management.

Step 5 – Consider the Role of Complementary Tools

Companies that self-insure their plans need to take into account the need to identify providers who will support and enhance the VBID initiatives. Pharmacy benefit managers provide data and administrative support for the prescription drug initiatives which often form the backbone of VBID programs.

Step 6 – Develop a Communications Plan

VBID program success depends heavily on an effective communications campaign. The campaign should not only aim to inform employees that a VBID program is being put into place but it should seek to educate participants so that they understand its components and how they work. This is particularly important where targeted VBID programs are chosen to avoid misconceptions that selected employees suffering from the disease are in effect getting a better deal than other healthier plan participants. The objective of the targeted VBID program—to reduce premium costs for everyone by reducing the high expenses associated with neglected medical conditions—should be clearly stated. Promoting understanding among employees goes a long way in avoiding resentments and putting all participants on the same page of healthier living.

A communications plan must also consider how employees prefer to communicate and gather information in the workplace. How have employees traditionally received important information? In some cases, this may involve announcing the VBID program during a special all-hands meeting with presentations by senior management, human resources professionals responsible for the operation of the program, and representatives of various VBID services such as PBM personnel prepared to discuss these services with employees.

It's important to use many approaches when communicating with employees. In addition to conducting live sessions, the communications campaign may also involve the distribution of hardcopy information about the program including the potential benefits and cost savings to employees. Some segments of the employee population are likely to rely on electronic communications such as e-mails that include attachments of documents explaining the program that can be read online or downloaded.

In many instances, a VBID communications plan should take a distribution approach using multiple means of communication to best meet the preferences of different groups in how they obtain and absorb information.

Step 7 – Enlist the Support of Senior Management

Finally, it is important to have the strong and visible support of senior management. These are the individuals most likely to have input into the ultimate design of the VBID program and who may be responsible for allocating needed personnel and resources. Getting organizational leaders on board will convey, by their example, whether or not the VBID program is viewed as a serious company effort.

Return on Investment (ROI)

VBID plans typically call for an upfront outlay of dollars by the employer to cover the cost of added benefits offered. Offering an enhanced package of benefits often results in short-run cost escalations as an increased number of employees take advantage of health care services. On the plus side of the equation, VBID plans offer the potential to lower long-term costs by reducing the number of situations where employees suffer serious illnesses requiring expensive medical care.

The establishment of a VBID plan may or may not lower employer health care costs in either the short or long-terms. The answer will vary from employer to employer depending on factors that include turnover, length of service, and the current health of the employee population.

The structure of the VBID also plays an important role. VBID plans aimed at targeted populations, such as just those suffering from diabetes, have the potential for an earlier payback of upfront costs. This is because fewer dollars are spent upfront than typically expended where enhanced benefits are offered to the entire employee population. This is also because the targeted population often suffers from health conditions where, if left untreated, produce a greater risk of high dollar expenditures.

Targeted programs, however, often entail higher administrative expenses including added staff time to support such initiatives. In contrast, non-targeted programs, offering enhanced benefits to a broader cross-section of employees, are easier to administer and should result in the expenditure of fewer staff hours to support.

Factors enhancing the returns offered on investment in VBID programs include the potential to lower the trajectory of future health care costs. In other words, while the flat dollar figure may rise from year to year, the increased percentage level of spending is reduced from what could otherwise be expected.

Example: ABCO adopts a VBID health care plan for its employees. Health care costs for ABCO have been rising at an average level of 10 percent per year. Several years later ABCO's analysis shows that the rise in its health care costs has been reduced to 7 percent per year. Although its dollar outlays on health care have increased, ABCO has realized the financial payback of lower average year-to-year increases in its health care expenditures as percentage increases have dropped from 10 to 7 percent. In simple terms, health care costs per $100 dollars have risen to $107 from year 1 to year 2 versus an expected rise to $110 dollars. Compounded over several additional years, these savings have the potential to become substantial.

Factors in the Calculation of ROI

There are less obvious factors that offer the opportunity to recapture the upfront expenditures of a VBID program. These are reduced incidents of time lost to:

- disability, unplanned absence
- presenteeism

Disability involves loss of time away from the job. For example, Melvin collapses at his place of employment due to diabetes. This event caused an unplanned absence from work. Melvin recovers after spending a week in the hospital physically away from work.

Presenteeism does not typically involve a loss of time away from the worksite. While present at the worksite, the employee is less effective in the performance of duties due to his or her illness. For example, Diego suffers from high blood pressure that has been left untreated. Due to his condition, Diego frequently experiences headaches which make concentration on his job as an accountant more difficult. It takes him longer to complete his analysis of numbers due to the condition. This slower work pace is a significant hidden cost. Reducing such hidden costs over an employee population can result in savings due to such factors as the need to hire fewer workers because of increased (higher) productivity from an employer's current workforce.

It is also important in establishing a VBID program to set and carefully consider an upfront timeline against which to measure results. Some aspects of a VBID program are relatively easy to measure such as drug compliance. If one assumes employees who fill their prescriptions will take their medications, then claims data can be analyzed to determine if there has been a measurable improvement in employee health statistics. It can be expected that this type of design element should show tangible results within a relatively short period—six months, according to some commentators.

Factors in the Calculation of ROI

Factor(s)	Comment(s)
Upfront outlay	VBID programs typically increase employee use of health benefits raising short-term costs.
Targeted versus non-targeted program	A targeted program has the potential to offer greater returns in a shorter period. A non-targeted program is usually easier to administer.
Mix of lowered and increased fees	The design may incorporate increased fees for selected services such as MRIs considered of lower value in achieving overall employee health. These fees can provide a source of funds to help offset higher usage of other services.
Timeline: General rule	The design must consider a realistic timeline. Short term results in the form of dollar savings generally cannot be expected.
Timeline: Measurable plan design goals	Some elements of a VBID program are easier to measure and offer shorter payback timelines such as drug adherence.
Lowered health care expenditures	Employers should consider the goal of lowered percentage increases versus pure dollar savings for years.
Savings through lowered incidents of disability	Fewer employee days lost to disability translates not only into lower health care expenditures but higher productivity.
Savings through lowered incidents of presenteeism	Increased employee's focus on job duties due to better health translates into higher productivity and improved bottom line.

Barriers to Adoption of VBID

VBID offers a way for some employers to enhance the value of their health insurance and wellness programs. VBID may not be appropriate for every situation. For example, employer size is just one factor that may enter into consideration. Generally speaking, VBID has tended to be implemented thus far by employers with large numbers of employees. The adoption of a targeted VBID program, for example, may raise too many concerns or offer too little in potential rewards for a smaller employer to consider it worthwhile.

Considerations for the Adoption of a VBID Program—Barriers and Paths

Barrier	Potential Path Around Barrier
Increased initial health insurance costs	Can be a barrier for firms with a high turnover with little opportunity to recoup savings. Firms with low employee turnover have time on their side to reap the benefits of increased adherence and capture long-term savings.
Implementation difficulties	It can be difficult to gather data sufficient to identify candidates for VBID initiatives such as lower copayments for selected treatments. One option is to allow individuals to self-identify. Another option is to alert those with claims related to specific illnesses such as diabetes that a more cost-effective care option is available.
Legal concerns regarding privacy	VBID programs require the identification of employees with specific conditions. Care must be taken to comply with HIPAA Privacy rules.
The ambiguity surrounding use with consumer-directed products	There can be questions regarding the scope of preventive care allowed regarding newer type products such as health savings accounts favored by many employees. Ambiguity usually only exists with health savings accounts (HSAs) since the rules are more rigid. Health reimbursement arrangements (HRAs) are flexible enough to coordinate with VBID easily. Under the Affordable Care Act, all plans will have to cover preventive care (as defined by HHS) without cost-sharing. This may minimize some of the conflicts but probably not all. Monitor developments of preventive care rules as health care reform rules and regulations unfold.
Human resource headache: Disgruntled workers	Many healthy workers will not be eligible for lowered out-of-pocket expenses under a VBID program. This has the potential to create dissatisfaction. One way to lower the potential for dissatisfaction is to carefully explain the program and its potential to benefit all employees in the future through long-term savings that can help keep their premium costs down.
Potential for fraud and abuse	There is the potential that some relatively healthy individuals with the help of their providers will try to

	fall into categories eligible for VBID benefits through misdiagnosis of their medical conditions. One way to combat this potential is to limit the program to diseases, such as diabetes, which are relatively easy to identify and verify.
Potential for adverse selection	If multiple plan options are made available, there is the potential for those with medical conditions targeted by a VBID program to gravitate to that particular plan. One way to solve this problem is to offer just one plan option for all employees. Another option would be to incorporate value design into all health plan options offered to employees.

Moving Forward: What the Future Holds for VBID Programs

Population health management and wellness programs are being widely adopted throughout the United States as employers look for ways to lower health care costs through improved employee health. This bodes well for the future of VBID programs which can easily build upon the administrative foundations and increased health consciousness of the workforce established by wellness programs. Similarly, the widespread use of pharmacy benefit management (PBM) services provides further administrative support for the use of VBID designs since PBM programs often incorporate features like reduced prescription drug copayments. Also, for companies that want to maintain a competitive market position, the strong drive to control health care costs serves as a motivator to adopt value-based designs in their employee benefits programs.

The scope of VBID programs may expand in the future by targeting the costs associated with conditions beyond diabetes, high blood pressure, heart disease, and asthma. With increased experience maintaining plan participants with these core conditions, VBID programs will be positioned to reach out to other segments, such as those suffering from mental depression and/or gastrointestinal ailments. Furthermore, one can expect these designs to become available to smaller employers as insurance carriers evaluate their own experiences with VBID programs and use that knowledge for the benefit of employers and other members of the American workforce.

Patient-Centered Medical Homes and Accountable Care Organizations: Additions to the Wellness Value Equation

Introduction

The benefits of a wellness program can be substantially enhanced for both employees and employers through readily available access to quality medical care. Some large employers provide this through onsite centers staffed by health care professionals who offer preventive services at little or no cost and, if needed, emergency care should acute care be necessary for situations such as an accident or asthma attack during work hours.

Onsite clinics tend to be the exception rather than the rule in today's workplaces and even where they exist few provide after-hours care. Patient-centered medical homes (PCMHs) offer a way to fill this void and enhance the benefits of a wellness program. Simply stated, the PCMH model of care delivery seeks to strengthen the physician-patient relationship by replacing episodic care based on illness with coordinated care and a long-term healing relationship.[cxliii]

The combined emphasis on coordinated care and long-term relationship can serve to avoid unnecessary hospitalizations and patient suffering—dual goals of wellness programs which can be particularly important to participating workers with chronic medical conditions. The Affordable Care Act (ACA) has focused increased attention on the PCMH model as a way to provide quality care while leveling the nation's escalating medical costs. And, as we will discuss later, the ACA has created a strong interest in furthering coordinated care through what is being termed accountable care organizations (ACOs).

The patient-centered medical homes (PCMHs) movement is sometimes referred to as **advanced primary care** because the latter term is often better understood by the layperson without a medical or health insurance background. Some suggest that advanced primary care has a less institutional tone associated with it compared to PCMH.

Objectives:

After completing this lesson and the accompanying exercises, you will be able to:

- define the concept and describe the role of patient-centered medical homes (PCMHs) in the coordination of patient care
- identify the seven core features of the PCMH team-based model
- understand how health information technology will be used to support a variety of PCMH initiatives
- comprehend the process of establishing a successful PCMH practice model

- explain the general concept of accountable care organizations (ACOs)
- recognize the link among employer-sponsored wellness programs, PCMHs, and ACOs

What Is a PCMH? A Closer Look

A PCMH is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.[cxliv] This includes responsibility for providing or coordinating preventive services, treatment of both acute illness and chronic conditions, and, where appropriate, assistance with end-of-life issues.

In a PCMH an individual's primary care physician (PCP) works closely with a team of other medical professionals in the coordination of care to achieve both better health outcomes and more efficient use of resources than might otherwise be the case. The PCMH coordinates an individual's care with specialists, testing facilities, and other health care professionals, such as occupational or physical therapists. The PCMH will also work to coordinate care if hospitalization is needed.

What are the core features of a PCMH?

The Robert Graham Center identifies the seven core features of a PCMH:

- A personal physician
- A physician-directed medical practice
- A whole-person orientation
- Coordination of care
- Strong adherence to quality and safety
- Enhanced access to care
- An appropriate payment structure for provider services[cxlv]

- **Feature 1 – Personal Physician**

  Each individual in a PCMH has an ongoing relationship with a personal physician. The role of this physician is to serve as the individual's first contact point when care is needed as well as serve as a coordinator with other health-related services and specialists if needed.

  The personal physician also serves as an educator. For example, the personal physician helps an individual understand the ongoing care they are receiving and prepare for potential procedures and treatment options they face.

  Example: Roger Jones is a worker who participates in his company's wellness program which incorporates a PCMH. Roger has enjoyed relatively good health throughout his life and credits the wellness program with helping maintain an excellent attendance record through its preventive care services. Recently,

Roger's physician, Dr. Mendez, detected the presence of prostate cancer during his annual physical examination. Rather than simply providing Roger with the diagnosis, Dr. Mendez explains what it means and discusses various surgical and nonsurgical treatment options with Roger.

- **Feature 2 – Physician-Directed Medical Practice**

A physician-directed practice is one in which a patient's doctor leads a team of individuals at the PCMH who collectively assume responsibility for an individual's ongoing care. For example, the team for a particular individual may consist of his or her doctor, a lab technician, and a disease specialist who shares information. In some instances, the team may consist solely of members located at one particular physical location. In other instances, some team members will work outside the practice but receive and share information.

- **Feature 3 – Whole Person Orientation**

The whole-person approach offers an alternative to a focus on isolated episodes of sickness which can leave the "medical dots" unconnected. The whole-person approach allows the PCMH to deal with both the mind and body, as well as consider the clinical alternatives and priorities in the context of the individual's values. This also means the individual's doctor assumes responsibility for integrating and coordinating care across a variety of settings. These can include the physician's office, a hospital, a rehabilitation facility following the hospital, or an individual's home.

The whole-person approach is designed to avoid a series of silo disease or organ-specific treatments that fail to consider, for example, drug interactions. The goal is to take into consideration the individual's priorities, treatment preference, and quality of life.

Example: After discussing the risks of full-scale surgery for prostate cancer and the possibility of incontinence with Dr. Mendez, Roger decides to forgo hospitalization. Dr. Mendez takes into account Roger's concerns that incontinence would impact his participation in sports. Instead, given Roger's age and the likelihood of slow disease progression, they opt for a wait-and-see approach to treatment coupled with ongoing monitoring.

- **Feature 4 – Coordinated Care**

A PCMH coordinates care within a localized medical practice and, if needed, across the entire health care system including internal medicine, specialty care, hospitalization, home health agencies, and nursing homes. The PCMH model also envisions coordination with an individual's family and services within his or her community.

Example: Jade, a middle-aged worker suffering from diabetes, participates in her company's wellness program. The wellness program offers Jade the opportunity to participate in disease management of her diabetes offered through a PCMH. Over time Jade is treated by both her primary physician, Dr. Smith, and a diabetes specialist, Dr. Ortiz, who share records and guide her ongoing treatment.

This coordination also envisions the integration and sharing of records. In this respect, the PCMH model relies heavily on information technology. This high tech vision contrasts with the problem faced by many individuals today as they struggle to remember the names of medications they are taking and what treatments have been delivered by whom for years.

Accountability is another element of coordinated care. In other words, clarifying who is responsible for each aspect of a patient's overall care. In a fragmented system of multiple providers working in silos, this is often unclear because they are unaware of the others' treatment recommendations and efforts. By breaking down barriers and sharing information, the PCMH makes it far easier to determine what care is and should be provided and by whom.

Examples of PCMH Activities Which Promote Care Coordination

- ✓ Initial determination and updating of individual patient care needs.
- ✓ Creation of proactive plan of care, incorporating individual treatment preferences, coupled with plan updates.
- ✓ Communication of plan of care and individual responsibilities to the patient.
- ✓ Provision of patient education as needed to follow the plan of care.
- ✓ Facilitation of transitions between care settings, such as a hospital to rehabilitation facility, and rehabilitation facility to home.
- ✓ Connection among providers and community resources for needed support services.
- ✓ Alignment of resources offered by PCMH with the needs of the population it serves such as disease management of asthma where lung damage prevalent among enrollees.

- **Feature 5 – Safety and Quality**

A PCMH seeks to provide optimal outcomes for the individuals under its care by delivering evidenced-based medicine coupled with clinical decision-making support tools to guide treatment. A PCMH also seeks to avoid the patient safety risks inherent in inconsistent treatment decisions which can occur in a fragmented health care delivery system.[cxlvi,cxlvii]

- **Feature 6 – Enhanced Access to Care**

  Today, many individuals struggle with long commutes, overtime at work, and extensive family commitments—childcare and eldercare being just two examples. This makes it difficult for them to visit a doctor when the need arises. Many medical offices are closed after work and during weekends. To help ease these barriers to health care, the PCMH responds through expanded hours. These expanded hours can be coupled with the use of technology to allow online scheduling of appointments—a further timesaver for busy workers. Technology can play a role in the delivery of care through the use of e-mail communications and telephone conversations with trained medical staff.

  Enhanced access to care in the context of the PCMH model also entails not just the provision of care when needed but the provision of appropriate care. This can help to avoid unnecessary visits to physician offices and can also avoid duplicative testing and overtreatment that can occur when a series of medical providers work independently and without consultation.

- **Feature 7 – Appropriate Payment Structure**

  The PCMH model recognizes that it takes extra time to not only provide care but to coordinate care and development of personal relationships with patients. There are costs associated with the acquisition, installation, and ongoing use of technology. The PCMH is reimbursed for these factors through a payment mix that can include dollars for care management, separate fee-for-service payments for face-to-face visits, plus additional sums for achieving measurable quality goals and improvements. This contrasts and helps to modulate the extremes offered by pure capitation and fee-for-service models. For example, a traditional fee-for-service payment system tends to encourage delivery of face-to-face medical services and testing to boost provider earnings without necessarily considering the extent to which they are appropriate.

Health Information Technology and PCMHs

Health information technology (HIT) will play a big role if PCMHs are to be successful. Electronic medical records are only a small part of the picture. HIT is needed to support a variety of other goals. These include:

- **Electronic Communication Between Providers and Patients**
  Moving forward, it is anticipated that e-mail will play an increased role in communications; for example, to determine patient needs for face-to-face visits as well as a follow-up once an illness is diagnosed and initial treatment administered.

- **Remote Monitoring of Patients**
  Technology advances now allow medical professionals to monitor factors such as patient blood pressure remotely. These tools will become increasingly important as the population ages, making travel difficult for older patients. It will also prove to be important in serving both younger and older patients in rural areas where providers must care for individuals over wide geographic distances. This currently involves and will increasingly involve not only the transmission of information but telephonic communication and visual communication between patients and medical professionals.

- **Data Transmission by Participants in Wellness Programs**
  As wellness programs become linked to PCMHs, participants in these programs will be encouraged to transmit data recorded before, during, and after exercise so that the PCMH can better monitor their general health and progress toward various health goals such as weight reduction or lower blood pressure levels. This will involve the use of tools by both the participant and the PCHM to record and then safely transmit personal health information without risking the loss of privacy.

- **Ability to Access Educational Tools**
  With time a valuable commodity in today's workplace, workers are likely to increasingly look to PCHMs for information that is both timely and accurate on health-related topics. For example, wellness participants may wish to gain better information on balanced meals or the appropriate type of exercise to build strength while avoiding back injury. Those participating in disease management programs may wish to learn more about the natural progression of their ailments or the pros and cons of various alternative medications available to them.

- **Support of Care Coordination**
  HIT also plays an important role in the ability of PCMHs to provide care coordination by allowing providers to quickly share information and analyze evidenced-based care alternatives.

- **Predictive Modeling**
  As more individuals enroll in PCMHs, predictive modeling through the aggregation of data is likely to result in increased quality of care as the needs of employee populations are anticipated and various treatment options for various diseases are analyzed and compared.

- **Financial Tool to Track Costs and Savings**
  To qualify for the mixed payment package likely to be made available to PCMHs by plans and the accountable care organizations (ACOs) which we will discuss later, PCMHs will need to carefully track both their fee-for-service and non-fee-for-service activities. This will prove to be very difficult, if at all feasible, without the use of technology which easily classifies, groups, and tracks their activities.

Current PCMH Initiatives

Large corporate self-funded plans and private insurers, such as several of the Blues, have already initiated PCMHs for their employee populations. Several health plans have also begun to encourage the formation of PCMHs and offer these networks to their clients. Thus far, these initiatives have proved encouraging regarding both improving employee health and lowering the health care cost curve.

BlueCross BlueShield of North Dakota's PCMH demonstration efforts, for example, yielded savings of $531 per participant in Year 1 and even higher savings per participant of $1,213 in Year 2. Its demonstration efforts began in 2005 and were focused on diabetes care.[cxlviii]

Year	Participants	Savings Per Participant	Total Savings
Year 1	192	$531	$101,952
Year 2	192	$1,213	$232,896

The PCMH demonstration project efforts of Regent BlueShield of Washington State have shown similar positive results. Outcomes of their PCMH work with a major employer showed higher self-reported productivity and annual savings of those enrolled in the program to be 20 percent lower than a matched control group. These savings resulted primarily due to reduced emergency room visits, fewer hospital admissions, and corresponding expenses related to inpatient days of hospitalized care.[cxlix]

Similar to many wellness programs, PCMH demonstration projects have tended to focus their efforts to reduce health care costs on chronic care and preventive initiatives including:

- immunizations for both children and adults
- cancer screening (breast, cervical, and colon)
- diabetes care, both adult and pediatric
- coronary artery disease
- asthma care

Additional Steps to Move Independent Practices to PCMH Model

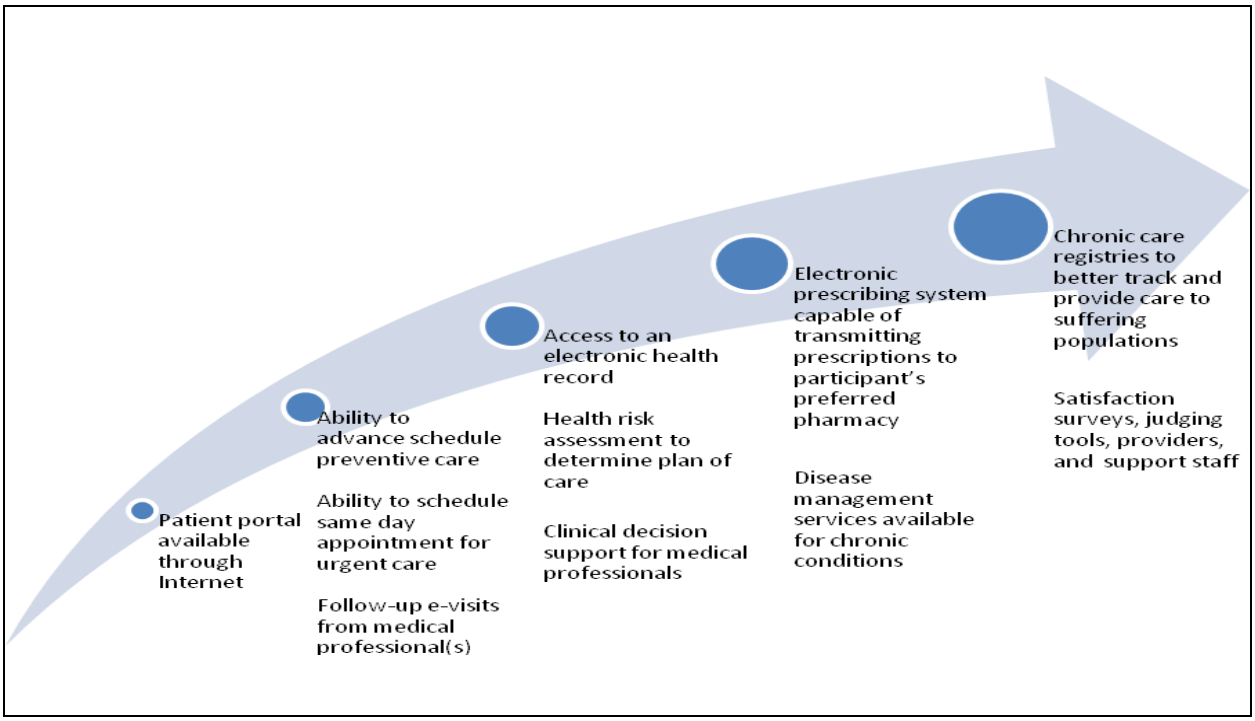
Increased use of technology and shared electronic medical record platforms are good first steps in establishing a PCMH. Additional steps are likely to be needed to successfully conduct a PCMH. These additional steps might involve:

- scheduling patients so they see groups of medical professionals in one visit
- active outreach to individuals who are overdue for preventive services
- hiring of a management coach to facilitate the transition to a PCMH model
- setting goals with patients so that they understand they share accountability for their health

- segmenting patients into those who can independently manage their health and those who require closer monitoring and care management
- seeking out and adding health care professionals to the home, such as registered nurses, certified diabetic educators, dieticians, and mental health specialists

There may also be a need to seek out managerial help. Many health care professionals are accustomed to working independently. The PCMH model is based on teamwork and collaboration. This can be a difficult transition, particularly where the PCMH brings together professionals who are working in different physical locations. In these situations, and even in those where professionals have worked in the same office location for years, practice coaches can help overcome these barriers by focusing their managerial skills on building teamwork and collaboration in addition to working with the various health care professionals to create shared data collection and reporting tools.

The Look of Preventive Care in a PCMH to an Individual Employee Participant



Accountable Care Organizations (ACOs)

Accountable care organizations (ACOs) have been receiving considerable attention since the passage of the Affordable Care Act (ACA), which seeks to promote their implementation. Currently, there are many questions about the exact structure of ACOs as the recently enacted health legislation is being digested and guidance issued. Simply speaking, however, an ACO is a group of health care providers who deliver comprehensive and coordinated care with an emphasis on screening, prevention, and ongoing treatment of disease. This group of providers

may, for example, include several PCMHs and specialty medical practices linked to a hospital where needed surgery or other advanced treatments are provided.

At this juncture, the movement to establish ACOs is focused on Medicare and ways that these organizations can help reduce the outlays associated with this government-funded program for those Americans aged 65 and older. The ACA directs the Secretary of Health and Human Services (HHS) to create the **Medicare Shared Savings Program**, which encourages groups of providers to come together to form ACOs to manage and coordinate inpatient and outpatient care for Medicare fee-for-service beneficiaries. ACOs that meet certain quality standards will be eligible to receive payments based on a share of the savings generated. The Medicare Shared Savings Program is scheduled to launch in early 2012 and organizations selected must agree to participate for at least three years.[cl] If successful, the Medicare Shared Savings Program could provide a path in lowering health care costs of non-Medicare populations—such as employees participating in employer-sponsored wellness initiatives.

Summing It Up: The Linkage Among Employer-Sponsored Wellness Programs, PCMHs, and ACOs

The incorporation of a PCMH into an employer's wellness program can serve to accelerate and maintain a favorable return on the dollars spent on the program. The PCMH emphasizes the role of the primary care physician and this factor can help to lower the medical outlays of an employee population. Adults with primary care physicians tend to have not only greater access to preventive care, but also enjoy lower health care expenditures and better quality of care.[cli,clii]

PCMHs reinforce wellness programs and the benefits to be derived from them including better employee health, increased worker productivity, and lower health care expenditures. If participation is extended to dependents, the cost savings offered through wellness programs can be expected to rise as the health care costs of family members decrease through easier access to quality prevention and early detection offered by PCMHs.

Currently, PCMH initiatives have focused primarily on those with chronic conditions to maximize cost savings—following in the footsteps of many wellness programs. Moving forward, we can expect the PCMH model to spread to healthier populations with the emphasis on maintaining good health and avoiding or delaying the onset of costly chronic conditions in both patient well-being and financial terms.

Under the Affordable Care Act, accountable care organizations (ACOs) would provide screening, prevention, and ongoing coordinated care for Medicare beneficiaries. These groups of health care providers would receive payments based on a share of the savings through the Medicare Shared Savings Program. Scheduled to take effect in 2012, this provision could open the door to lower costs for others, including corporate wellness participants.

Managing a Wellness Program: A Closer Look

Introduction

Wellness program management is not a one-size-fits-all endeavor where one approach can be effective for a wide range of organizations no matter the culture or scope of business operations. To be successful, wellness programs must be flexible and fine-tuned to the specific needs of the company and its employee population. For larger employers, programs would be tailored to a wider array of employees and take factors like age, gender, and ethnic preferences into consideration to achieve broader participation.

Wellness initiatives and prevention of chronic conditions can have a favorable impact on a company's bottom line through increased employee productivity and reduction in absenteeism and health care costs, resulting in savings on insurance premiums. To reach these goals, employers must make numerous decisions. For example, should an employer use in-house staff or hire outside consultants to operate their wellness programs? In the sections that follow we'll take a closer look at how wellness programs are planned and implemented. We'll review the ongoing process of program administration, examine the role of the wellness coordinator, and study evaluation methods.

Objectives:

After studying this lesson and completing the accompanying exercises, you will be able to:

- explain why wellness program planning needs to incorporate input from targeted participants
- define the implementation process and identify primary factors for gaining employee participation
- recognize the role of the wellness coordinator and how responsibilities may differ based on whether operations are outsourced or managed internally
- describe the need for an HR presence on the wellness committee and the link to other resources like employee assistance programs
- understand the methods for program evaluation and ways data and costs are tracked and reported

Planning for Success

In establishing a wellness program, thorough planning is vitally important. Getting input from employees throughout the organization is essential to the planning process. Assembling a wellness committee represented by employees with a strong interest in developing a successful program is a key factor.

According to recent research[cliii1] employer's efforts to create incentives for employee participation in wellness activities are likely to fail unless the programs are planned and implemented correctly. Programming to help employees shed excess weight, stop smoking or improve fitness levels are laudable goals, but many employers fail to properly implement these programs to achieve maximum buy-in from employees.

From the earliest stages in wellness program development, routine communications to employees will alert them to what's coming. Promoting the new initiative and capturing employee interest as early as possible will pay off later as these potential participants realize their importance to the planning and success of the program.

Surveying the workforce provides data on employee interest in the types of the desired programming and helps assess the corporate culture. In the analysis, program developers must always keep a watchful eye on the company's finances so it is understood what is affordable and what is beyond the available funding. For instance, are employees more interested in nutrition than fitness and is the use of tobacco products an issue?

Understanding the targeted workforce as well as the overall organizational culture will ensure that the program implemented meets the greatest needs. This knowledge will help the employer avoid creating a program that is inappropriate for the life situation of major segments of its workers. The program must consider not only the variety of employee interests but the physical capabilities of various cohorts.

Affordability may be the ultimate determining factor in the selection of wellness tools. Keeping the scope of the wellness program within budget is essential to its success. If the company cannot sustain or manage its program effectively, failure will surely result. The initial employee interest assessment should also include questions concerning costs. Are employees willing to pay to participate? If limited corporate funds are available, an employee cost-share may be needed. This is not necessarily a negative because an initial investment on an employee's part can serve as an incentive to remain engaged in the overall program.

Program Implementation

Worksite wellness program implementation involves a step-by-step process of putting the plan design into action. The wellness plan may necessitate making arrangements with wellness vendors, recruiting health and wellness speakers, negotiating with health plans or health clubs, scheduling wellness activities, and more. To some extent,

implementing the program, marketing, acquiring resources, and evaluating the process can all occur simultaneously.

Selecting a Wellness Coordinator

Employers should begin the wellness process slowly and lead off with those activities that it deems most likely to succeed. The employer's wellness committee and management team at all levels will need to be involved. Gathering input can be accomplished through employee surveys, focus groups, and informal, but documented polling. The selection of a point person to coordinate activities or interface with employees is another essential whether or not the program is to be implemented by an internal manager or presided over by an outside vendor.

The program coordinator should have both the time available and the interest in wellness to successfully administer the program. This individual should possess some knowledge of health issues or a willingness and interest in learning about them. The individual should also have excellent communication, managerial, and leadership skills. The ability to analyze data and collaborate with others who have expertise is also helpful. Coupled with administrative oversight, the program coordinator may act as the liaison to the accounting department, monitoring data related to wellness and keeping a watchful eye on costs.

Another function of the program coordinator may be to head the wellness committee. The role of committee members means more than just attending meetings. To achieve program success these leaders must actively engage employees and foster a culture of wellness. They must be visibly active in participating in program activities themselves. By taking part in fitness programs, healthy eating initiatives, and participating in health screenings, they demonstrate to staff that management is on the wellness bandwagon, making it more likely employees will want to join the action.

Depending on the organization's size, the wellness coordinator's responsibilities may include the design and implementation of the program or contract management if the employer elects to hire an external vendor/consultant to create the program. It may be more efficient for the organization to contract with an outside wellness consulting firm to design and conduct the wellness program versus relying on internal staff. Several small businesses find this method to be more effective.

Role of Human Resources (HR)

In addition to program management and oversight, a large part of HR's role in advancing workplace wellness initiatives involves motivating employees to participate. This isn't about cheerleading. It's about succinctly putting forth or "selling" the benefits employees can achieve through healthy outcomes. Increasingly employers are offering financial incentives to employees who accomplish goals, such as quitting smoking. Because of the HR department's influential presence in most organizations, its link to top management decision-making, members of the department should be visible in the wellness process. Ideally, a representative from HR will serve on the worksite wellness committee.

If the wellness program is contracted to a consulting agency, the employer may assign administrative responsibilities to an HR manager. Professionals schooled in human resource management are often effective communication coordinators, adept at understanding corporate culture, and making connections throughout the organization to ensure that the program functions smoothly. Whether the program is operated internally or managed by a consultant, the appointed HR manager will become a contact person who oversees wellness activities.

Human resource personnel also have the capability of linking employees to other wellness resources. A prime example is a liaison between HR and the employee assistance program (EAP).

Link to Employee Assistance Programs (EAPs)

Many HR benefits managers work with employee assistance plan managers or work-life coordinators to integrate the growing number of programs that deal with mental and physical health, such as stress management, obesity, and smoking cessation, into their health benefits programs.

Employee assistance professionals can be an important ally in wellness efforts by helping identify employee needs, getting top-level buy-in, and assisting employees and supervisors in recognizing the link between employee wellness and work. Employers need to lower health care costs to stay competitive, and keeping employees healthy through worksite wellness has emerged as a business strategy. But pulling together all the components that comprise a successful wellness program can be a challenge.

Workplace health has evolved from crisis intervention to personal assistance, prevention to health promotion. Today's wellness movement goes a step beyond to include environmental and organizational issues that may add to the stress load on employees.[cliv] In helping employees manage stress, a collaborative approach between employee assistance and worksite wellness programs assures the employer that employee needs are being met.

EAP programs offer additional resources not traditionally found in workplace wellness programming. The EAP emphasis on stress relief is a great complement to typical wellness programming as employees may be burdened by non-employment stressors, such as childcare issues, the needs of aging parents, or financial problems, all of which ultimately impact the employee at work. EAPs can assist employees in resolving these stressful problems where typically wellness programs do not address them. Integrating wellness and employee assistance programming is key to creating a comprehensive culture of health where employees can thrive personally and professionally.

Employee Assistance Professionals

Employee assistance plan managers, also called employee welfare managers or work-life managers, are responsible for a wide array of programs to enhance employee safety and wellness and improve work-life balance. These may include occupational safety and health standards and practices, health promotion and physical fitness, medical examinations and minor health treatment, such as first aid, flexible work schedules, food service and recreation activities, carpooling and transportation programs such as transit subsidies, employee suggestion systems, child care and elder care, and counseling services. Child care and elder care are increasingly significant because of growth in the number of dual-income households and the older population. Counseling may help employees deal with emotional disorders, alcoholism, or marital, family, consumer, legal, and financial problems. Some employers offer career counseling and outplacement services through EAPs.

Inside Operation or Outside Vendor?

In addition to the actual programs or wellness initiatives selected, an administrative decision is also necessary at the outset and the two decisions may go hand-in-hand. If the company's wellness budget is small, then the program selected needs to be one that can either be implemented by existing internal staff or administered easily by an outside vendor on a small contract basis. Best decided simultaneously, these decisions are also dependent upon whether existing staff has the expertise required to effectively implement the desired wellness initiative(s).

To solicit proposals for possible wellness program vendors, businesses can issue a request for proposal or RFP and invite bids by wellness program consultants and firms. Businesses should contact reputable providers that have a solid track record in the wellness program industry with proven strategies for delivering a solid return on investment for past clients.

Outside wellness vendors offer myriad options to address the needs of individual businesses. The process usually begins with a survey of employees to assess needs and interests. A program would be designed to meet those needs within the financial constraints of the organization. These wellness consultants possess the tools to facilitate program implementation and provide ongoing management including the following:

- newsletters and other wellness educational materials
- lifestyle coaching
- web-based health improvement tools
- speakers

Outside vendors may also offer extra components that dovetail with the health risk assessment (HRA) or biometric test results to provide a value-added mechanism to the wellness program. These might include services such as personal counseling or weight management. During the negotiation/contracting process, employers will want to ask

consultants if such services are automatically offered to employees identified with certain health risks, like obesity or diabetes for example, and get an estimate of associated costs. With the provision of administering the wellness program settled, attention then turns to begin the process of implementation.

The Implementation Process

In launching the new worksite wellness program, employers should use multiple avenues to seek employee engagement from the outset. Methods for transmitting information can include bulletin board material, emails, newsletters, and intra-office flyers distributed on payday. Employers should always refer back to the surveys employees completed to be sure employee input was addressed. Assessing employee interests in wellness at the beginning will aid tremendously in focusing the program for success and making sure that employee interests were considered in the program's development.

There are many challenges businesses face when attempting to engage employees in participating in a new wellness program. Employees come in all shapes, sizes, and fitness levels. A one-size-fits-all approach that caters to the athletic employees could turn off a large majority of the workforce. Remember, it's easy to participate in a wellness program if the employee already belongs to a gym and has a body mass index equivalent to their shoe size. It is harder to motivate participation among the less physically fit and inactive employees who may have been discouraged by previous attempts or embarrassed by their physique. This is why it is important to include a broad array of wellness programming as is possible within the organization's budget. These might include nutrition and cooking classes as well as light physical activities such as a walking club.

Ways to Gain Employee Participation

With a new wellness initiative, it is sometimes helpful to begin with a big kick-off event such as a health fair. At the same time, a letter or email from the CEO introducing the program and explaining how improving the health of the company's number one resource—its employees—
ties in with the company's bottom line.

Other components of the program's kick-off could include a booklet describing program offerings. Announcing a contest with prizes for attaining individual goals or winning team competitions usually attract attention. These methods are useful in achieving higher year-one participation which often is at just 20-30 percent on the high end.

Health Screenings and Wellness Budgets

An important early component of many wellness programs is a health screening. While there are numerous types, perhaps the most prevalent is the health risk assessment (HRA). To conduct these screenings the company or wellness provider should contract with a third party health screening agency to protect health information privacy. While

results can be used to implement behavioral health changes or set up an individualized fitness program, using a third party secures individual data. Screenings are generally conducted on an annual basis and provide an excellent baseline to judge progress toward employee health and fitness goals.

Many common types of health screenings can be done in the workplace. Some of the more popular measure height and weight, body fat percentage, bone density, body mass index, cholesterol levels, heart rate, blood pressure, and diabetes risks. These tests are not complicated, they can be completed in the workplace, and they are essential to every individual's overall health.

Keep in mind that workplace wellness health screenings should be completed by qualified and licensed personnel. This is important because employees need assurance that the results they get are 100 percent accurate and reliable. The data provides feedback to employees marking progress (or lack thereof) toward their health goals. Over several years, companies sponsoring wellness programs should see lower than expected health care costs and improved employee health outcomes overall in the aggregate trends for the employee population.

Workplace health screenings can be very costly to the company as well as the wellness budget. You may find the need to be creative in paying for these tests. Employees may be willing to pay for all or a portion of the testing, and they will appreciate the convenience of onsite screenings. For example, a cholesterol level test may cost approximately $20. Biometric screenings are short-form physical assessments that track a small number of significant indicators of a person's overall health and generally cost $100 per individual.

Ongoing Program Management

After the initial wellness program implementation employers should continually outreach to employees and engage them in the process. At the outset, employers should not expect 100 percent participation. Achieving maximum participation takes time and it is possible the program will not engage all the employees all the time. But incremental steps and outreach to friends and colleagues by employees who do find wellness of value will likely yield the greatest increases in participation.

Financial Incentives to Increase Participation

Whether through a discount on premium contributions or cold hard cash, employers increasingly are using financial incentives to encourage employees to adopt healthier lifestyles. Such incentives are governed by the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state nondiscrimination laws which determine how generous offerings may be, among other factors.

Approximately two-thirds of the employers currently offering wellness programs are using financial incentives to encourage participation, according to a recent survey of members of the ERISA Industry Council and the National Association of Manufacturers. The most common incentive is health insurance premium reductions, which are offered by 40 percent of employers that responded to the survey. Cash or bonuses were a strong second, offered by 29 percent of the companies surveyed.[clv]

Best Practice

According to data compiled by Tom Underwood of Alere Health, many employers in his recent research on wellness programs had participation well over industry averages of 40 to 50 percent. But a few had participation rates of 80 to 90 percent. Underwood asked what they were doing to achieve that level of success and discovered these employers were following four basic recommendations:

1) Make the wellness programs relevant to employees
2) Engage employees at every level of the health continuum
3) Provide personal health support
4) Offer really good and meaningful incentives—like cash, extra vacation days, whatever motivates employees—and not just gift cards

Wellness Strategies

In planning and implementing wellness programs, business owners can employ a myriad of strategies to achieve their wellness goals and employee behavioral change. These strategies range from low or no-cost programs such as workplace motivational signs and designated physical activity breaks to high-cost efforts including onsite fitness classes and personal training. Those employees who improve their physical fitness will reduce their risk of chronic conditions like heart disease and diabetes. Their health insurance premiums will be reduced, absenteeism will lessen, and productivity will increase, all saving the employer money or producing additional revenue. Beyond efforts to increase employee's physical activity, wellness efforts can also focus on nutritional improvement. Low-cost workplace efforts can include replacing vending machine junk food with healthier options. Among high-cost nutritional programs, effective options include offering incentives for employee participation in nutrition and weight management programs.

Program Evaluation

Program Goals and Outcomes

Year 1 Goal – 40 percent of employees participate in at least one program element.

Year 2 Goal – Add risk reduction and satisfaction metrics:

- Health risks improve by at least 2 percent as measured by the health appraisal questionnaire
- 90 percent of employees who participate report satisfaction with the program
- Biometric scores (e.g., BMI, cholesterol, blood pressure) show measurable improvement compared to year one

Year 3 Goal – Increase expectations; add financial performance metrics:

- 80 percent employee participation in health screening and other programs over the previous three-year period

Role of Accounting and Finance

With the aid of accounting systems, program outcomes can be measured in terms of improvements in employee productivity and reductions in health care costs. The cost-benefit data are analyzed, compared, and tracked against benchmark projections and return on investment (ROI) goals established by the business. Although improving employee health and well-being is the primary worksite wellness goal, producing a solid return will ensure the program remains sustainable over a long period. Research has proven that wellness programs achieve a typical ROI of $3.48 when considering health care costs alone, $5.82 per $1 when examining absenteeism, and $4.30 when both outcomes are considered.[clvi4]

To develop successful methods of wellness program evaluation, data gathering mechanisms need to be planned at the outset to attain consistency and usefulness of data. From the start of the program, the business should detail what they want to learn from the wellness program evaluation and identify data needs through strategically planning the outcomes they want to report. Since evaluation is determining the value created from an enterprise, it is vital to determine what data means in relation to the program objectives. In the end, the business needs to understand whether or not the wellness program achieved the desired outcomes. In this process, it will also learn what areas need improvement and be equipped to make strategic changes. The benefits of evaluating wellness program outcomes to:[clvii]

- see if the intervention worked
- demonstrate the cost-benefit of the intervention
- compare different types of interventions
- provide status reports to management
- give meaningful feedback to program participants

Ensuring that the evaluation is done honestly is a must. Employers need to recognize that some interventions did not work as well as hoped. In some cases, the results may not be worth the expense or did not improve employee health in any meaningful way.

Focusing the Evaluation

In workplace wellness programming there are endless variables that can be measured and evaluated. Business owners need to focus on their highest level outcome reporting needs. According to the Wellness Council of America (WELCOA), the way to accomplish this is by asking a few basic questions:[clviii]

- What results do senior managers want from the program?
- Does senior management see the primary mission of the program as reducing health risks or as presenting a caring image to employees?
- Most importantly, what do the employees themselves want to learn about their own experiences and health outcomes?

Types of Evaluation

There are two primary types of evaluation used in assessing worksite wellness initiatives. Process and outcome evaluation methods are both effective means to determine the success of programming.

A **process evaluation** is generally easier to conduct and provides more immediate feedback on the efficiency of implementation and satisfaction of employees. Some examples of process reporting include the following:

- number of staff enrolled and participating,
- website hits,
- participant satisfaction surveys, focus groups, etc.
- policy or environmental changes.

Outcome evaluations are more robust and generally require a greater amount of time to process. To employ an outcome approach effectively, the marker being assessed should be identifiable and the baseline data should be available. An example would be a comparison of employee absenteeism before and after program implementation. Some examples of data reported from an outcome evaluation are:

- pre/post survey results of employee attitudes concerning wellness, nutrition, and fitness
- vending items being chosen pre/post wellness program implementation
- health indicators such as reduced risk factors
- return on investment

Reporting

The wellness program evaluation needs to summarize the evaluation outcomes for all stakeholders and gain their feedback to continually improve and update the outcome reporting process. It is also important to share the evaluation with the wellness committee as they are likely the most engaged stakeholders of the program. This way the committee can fine-tune the components that did not meet program goals or objectives going forward, build on program strengths, and address shortcomings. Through the evaluation, the committee can compare different types of programs to determine which approach was the most effective and can boost

participation by reporting data to employees. Just as board members and senior managers receive routine reports on operations and financials, the wellness program outcomes and status should also be reported to the leadership group in the same manner at least once a year.

In reporting outcomes to employees perhaps non-participants will be influenced when they realize the positive impact wellness is having on their participating co-workers and be motivated to participate themselves.

Return on Investment

Researchers at the Center for Studying Health System Change conducted a study for the National Institute for Health Care Reform and found that wellness program return on investment (ROI) is uncertain. They particularly cited programs that were one-size-fits-all purchased from vendors with little direct employer involvement as particularly poor in ROI.

Evidence continues to grow that well-designed and well-resourced wellness and illness avoidance programs provide multi-faceted payback on investment. A review of scientific studies with their findings and meta-analyses show that ROI is achieved through improved worker health, decreased benefit expense, and enhanced productivity. Here's a sampling from that review:[clix]

- Goetzel and colleagues performed a meta-analysis of two dozen articles summarizing economic examinations of health and productivity management programs and found an average return of $3.14 per $1 invested in traditional wellness programs. The ROI estimates for the individual programs ranged from $1.49 to $13.7.
- Aldana reviewed 72 articles and concluded that wellness programs achieve a typical ROI of $3.48 when considering health care costs alone; $5.82 per $1 when examining absenteeism; and $4.30 when both outcomes are considered.
- Ozminkowski and colleagues conducted a 38-month case study of 23,000 participants in a health management program at Citibank, N.A., and found that within two years Citibank realized an ROI between $4.56 and $4.73. Follow-up studies[clx] showed improvements in the risk profiles of participants, with the high-risk group doing better than the "usual care" group through more intensive programming.
- Chapman's 2004 meta-evaluation of 42 studies, ranking the overall validity of each study,[clxi9] reported cost-benefit ratios from $2.05 to $4.64.

Summary

As we've just seen wellness program management offers employers a wide-range of opportunities to improve overall employee productivity, reduce absenteeism, and provide a solid return on investment. Wellness programs offer many solutions for large and smaller employers that are both flexible and comprehensive. Thorough planning and a dedicated wellness committee with buy-in from leaders throughout the organization help tremendously in meeting wellness program goals and objectives. Evaluation of results and continuous improvement are also important to achieve the desired employee health outcomes.

Creating a Culture of Health Through Wellness Programs

Introduction

What do we mean when we talk about the culture of health? One source defines the term as an integrated effort to align management support, benefit design, policies, environmental supports, and sponsored programs with the health goals of the organization. Another suggests it is meant to communicate to an eligible population that health matters, not only to the health of the organization but to the individual's total value and well-being.[clxii] Alluded to throughout this course, we aim to flesh out the concept in our concluding discussion of wellness, prevention, and value-based care.

Objectives:

After reviewing this lesson and completing the accompanying exercises, you will be able to:

- define and discuss the role of culture as it applies to organizations
- recognize ways leaders use their power to promote ideas and influence people
- acknowledge the importance of supportive policies and tools like the employee handbook and how they tie in with wellness goals
- determine which policies and benefits need to be in alignment with wellness initiatives
- understand the demographics of the current workforce and methods for tailoring programs to meet population needs

Role of Corporate Culture in Wellness Programs

Organizational development consultant Ellen Wallach has said corporate culture is hard to define but you'll know it when you see it. That's certainly true for employees who get to know an organization's culture by living it.

Every organization has its own unique culture or personality. Employment counselors often advise job seekers to do their homework. Find out how the organization rates on certain factors like staff turnover, leadership styles, and work/life balance. Pay attention to what you see, hear, and feel on a job interview.[clxiii]

Edgar Schein, noted for his studies of corporate culture, defines it as "what a group learns throughout its history."[clxiv] Schein categorizes three aspects of culture:[clxv]

- **Artifacts**—structure and processes you can observe
- **Values**—strategies, goals, and philosophies espoused by the organization
- **Basic assumptions**—tacit, shared, taken for granted, the drivers of behavior and personal interactions

To retain the best workers, most employers offer a safe and pleasant workplace, one that follows fair business practices and promotes employee growth and development. Many of today's far-sighted business leaders have taken these principles a step further by creating a

culture of health, a work environment that fosters healthy lifestyles and decision making. Chrysler and Johnson & Johnson are examples that come to mind.

A culture of health is one where employees not only feel supported in changing unhealthy behaviors, they also feel motivated and accountable to maintain those changes and to build on past successes, says David Anderson, vice president of programs and technology for StayWell Health Management.[clxvi] Culture is an important factor in the change process. Understanding its role helps us remove the barriers and establish motivators for getting employees (and their families) to adopt healthier lifestyles.

Actions Speak Louder than Words

Sometimes, even with the best intentions, an organization can send mixed messages to employees about what it values. Consider this example:

> ***Example:*** Jamie has a sedentary desk job and frequently experiences back and neck pain from long hours sitting in front of the computer. Many of her colleagues who smoke are permitted 15-minute smoke breaks outside the building throughout the day. But when Jamie was caught taking a 15-minute stretch break, her supervisor frowned upon the practice.

Management Practices and the Work Environment

Management practices and the work environment can have a significant impact on the health and well-being of employees. The furniture may be contemporary, the technology state-of-the-art, but check out the vending machines. Are healthy snacks available, like nuts and dried fruit?

Unhealthy weight gain due to poor dietary habits and sedentary lifestyles are major contributors to serious health problems like diabetes and cardiovascular disease. Does your company offer education and incentives to engage employees in weight reduction efforts?

Stress is another big factor for workers. Many employers do take the psychosocial needs of employees into account by offering more flexible job structure arrangements that help employees better manage work/life issues.

The Centers for Disease Control and Prevention (CDC) provides a checklist called the TOWE (Tool for Observing Worksite Environments)[clxvii] that can be used for assessing the physical environment where you work. Other methodologies measure values, attitudes, and employee support for workplace health improvement initiatives. One example is the survey questionnaire to get feedback from workers that will help measure an organization's culture of health.[clxviii]

Role of Leadership in Creating a Culture of Health

Creating a culture of health calls for a top-down approach. CEOs and senior management need to be on board from conceptualization to realization of workplace wellness initiatives. Writing about health as a workplace leadership issue, Canadian journalist Brian Duggan said authority figures must accept the role of influence.

"Most employees want to see the visible and authentic direction from management. Promoting a healthy workplace is a prime opportunity for leadership taking action that is visible, encouraging, and proactive," Duggan said.[clxix]

Elements of the Leadership Role

Leadership is typically defined as the process of influencing the activities of an individual or group in efforts toward the accomplishment of goals.[clxx] Effectiveness as a leader is not just a matter of style or charisma. Theoretically, a leader knows how to wield power in positive ways to achieve successful outcomes. He or she may tap various sources or "power bases" to influence the behavior of others.

BASES OF POWER

- **Coercive power** is based on fear. A leader high on this scale induces compliance in others because failure to comply will lead to punishment.
- **Connection power** is based on *who you know*, the leader's connection to influential or important people inside or outside the organization.
- **Expert power** is based on *what you know*, the possession of expertise, which others acknowledge.
- **Information power** is based on the possession of or access to information, perceived to be of value to others.
- **Legitimate power** is based on the position held by the leader.
- **Referent power** is based on the leader's personal traits.
- **Reward power** is based on the leader's ability to provide rewards for other people.

Creating a Vision, Establishing Goals, Implementing Strategies

In establishing a company wellness program, a leader, such as a corporate CEO, sets goals for the organization, individuals, and certain groups within the employee population. He or she, perhaps with a task force, may write a mission statement that communicates the vision for the program. The CEO may select a senior manager to serve as a point person or wellness coordinator, which we defined in the lesson on management.

In implementing strategies to achieve wellness goals, this individual exerts influence. As the public face of the program, he or she may become a role model for desired behaviors.[clxxi]

Profile of a Leader…

Soon after Chuck became vice president of corporate services at Bowles Fluidics Corp., wellness became an issue because of rising health care costs. This VP took on the task by assembling a wellness team, tapping members throughout the company. Together they created a vision for improving the mental and physical health of employees through fun and fitness.

Launched in March 2006, the wellness program included educational elements and physical activities. Bowles held "Lunch and Learn" sessions, inviting speakers from a community association and from its health insurer, UnitedHealthcare, at no cost to the company.

The company began distributing a monthly health newsletter with paychecks. Free onsite health screenings gave employees a chance to check their weight, blood pressure, blood sugar, and cholesterol levels. To get people moving, Bowles awarded activity points for participation in any type of physical fitness.

Like Bowles, many workplace wellness programs receive recognition for outstanding achievements. The C. Everett Koop Worksite Award is given by a nonprofit, private-public

consortium chaired by the former U.S. Surgeon General. Each year, the organization awards worksite, community, or provider programs that demonstrate soundly documented improved health and decreased medical costs. Here are examples of corporate winners with a few notes explaining why they won:

- Perdue Farms Incorporated was awarded an Honorable Mention in 2005 for its Health Improvement Program (HIP) encouraging associates to participate in a health screening and behavior modification program offered through onsite health care professionals.

- **Pepsi Bottling Group, a winner in 2007,** provides a comprehensive, integrated health management program to U.S. employees, covered spouses, and domestic partners. A unique strategy is the use of marketing and branding techniques to sell "health" as a product, which aligns well with a corporate culture that is marketing oriented.[clxxii]

- Energy Corporation of America (ECA), a natural gas company, received the national honor in 2008 for its wellness health improvement programs and its demonstrated medical cost reduction trends.[clxxiii]

Studies of these efforts and others show that environmental supports, committed upper management, effective communication, and use of existing resources are critical to successful outcomes in building a culture of health. These strategies are integral to the process.

Identify elements that connect

Employee well-being and organizational success are inextricably linked in a culture of health.[clxxiv] To reduce barriers to active employee engagement and the long-term sustainability of the wellness program, leadership, benefits, policies, incentives, programs, and environmental supports should all be in alignment.[clxxv] In recognizing how these areas interconnect, program leaders will need to identify those elements that mesh well along with those that don't and need to be improved or changed.

Develop supportive policies

The process for developing supportive policies may start with a review of the employee handbook, especially policies related to leave, conduct, work schedules, and employee benefit programs. See which policies already tie in with stated goals for a wellness program. For example:

- Establishing a tobacco-free environment
- Providing personal time versus company time for participating in company-sponsored health programs
- Offering healthy snacks in the vending machine
- Identifying safe areas for employees to walk and exercise

Align policies with benefits

The next step is to examine the employer's health plan to see which benefits fit with objectives that have been established for the company's wellness and prevention program. The following may apply:

- Reduce cost and access barriers to preventive screenings, immunizations, and evidence-based treatments for managing chronic health conditions.

- Provide financial incentives through benefit credits or contributions to health savings accounts (HSAs) or flexible spending accounts (FSAs) for employees who want to participate in sponsored programs, such as health risk assessments, biometric screening, health counseling, weight loss or smoking cessation programs.

Monitor progress

Periodically, there's a need to audit the wellness program, refresh goals, and review and reset objectives. Program managers will need to monitor employee participation and satisfaction level for various activities at different stages of program development. Are registrations and attendance rates up? Or is there a drop-off? Are goals being met and outcomes measured? These statistical trends are indicators of a program's viability. Sagging numbers call for interventions. Seek feedback from current participants and dropouts. Find out what's not working and fix it.

Celebrate success.

The organization's leaders should be involved in a kick-off event heralding the yearly re-launch of wellness initiatives with appropriate bells and whistles. In launching a new wellness program or announcing milestones in an existing one, the program administrator can appoint a spokesperson, someone who is a great communicator, to champion the cause and sell the benefits. Have participants/employees deliver personal testimonials about achieving goals—for example, losing 50 pounds and lowering high blood pressure. Prepare and distribute a media release advertising your program's progress and highlighting its struggles. Invite local news people and luminaries in health and fitness to attend or speak at the event.

Crafting Supportive Policies: The Employee Handbook as a Tool

The employee handbook is an important communication tool between an employer and employees. A well-written handbook sets forth the employer's expectations for employees and describes what they can expect from the company. It is also the place to define the company's position on health promotion in the workplace.

In a simple statement, the handbook should annunciate the company's support of the wellness program and its dedication to the creation of a culture of health. The objective is to let employees know that wellness initiatives are important to the employer. Information to include:

- Statements in support of fitness, nutrition, and quit smoking efforts
- Smoking policy, a statement prohibiting smoking on the company premises
- Drug and alcohol policies, a statement concerning the use of illegal drugs and prohibiting the consumption of alcohol on the company premises during work hours

Many employee handbooks describe the legal and administrative obligations an employer has as well as employees' rights. In this respect, be careful what you state. Employee handbooks do have some legal implications…

- From the employer’s viewpoint, the handbook can be cited as putting employees on notice regarding workplace issues, such as a ban on drinking or use or distribution of illegal drugs.
- From the employee’s perspective, the handbook can be cited as a violation of individual rights or as a source for claiming benefits.

It’s always wise to seek legal advice when creating and/or updating the employee handbook to avoid unintended problems. When covering administrative issues relating to wellness initiatives, the information placed in the handbook should remain fairly consistent. Nevertheless, keep a check on program specifics because time, place, and cost may change. Other items that could encounter cost cuts, such as level of support to cover gym membership due to fluctuations in profits, may also need clarification.

Aligning Work Time Policies with Wellness Initiatives

Considering the chunk of time (2,000+ hours a year) the average American spends on the job makes the workplace seem like an ideal setting for wellness activities.[clxxvi] Yet, finding space to squeeze health education classes, physical exercise, or counseling into busy work schedules is a challenge for employers as well as employees. Let’s look at some policy options employers could manipulate to encourage workers who want to pursue wellness activities but can’t seem to find the time.

Flex Time

A flexible work schedule is an alternative to the traditional 9 to 5, 40-hour workweek. It allows employees to vary their arrival and/or departure times. Under some policies, employees must work a prescribed number of hours a pay period and be present during a daily "core time." The Fair Labor Standards Act (FLSA) does not address flexible work schedules. Alternative work arrangements such as flexible work schedules are a matter of agreement between the employer and the employee (or the employee's representative).[clxxvii] There’s leeway here for employers to adopt work arrangements that give employees more personal control.

Time Off Policies

Currently, there are no federal legal requirements for vacations, sick leave, or holidays. For companies subject to the Family and Medical Leave Act (FMLA), the Act does require unpaid sick leave (up to 12 weeks of unpaid leave for certain medical situations for either the employee or a member of the employee's immediate family). Here again, employers have a bargaining chip for incentivizing employees. Time off for good health behavior permits an employee to attend a smoking cessation program or weight-loss class without dipping into annual leave.

Telecommuting

Technology is wonderful. E-mail, the Internet, Go-to-Meeting, flash drives, Web-cams can transform almost any space into a workplace. Instead of going to work, many telecommuters let work come to them.[clxxviii] How does this choice mesh with wellness initiatives? Working at home gives employees more flexibility. For parents of young children or families with eldercare issues, it helps the employee arrange the workday to fit individual needs. Telecommuting also helps with budget issues—cutting the cost of long commutes and expenses for business attire.

Child Care

In addition to juggling hectic schedules, working parents often struggle trying to find affordable child care. Most wealthy countries do far better than the United States when it comes to this issue. In her book, *The War on **Moms**: Life in a Family-Unfriendly Nation*, Sharon Lerner talks about the backflips American **moms** do just to get by**.**[clxxix] **Imagine the panic a working parent feels when running late or missing an important meeting at work because the babysitter didn't show up.**

A lot of employers take child care issues in stride and attempt to create family-friendly policies. Larger employers—big companies, hospitals, and government agencies, for example—may offer child care services and facilities onsite, while smaller employers may provide a list of "certified" licensed child care providers within close proximity to the company. In pursuing health goals, gyms and fitness centers, like the YMCA, offer child care services.

Aligning Employee Benefits with Wellness Initiatives

The employee benefits package is important perquisite employees have come to expect and employers deliver to recruit and retain the best workers. Employer-sponsored health plans offer workers a menu of options, such as the PPO and HMO health plans with wellness and prevention benefits included.

- Preferred Provider Organizations or PPO health care plans offer members the flexibility to choose their doctor or hospital and control health care costs. Members save money when they obtain their health care from a large preferred provider network, where they can self-refer to any physician or provider in the network.

- Health Maintenance Organizations or HMOs are an organized health care delivery system responsible for both the financing and the delivery of health care services to an enrolled population. Members are required to choose a primary care physician (PCP) upon enrollment. An open access model provides the cost savings of an HMO with the freedom to see network providers without a referral from a PCP.

Both PPO and HMO plans include preventive care and wellness benefits, such as:

- Annual routine examinations and office visits
- Well-childcare and immunizations
- Women's health coverage, such as routine mammograms and Pap tests
- Men's health coverage, including routine prostate cancer screening

Some plans are robust: Members may receive discounts for fitness center memberships and weight loss programs and have access to health care advice from registered nurses who can answer employees' health care questions and offer guidance to the most appropriate care. Routine vision care and discount dental plans may be offered, possibly as voluntary selections, and discounts on alternative therapies like acupuncture, massage therapy, and chiropractic care included as well.

Facts About Complementary and Alternative Medicine (CAM)

CAM is a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine. Complementary medicine is used together with conventional medicine, and alternative medicine is used in place of conventional medicine.

- In the United States, approximately 38 percent of adults (about 4 in 10) use some form of CAM.
- People of all backgrounds use CAM. However, CAM use among adults is greater among women and those with higher levels of education and higher incomes.
- Nonvitamin, nonmineral natural products are the most commonly used CAM therapy among adults. Use has increased for several therapies, including deep breathing exercises, meditation, massage therapy, and yoga.

Market Trends (Large and Small Employers)

Some interesting trends emerge when we examine the U.S. labor market. Many employers do not provide health insurance of any kind. The coverage deficit falls mainly on workers employed by small companies. Individuals who lack coverage for preventive services (e.g., health assessments that identify risks associated with specific diseases or identify health conditions in their early stages when treatment outcomes have a higher rate of success) are significantly less likely to receive them than their insured peers.[clxxx,clxxxi]

In addition to no coverage, inadequate coverage for preventive services is also a problem. And even when preventive health services are available to employees through employer-sponsored plans, often they are underused.[clxxxii] Experts have also noted that high copayments/coinsurance for preventive services create additional barriers to accessing evidence-based services.

Health Benefit Design

Employee health promotion programs are usually part of a larger employee health benefit function. But despite what we would hope for, the operational goals of health promotion and health benefits are not always fully aligned with each other, let alone with the organization's business goals.[clxxxiii]

This is changing, however, as health benefit managers, especially in the United States, are being challenged to address escalating health care costs and realize the value of health promotion as a critical component of a total health management strategy. As discussed in prior lessons, common approaches that align benefits with health promotion are incentive programs and value-based benefit design.

- Incentive programs keep healthy employees healthy and motivate participants to reduce identified risk factors. For example, to drive greater participation rates, organizations can provide benefit dollars (contributions to health savings accounts [HSAs] or health reimbursement accounts ([HRAs]) to employees and sometimes spouses, for complying with health risk appraisal programs, preventive screenings, and/or health coaching. The same incentives can be integrated within risk reduction and disease management programs. Other common incentive programs include merchandise, cash cards, health club memberships, and prize drawings for reaching defined program goals.[clxxxiv]

- Value-based benefit design encourages organizations to make strategic investments in selective interventions/programs that have the greatest potential for realizing total value (e.g., decreased direct and indirect health-related costs) to the organization. A critical objective of value-based benefit design is to reduce cost and access barriers that may prevent participants from being fully engaged within a specific intervention. Current practices include the waiving of copays for preventive screenings and/or reducing copays for selective medications in the treatment of high-cost chronic health conditions, such as asthma and diabetes, or tobacco cessation therapies.[clxxxv]

Strategies for Employers and Health Plans

- Form or participate in purchasing cooperatives to negotiate for affordable health insurance premiums and health plans that cover appropriate clinical preventive services.
- Reduce costs and barriers (e.g., high copayments) to clinical preventive services within health benefit plans.
- Administer COBRA provisions fully for those affected by a qualifying event.
- Exclude preventive screenings from annual deductible limits within high deductible health plans (HDHPs).
- Provide benefit credits to HSAs or HRAs for employees who comply with clinical screening guidelines.
- Offer group health plan coverage or a medical savings account (MSA) option that is paid fully by employees (only as an alternative for small employers who cannot otherwise offer employees health benefits).

Gaining Participation: Tailoring Programs to Population Needs

Easy access to wellness programs through an uncomplicated enrollment process is one rule for fostering employee participation. Modest and appropriate incentives also help in motivating employees to take health-risk assessments.[clxxxvi] The HRA is an important lynchpin in the wellness continuum because this instrument uncovers the data that guide program design. It is a key factor for developing programs based on the real health needs, interests, and demographics of a specific workforce.

One company that raises the bar for success in this field is Chrysler. In existence for more than 20 years, the Chrysler/UAW wellness program takes a “holistic” or comprehensive approach to achieving wellness goals. It offers services to employees in a wide range of formats, including health assessments, biometric screenings, workshops, campaigns, and health coaching. The National Business Group on Health has recognized Chrysler as one of the nation’s leading corporations for innovative programs promoting a healthy workplace.[clxxxvii]

Developing a comprehensive health promotion program similar to Chrysler’s may sound like the ideal approach, but for many businesses, it’s not realistic. Small and mid-size firms would find it difficult to try and hit all the targeted areas at once. These employers may want to focus efforts on one or two of the more critical trends.

Workforce Trends: Aging and Chronic Illness

Keep in mind that there are currently four generations of Americans working today. Here we simply reiterate key factors related to age, gender, and health concerns that plan designers may

need to address within their pool of workers. Let us begin by looking at some national health trends:

- About 37 percent of deaths in 2000 were attributable to tobacco, physical inactivity/poor diet, and alcohol. These behaviors often underlie the development of the nation's leading chronic diseases: heart disease, cancer, COPD, stroke, and diabetes.[clxxxviii]

- It is estimated that health care costs will increase 18 percent over the next 50 years due to the aging of the U.S. population. These cost increases will primarily cover the rising need for management of chronic diseases, including coronary heart disease and congestive heart failure.[clxxxix]

- In 2006, 70 percent of people aged 50 to 64 were actively engaged in the workforce, up nearly 4 percentage points from a decade earlier. In the 65 to 74 age bracket, 22.8 percent were employed in 2006, representing a nearly 6 percent increase over the preceding 10 years. These trends indicate a shift to older Americans staying engaged in the workforce for a longer period.[cxc]

We briefly summarize characteristics and health considerations related to the four cohorts that populate the U.S. workforce today.

Cohort	Description	Characteristics	Considerations
Silent Generation ***1925-1945***	Born between the Great Depression and World War II, the so-called Silent Generation survived two of the nation's most horrific events. This older group is characterized as self-reliant and hard working.	Some members of this group are still in the workplace full time or have returned to work due to the Great Recession's impact on savings.	If working part-time, the status of these older workers would raise issues about eligibility for wellness benefits. Most would be receiving health insurance through Medicare.
Baby Boomers 1946-1964	"Boomers" were born in the post-WWII era. This huge cohort continues to dominate U.S. demographics as they move through their life span.	Worksite efforts need to address some of the unique characteristics and needs of this multi-generational group to assure their active engagement in wellness programming and wellness-oriented lifestyles.	The cohort represents a challenge to employers that will require special consideration in physical and psychosocial work arrangements, health management programming, and options for updating professional training.[cxci]
Generation X ***1965-1981***	The 51 million people who make up this cohort are mid-lifers in careers and personal lives. They were the original "latch-key" kids due to divorce and working moms.	Self-reliant and individualistic. Adept at multi-tasking and technically savvy. Prefer a casual, friendly work environment and appreciate flexibility.	Work/life balance, flexibility in scheduling, and child care issues are important considerations when designing wellness programs to appeal to this group.
Millennials	Also called Generation Y, these newcomers to	Millennials like a supportive work	Exposure to smoking resurgence in movies

1982-2002	the workplace are described as self-inventive and individualistic.	environment. Be prepared for demands and high expectations from these younger workers. They prefer to band together and work well in teams.	and current culture makes this young cohort a target for smoking cessation campaigns.

Gender and Generational Differences

Women and men have many of the same health problems, but they can affect each sex differently. For example, women may have different symptoms of heart disease. Some diseases or conditions are more common in women, such as osteoarthritis, obesity, and depression. And some conditions, such as menopause and pregnancy are unique to women.

Heart disease, cancer, and unintentional injury top a relatively short list of men's health threats, according to the Mayo Clinic. The good news, most are preventable. Making healthy lifestyle choices related to diet and exercise, and managing risky behavior, such as drinking too much and engaging in casual sex, are ways to reverse negative trends.

In planning wellness programs for workplace populations, gender and age need to be taken into consideration. For example, an exercise program for truckers or mail handlers who do physical labor may state that "maintaining strength" is an objective. While a program designed for younger male workers may have "muscle-building" as a goal. Younger women may want to develop strength without bulk in physical fitness programs. Older women are likely to prefer a focus on weight reduction. Some initiatives may be gender-neutral, such as the prevention of workplace injuries.

Health Risks and Concerns

Structuring programs around health risks is an evidence-based approach to wellness and prevention. By reviewing data from your organization's health risk assessment (HRA) you can uncover key health problems and develop appropriate ways to address the risks. For example, if the health risk data indicate a high percentage of workers have pre-diabetic conditions, then nutrition counseling and food preparation classes would be in order. Inversely, if the assessment shows that the vast majority of employees are nonsmokers, a large scale smoke-out campaign would be inappropriate. Individual counseling would work better to address the needs of a few smokers.

Personal Preferences

Make it easy for employees to participate. Catering to personal preferences concerning flexible scheduling and selection of activities helps to attract and retain enrollees. An employee survey will reveal levels of interest in different topics and formats.

Some individuals may prefer physical activities while others seek educational opportunities. Some want to work-out alone or receive counseling by phone or Internet, and ones who gravitate toward group activities, such as company softball games or aerobic exercise classes with co-workers.

The more that employees are made to feel at home with an organization's approach to wellness, the more likely they will buy-in and take ownership of their own personal health issues.

Summary

Supportive or authoritative, the image an organization conveys to its employee population makes a difference in the pursuit of successful outcomes in wellness and prevention programs. What we know from research and case studies is that creating a culture of health starts at the top. Management practices and the work environment have a significant impact on the health and well-being of employees. That work time policies and employee benefits must align with the corporate vision for health promotion. And wellness programs should be based on employee health risk assessments, data that reflect the real needs of the targeted population. Personal preferences and age and gender issues should also be taken into consideration. Ultimately, wellness initiatives in the workplace, whether large or small, all-encompassing, or precisely targeted, should promote a consistent message—that the health of employees matters.

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