Worksite Wellness: You Can Benefit from Benefits

How do you bring employees onboard and make worksite wellness a permanent positive part of your mission and benefits?
Recap of Webinar #1

• In our last webinar we discussed an overview of worksite wellness including the rationale, history and potential future of the movement
• We emphasized how clearly worksite wellness fits with the Value proposition
• In addition, we looked briefly at some examples of companies on this journey to wellness
Today we will look again the big picture then look more deeply into the integration of wellness programing with the benefit and incentive structure of the worksite.

While there are obstacles and pitfall ahead the potential rewards of well constructed wellness programming have never been more clear!
Introduction

The diagram illustrates the market dominance of a product over time, categorized into four phases: Introduction Phase, Growth Phase, Maturity Phase, and Decline Phase. The GDP is measured along the vertical axis, with percentage values of 20%, 15%, 10%, and 5% indicated. The X-axis represents time.

Key points in the diagram include:
- **Introduction Phase**: Initial market growth with rising costs and technology.
- **Growth Phase**: Steep increase in market dominance and peak in technology.
- **Maturity Phase**: Plateau of market dominance with declining technology and costs.
- **Decline Phase**: Decreasing market dominance with increased costs and technology.

The diagram also highlights the interplay between market dominance, costs, and technology throughout these phases.
What, then, is “worksite wellness”?

“A comprehensive worksite health program is a planned, organized and coordinated set of programs, policies, benefits and environmental supports designed to meet the health and safety needs of all employees”

Such a program puts in place:

- Interventions that address multiple risk factors and health conditions
- Interventions and strategies that can target the employee at the individual level and the employer at the organizational level
Economics

EXHIBIT A

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2001–2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Employer Contribution</th>
<th>Worker Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>$7,061</td>
<td>$5,269</td>
</tr>
<tr>
<td></td>
<td>$1,787</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>$15,073</td>
<td>$10,944</td>
</tr>
<tr>
<td></td>
<td>$4,129</td>
<td></td>
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</tbody>
</table>

113% Premium Increase
131% Worker Contribution Increase


Employer Health Benefits: 2011 Summary of Findings
The Kaiser Family Foundation and Health Research & Educational Trust
Causes of Premature Death and Major Illness In The US

- **70%** Lifestyle
- **10%** Heredity
- **10%** Environment
- **10%** Lack of Medical Treatment

Surgeon Generals Report
Cancer

Diabetes
Heart disease and stroke

Chronic lung Diseases
Other NCDs

Physical inactivity
Unhealthy diets
Smoking
Cultural Factors

Structural Factors

Work Factors

The Employee

Exogenous Factors

Employee Health/Work Performance

Employee Health Cost Variables/Employee Productivity
Structural Factors

- Administrative Structure
- Health enhancing facilities
- Awareness building and communications
- Wellness Programs and projects
- Services (EAP, health clinics, etc.)
- Policies and procedures
- Benefit plans and incentives
Cultural Factors

Structural Factors

Work Factors

Adaptive Leadership

General Factors

The Employee

Exogenous Factors

Employee Health/Work Performance

Employee Health Cost Variables/Employee Productivity
### Strategic Framework

<table>
<thead>
<tr>
<th>Environment</th>
<th>Physical Activity</th>
<th>Healthy Foods</th>
<th>Tobacco</th>
<th>Mental Health &amp; Stress Management</th>
<th>Chronic Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Benefit Design</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Building a Foundation**

- Communications
- Data
- Wellness Committee
- Leadership
- Incentives

*Good Health is Good Business*
What Do You Hope to Achieve?
Benefits Definition

- Employee benefits and benefits in kind (fringe benefits or perks) are various non-wage compensations provided to employees in addition to their normal wages or salaries.
- Examples of these benefits include: group insurance (health, dental, life, etc.), disability income protection, retirement benefits, daycare, tuition reimbursement, sick leave, vacation, social security, profit sharing, housing, funding of education, and other specialized benefits.
Perks

- Other benefits can be more discretionary and include benefits granted to employees who are doing notably well or who have seniority. Examples are: take-home vehicles, hotel stays, free refreshments, leisure activities on work time, food allowances, golden parachutes, first choice for assignments and vacations, etc.
Why benefits are so important

- The primary purpose of benefits is to increase the economic security of employees.
  - Promotes employee retention
  - Relieves undo stress on employees
  - Attract new hires and, depending on the benefits, may serve as a corporate advantage.
What are the kinds of Benefits?

- In our general discussion of benefits we noted a range from health insurance to housing or enhanced vacation.
- Let’s now focus on health and wellness benefits and how they differ from other types of benefits.
Health and Wellness Benefits

- Illness benefits
  - Outpatient care, hospitalization, pharma
- Wellness benefits
  - Gym membership, education, cash rewards for specific behaviors such as taking an HRA or gaining points through some wellness program structure that allows forgiveness of premiums, copays, deductibles, etc.
- Cross over benefits
  - Benefits where wellness and illness are linked. A good example would be dental insurance that only pays for repair if preventive visits occurred on schedule
Companies Are Doing Wellness

<table>
<thead>
<tr>
<th>Wellness Program</th>
<th>All Small Firms (1-199 Workers)</th>
<th>All Large Firms (200 or More Workers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gym membership discounts or on-site exercise facilities</td>
<td>29%</td>
<td>64%</td>
</tr>
<tr>
<td>Smoking cessation program</td>
<td>31%</td>
<td>63%</td>
</tr>
<tr>
<td>Web-based resources for healthy living</td>
<td>47%</td>
<td>78%</td>
</tr>
<tr>
<td>Wellness newsletter</td>
<td>42%</td>
<td>61%</td>
</tr>
<tr>
<td>Personal health coaching</td>
<td>27%</td>
<td>42%</td>
</tr>
<tr>
<td>Weight loss programs</td>
<td>28%</td>
<td>53%</td>
</tr>
<tr>
<td>Classes in nutrition/healthy living</td>
<td>28%</td>
<td>49%</td>
</tr>
<tr>
<td>Offer at least one specified wellness program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other wellness program</td>
<td>15%</td>
<td>36%</td>
</tr>
</tbody>
</table>


* Estimate is statistically different between All Small Firms and All Large Firms within category (p<0.05).
Among Firms Offering Health Benefits, Percentage Offering a Particular Wellness Program to Their Employees, by Firm Size, Region, and Industry, 2011

<table>
<thead>
<tr>
<th>FIRM SIZE</th>
<th>Gym Membership Discounts or On-Site Exercise Facilities</th>
<th>Smoking Cessation Program</th>
<th>Web-based Resources for Healthy Living</th>
<th>Wellness Newsletter</th>
<th>Personal Health Coaching</th>
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</thead>
<tbody>
<tr>
<td>3–24 Workers</td>
<td>25%*</td>
<td>29%*</td>
<td>43%*</td>
<td>40%*</td>
<td>26%</td>
</tr>
<tr>
<td>25–199 Workers</td>
<td>44%*</td>
<td>41%*</td>
<td>61%*</td>
<td>51</td>
<td>28</td>
</tr>
<tr>
<td>200–999 Workers</td>
<td>63%*</td>
<td>60%*</td>
<td>76%*</td>
<td>61%*</td>
<td>40%*</td>
</tr>
<tr>
<td>1,000–4,999 Workers</td>
<td>70%*</td>
<td>70%*</td>
<td>87%*</td>
<td>63%*</td>
<td>51%*</td>
</tr>
<tr>
<td>5,000 or More Workers</td>
<td>71%*</td>
<td>81%*</td>
<td>91%*</td>
<td>57%*</td>
<td>64%*</td>
</tr>
<tr>
<td>All Small Firms (3–199 Workers)</td>
<td>29%*</td>
<td>31%*</td>
<td>47%*</td>
<td>42%*</td>
<td>27%*</td>
</tr>
<tr>
<td>All Large Firms (200 or More Workers)</td>
<td>64%*</td>
<td>63%*</td>
<td>78%*</td>
<td>61%*</td>
<td>42%*</td>
</tr>
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<table>
<thead>
<tr>
<th>REGION</th>
<th>Gym Membership Discounts or On-Site Exercise Facilities</th>
<th>Smoking Cessation Program</th>
<th>Web-based Resources for Healthy Living</th>
<th>Wellness Newsletter</th>
<th>Personal Health Coaching</th>
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<tbody>
<tr>
<td>Northeast</td>
<td>37%</td>
<td>37%</td>
<td>52%</td>
<td>49%</td>
<td>27%</td>
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<tr>
<td>Midwest</td>
<td>32</td>
<td>37</td>
<td>54</td>
<td>49</td>
<td>28</td>
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<tr>
<td>South</td>
<td>34</td>
<td>25</td>
<td>38</td>
<td>32</td>
<td>20</td>
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<tr>
<td>West</td>
<td>15*</td>
<td>32</td>
<td>49</td>
<td>43</td>
<td>34</td>
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</table>

<table>
<thead>
<tr>
<th>INDUSTRY</th>
<th>Gym Membership Discounts or On-Site Exercise Facilities</th>
<th>Smoking Cessation Program</th>
<th>Web-based Resources for Healthy Living</th>
<th>Wellness Newsletter</th>
<th>Personal Health Coaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture/Mining/Construction</td>
<td>27%</td>
<td>46%</td>
<td>45%</td>
<td>48%</td>
<td>36%</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>65%*</td>
<td>67%*</td>
<td>87%*</td>
<td>59</td>
<td>58</td>
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<tr>
<td>Transportation/Communications/Utilities</td>
<td>23</td>
<td>41</td>
<td>75%*</td>
<td>69%*</td>
<td>46%*</td>
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<tr>
<td>Wholesale</td>
<td>39</td>
<td>43</td>
<td>52</td>
<td>32</td>
<td>36</td>
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<tr>
<td>Retail</td>
<td>17</td>
<td>21</td>
<td>44</td>
<td>31</td>
<td>25</td>
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<td>Finance</td>
<td>25</td>
<td>18</td>
<td>45</td>
<td>22%</td>
<td>8*</td>
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<tr>
<td>Service</td>
<td>28</td>
<td>25</td>
<td>47</td>
<td>42</td>
<td>24</td>
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<tr>
<td>State/Local Government</td>
<td>34</td>
<td>26</td>
<td>29</td>
<td>75%</td>
<td>17%*</td>
</tr>
<tr>
<td>Health Care</td>
<td>25</td>
<td>33</td>
<td>27%*</td>
<td>46</td>
<td>14</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>ALL FIRMS</th>
<th>Gym Membership Discounts or On-Site Exercise Facilities</th>
<th>Smoking Cessation Program</th>
<th>Web-based Resources for Healthy Living</th>
<th>Wellness Newsletter</th>
<th>Personal Health Coaching</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30%</td>
<td>32%</td>
<td>48%</td>
<td>43%</td>
<td>27%*</td>
</tr>
</tbody>
</table>
Incentive Benefits: What are they and do they work?
Types of Incentives

- In a 2009 Watson Wyatt survey of hundreds of worksites only 47% were offering any kind of wellness incentive programs. Of those who were:
  - 29% provided monetary payments
  - 15% provided lowered medical copayments
  - 30% provided member reimbursement of a program cost
  - 48% listed “other” such as FSA contributions, raffle give-a-ways, gift certificates, time off from work, etc.
Do Incentives work?

- Finkelstein and Kosa performed an extensive data search to try and answer this question. The results were inconclusive. There was almost a universal agreement that incentives had a positive effect; but the magnitude of this effect and the type(s) of incentives to use, when and where to use them, whether they should be tied to participation or outcomes, and whether incentives result in sustained positive behavior are all up in the air.

Is there newer evidence?

- A study of 147 organizations by fidelity Investments and the National Business Group on Health revealed a marked increase in average incentives in the last few years.

- **Between 2009 and 2010** the average incentive provided by the selected employers rose from $260 to $430!
How do workers feel about incentives?

- 67% of workers in 2010 were comfortable with their health plan or employer reducing premiums for healthy workers and for those workers willing to take steps to manage their illness or lower their risks.

- In addition, it is significant that 47% would be comfortable if their health plan or employer raised premium costs for workers unwilling to take such steps. This is up from 39% in 2008.
“The ideal program may start with an incentive but companies need to encourage individuals to become self-leaders and take responsibility for their health status.”

Catherine Fillmore. University of Michigan’s Health Management Research Center.
Currently, the cap on incentives is 20% of the total premium. Proposed regulations would increase this to 30 or even 50% and could force lower paid employees with few life options and those unable to achieve significantly positive lifestyle outcomes to shoulder an increasing percentage of the cost of healthcare at the expense of the well-off.

Others including Aldana and Edington find incentives to be an overall positive and believe that if employees are given a voice in the overall construct and implementation of worksite wellness program the overall fairness will be maintained.
Summary of Wellness Incentives in the Current Legislation.

The “Affordable Health Care for America Act” (House of Representatives), section 112, requires that qualifying programs:

- Be evidence-based and certified by the Department of Health and Human Services
- Provide support for populations at risk for poor health outcomes
- Include designs that are “culturally competent [and] physically and programmatically accessible (including for individuals with disabilities)”
- Be available to all employees without charge
- Not link financial incentives to premiums
- Entail no cost shifting

The “Patient Protection and Affordable Care Act” (Senate), section 2705, proposes to increase reimbursement levels to 30% of the cost of employee-only coverage, or up to 50% with government approval. In part restating provisions for current wellness programs, it also requires that qualifying programs:

- Be “available to all similarly situated individuals”
- Have “a reasonable chance of improving the health of, or preventing disease in, participating individuals”
- Not be “overly burdensome, [be] a subterfuge for discriminating based on a health status factor, [or be] highly suspect in the method chosen to promote health or prevent disease”
- Provide an alternative standard for employees whose medical condition — as certified by a physician — precludes participation in attainment-incentive programs
- Not pose an “undue burden for individuals insured in the individual insurance market”
- Entail no cost shifting
- Be evaluated in pilot studies and a 10-state demonstration project
Moving On!

- This debate over incentives needs to be placed in its proper context. In the end, it will be the entire design and execution of wellness programing that will make a difference.
- Because of this we now turn to the issue of Value and Value-Based Benefits.
What are Value-Based Benefits?

- Value based insurance design (VBID) is an employer-drive benefit design strategy to optimize use of higher-value health care services and reduce use of lower-value services.
- The goal is to generate better results from employer healthcare expenditures. The underlying premise of VBID is getting more out of the health care dollar by removing barriers for essential, effective services and products. VBID is a demand-side initiative that focuses on patient incentives to enhance use of medical services of proven value.
Description of VBB: The Components

1. Appropriate use of high value services, including certain prescription drugs and preventive services.
2. Adoption of healthy lifestyles, such as smoking cessation and increased physical activity.
3. Use of high performance providers who adhere to evidence-based treatment guidelines.
A Vision for Value-Based Benefit Design

- Benefit Plan selection
  - High provider performance
    - Provider selection
  - Healthy lifestyles
    - Health promotion and disease management
    - Health coaching and treatment option support
  - High value services and drugs
    - Prescription drug options
    - Preventive medical and diagnostic services
Consumer

- Preventive Medical and Diagnostic Services
- Prescription Drug Options
- Health Coaching and Treatment Option Support
- Health Promotion and Disease Mgmt
- Benefit Plan Selection
- Provider Selection
Implementing Value-Based Benefit Design

Value-Based Benefit Design: A Purchaser Guide
(The National Business Coalition on Health)
Step 1: Population analysis

- HRAs
- Attitudes surveys
- Claims data (insurers and third party payers)
- Cost data (from finance department and from pharmacy benefit managers PBMs)
- Current demographics, geography, cultural diversity and current health provider/service usage patterns

- Understanding the data
  - Targeting at risk populations
  - Determine the magnitude of the modifiable problem
Step 2: Developing the Value-Based Initiative

- Go beyond gift certificates and discounts to reduce barriers to valuable services!
  - Reduce or eliminate co-payments for office wellness visits
  - Modify deductibles for completing health risk assessments
  - Reduce co-payment amounts for using high quality providers.
Determine the best basic value approach for optimal value

- **Design by service** - waive or reduce copayments or coinsurance for select drugs or services.
- **Design by condition** - waive or reduce copayments or coinsurance for medications or services, based on the specific clinical conditions with which patients have been diagnosed.
- **Design by condition severity** - waive or reduce copayments or coinsurance for members with a particular condition—usually high risk for excessive costs.
- **Design by disease management participation** - reduced or waived copayments or coinsurance to high-risk members who actively participate in a disease management program.
Step 3: Communication Strategy

- Critical for buy-in!
  - There needs to be a healthy period of communication that proceeds implementation to give time for employees to understand and begin to embrace the concepts.
  - Higher quality (and sometimes higher cost services) for the those with the highest potential for at risk employees can be counter intuitive and needs to be explained carefully.
  - Senior management needs to be on the communication team and needs to stress the confidentiality of the plan.
Step 4: Vendor Management

- How do you select your vendors?
  - First and foremost their ability to work with you as you develop and implement the elements of Step 2!
  - Which vendors are working toward use of electronic records and certification as a PCMH and achieving “meaningful use”
  - Performance-based utilization of providers ... which providers are participating with local business coalitions and/or are willing to share performance data
  - Pharmacy benefits managers that can match their program with the type of tiering and differential use of tiering design you have chosen in Step 2.
Examples of VBBD - Caterpillar
Summary of findings or evaluations

90% HRA participation
50% of enrollees in diabetes management experienced HbA1C reduction (7.2 as compared to average of 8.7 one year previous)
+ 96% of enrollees are measuring A1C
+ 72% meeting Surgeon General’s activity recommendations
+ 98% are on aspirin

In the general employee group:
+ 50% Reduction in disability days
+ Smoking cessation rates of 35%, even after 3 years.
1. The Health of Your Organization Begins with Your People
2. To Realize Total Value, You Must Understand Total Costs
3. Higher Costs Don’t Always Mean Higher Value
4. Health Begins and Ends with the Individual
5. Avoid Barriers to Effective Treatment
6. Carrots Are Valued over Sticks
7. Total Value Demands Total Teamwork
Looking to the future

- There is a rapidly accelerating movement toward value that has the potential to be a “game changer” for the better
Next in our series...

- We have now completed the second in our series of Worksite Wellness Webinars; the next in our series will deal with policies and programs at the worksite and address in more detail how wellness can fit into your own corporate mission and vision.
Where Do We Go From Here?

http://wichita.kumc.edu/worksitewellness