

Taking Stock of Wellness

by Kathryn Fitch and Bruce Pyenson

The health cost crisis has spawned a thriving cost-control industry that offers an ever-growing number of “solutions.” The authors of this article encourage employers to go back to the basics in evaluating these offerings, including their wellness policies and programs. This article describes the many ways different employers do wellness, the evidence base for wellness, how employers should target wellness candidates, and the elements of success and failure for wellness initiatives.

Wellness programs seem to be an amazing countertrend in American business. While pundits talk about declining employer/employee loyalty (often mentioned in the context of globalization), the growing employer interest in wellness and health promotion expresses the opposite:

- Corporations are helping employees (and their dependents) in nontraditional ways.
- Employees are being asked to trust their employers’ interest in their personal behavior.
- While American businesses struggle to control exploding health benefit costs, many businesses are spending large amounts on wellness and embodying wellness as part of their corporate culture.

WHAT’S GOING ON?

“Wellness” or “health promotion” has become mainstream for employers. Several 2007 surveys of mid- to large-sized employers report that 77% to 89% offer wellness programs.¹ The government is also getting involved, with initiatives such as the Centers for Disease Control and Prevention (CDC) National

Chronic Disease Prevention Agenda and school/community-based programs. Recently proposed federal legislation would provide tax incentives for employers’ wellness programs. Governor Schwarzenegger’s health proposal for California prominently features wellness in the “Healthy Actions Incentives/Rewards” program, with public and private sector health benefits structured to provide incentives/rewards to promote prevention, wellness and healthy lifestyles. And the presidential candidates include wellness prominently in their health care platforms. Wellness seems to fit well with other health care trends such as disease management and consumerism.

We believe the wellness movement reflects both wisdom and naiveté, promoted with doses of “true believer” enthusiasm and vendor self-interest. Comprehensive information is readily available on wellness program design and implementation.² The purpose of this article is to help buyers take a step back and consider what they are building or being sold. The authors recommend:

- Have realistic expectations. Don’t expect wellness to become a profit center (unless selling wellness to others). Don’t underestimate the cost of incentives, gyms, e-health, administration, etc.
- If implementing wellness, do it effectively and measure meaningful outcomes regularly (like anything else).

- Insist that wellness programs are supported by evidence-based medicine and bring value to the population.

THE MANY WAYS EMPLOYERS DO WELLNESS

While wellness programs are often considered part of medical benefits, they are different. Wellness can cost a lot less; vendors may charge about \$1 to \$2 per member per month (PMPM) for promotion, not including incentives or medical benefits. That piece of wellness is small change compared to the \$300 PMPM or more typically charged for many medical benefits (and less than a typical annual increase in medical benefit costs). While most medical spending goes to people who need medical care, wellness focuses on low-cost people—the mostly healthy people at risk of becoming unhealthy. Because wellness focuses on changing people’s behavior (i.e., promoting healthy habits), it fits squarely in the “positive corporate culture” movement.

While almost all medical benefits provide comprehensive services, what constitutes wellness varies:

- **Many different vendors.** For outsourcing wellness services, vendors include disease management companies, health and productivity management firms, employee assistance programs, e-companies, pharmacy benefit management companies and insurers/HMOs.
- **“Insourcing” is a real option.** Unlike most other benefits, many companies are building and running their own wellness programs in-house. This suggests that some corporate buyers perceive a different outsource/in-house balance for wellness than for, say, medical management or claims administration.
- **Enforcement varies.** Employee “coercion” varies from very passive (posters promoting health) to voluntary (registration on an interactive Internet site) to aggressive (incentives or penalties for taking or not taking a health risk assessment and participating in targeted risk reduction programs).
- **Content varies.** Program intensity (and cost) varies from low (newsletters) to high (annual health risk assessment plus an on-site gym and regularly scheduled on-site activities led by clinical professionals).

With this variety, employers may hear vendors or in-house advocates say, “How much can you spend? We’ll give you wellness to meet your budget.” The authors prefer that the employer ask, “What results can you deliver?” whether purchasing from a vendor or creating an in-house program.

AS AMERICAN AS APPLE PIE

Isn’t wellness just Ben Franklin’s reminder, “An ounce of prevention is worth a pound of cure?” The most common wellness initiatives take aim at two modifiable risk behaviors: obesity and smoking. Recent data indicate that 35.5% of a typical working age population is obese and 24% smoke (Milliman analysis of National Health and Nutrition Examination Survey 2003-2004 (smoking) and NHANES 2005-2006 (obesity)). Wellness advocates point to higher medical, disability, absenteeism and workers’ compensation costs for smokers (and their dependents) and for obese people. The medical benefits of smoking cessation, moderate weight loss (5% to 10% of body weight) or maintaining a healthy weight are well established. Advocates claim that efforts to change harmful employee behaviors can save employers money, taking low-cost actions now to avoid future high-cost illness.

WHERE IS THE EVIDENCE BASE FOR WELLNESS?

Evidence-based medicine³ is one of the cornerstones of 21st century medicine. The best evidence is considered to come from controlled, randomized clinical trials, where the outcomes can prove the advantages or disadvantages of particular treatments, and where the data analysis or experimental design accounts for other influences, such as age, sex and comorbidities. Except for clinical trials, payers generally do not want practitioners to “experiment” on their members—Patients and payers want care that’s been proven to work.

Many wellness programs seem to be experiments on employees. Applying anecdotes about what works with teamsters in Tennessee might produce failure with Seattle software engineers. The incentives that motivate production workers in Iowa might generate sneers from northeast municipal workers.

While wellness vendors offer many different programs, most include smoking cessation and obesity (diet and exercise). The reasons for this focus are:

- Smoking cessation and weight control are prominent public health and personal goals.
- There is a solid evidence base for how health improves with smoking cessation⁴ and even modest weight loss.⁵

- There is overwhelming scientific evidence that appropriately designed smoking cessation programs work⁶ and strong evidence supporting the success of certain obesity management programs.⁷ (Most of that evidence is about medical interventions, not wellness.)

However, it's a huge leap from knowing that a leaner, nonsmoking workforce is better, to knowing how effectively a wellness program will reach that goal for a company's workforce. Will a particular vendor's Web site help obese employees lose weight?

Medical claims are not particularly helpful when targeting wellness candidates, because wellness focuses on people who are not sick and have little interaction with the health care system. ◀

Will workplace meetings about smoking cessation motivate smokers to quit? Few other business investments assume "if you build it, they will come." A visible display of corporate concern for wellness may have an impact on engaging employees' behavior—But engaging individuals and their challenging behaviors are wild cards.

There are many wellness programs that identify risk factors other than obesity or smoking. These programs typically don't take on challenges as tough as smoking cessation and weight loss, and they rely heavily on compliance with prescribed or recommended medical services (e.g., pharmacotherapy, an annual screening, immunization, etc.). Common initiatives include:

- Cholesterol management
- Hypertension management
- Cancer detection/prevention
- Back care
- Substance abuse prevention
- Stress management
- Job hazards/injury prevention
- Immunization programs.

It is well known that each of these risk factors can be improved with better patient behavior. However, what constitutes an effective program is sometimes not clear. On-site flu shots and referrals to Alcoholics Anonymous (AA) both may be considered wellness benefits. The connection between evidence-based med-

icine and flu shots and the portion of employees receiving the shots on site is apparent, since success can be boiled down to the number of employees participating in a one-time program. The connection between AA's proven track record and a substance abuse referral service is less obvious. In short, the connection between theory and reality is clearer with some programs than others, which is one of the complications facing wellness as a health care management concept.

HOW SHOULD EMPLOYERS TARGET WELLNESS CANDIDATES?

Identifying people's behavior-related risk factors can help determine if they are good candidates for a wellness program.

This is easier said than done. Medical claims are not particularly helpful when targeting wellness candidates, because wellness focuses on people who are not sick and have little interaction with the health care system. And medical claim data does not typically code for obesity or smoking.

Health risk assessments (HRAs) are questionnaires about health status; they are vital in identifying individuals' wellness needs. HRAs can include self-reported information and results from on-site medical examinations. Typical HRAs include questions about smoking, weight and height, perceived physical and mental health status, and known medical conditions as well as biometric screening. While HRAs can identify people with acute or chronic medical needs—people who should be targeted for medical care and disease management—HRAs can also identify a different subset of the population: those who can benefit from wellness programs.

Still, problems with HRAs illustrate the difficulty of measuring wellness:

- Unless there are significant incentives, the portion of employees filling out HRAs will be far lower than 100% and even lower for dependents.
- The people most compliant with HRAs could be a biased sample of highly motivated people. A portion of employees will quit smoking (or lose weight) on their own. Did the wellness program really help these people quit smoking, or just attract the most motivated people to quit? Consequently, nonparticipants make a weak control group to compare to participants.
- Self-reported data suffers from many of the same quality and consistency issues as information from medical claims. This, combined with the fact that self-reported data is not subject to audit or standard medical coding rules, can make it a weak source of information.

TABLE I
TYPICAL PORTION OF ADULTS IN VARIOUS CARE CATEGORIES
FOR A TYPICAL EMPLOYER-SPONSORED WELLNESS PROGRAM

Risk Category	Typical Portion of Adults (employees and adult dependents)
Wellness	100%
People identified under typical disease management (asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, diabetes)	10%
People aggressively managed by disease management	2%
Obese	35%
Smoking	24%
Obese or smoking	50%
Obese or smoking and NOT identified by disease management	> 40%
Hospitalized in a year (about one-third of these are maternity)	5%
No medical claims in a year	11%

On the positive side, basic health problems such as obesity are easily recognized by most interviewers, even though such problems are rarely coded in medical claims.

The large percentage of employees who are potentially “at risk” poses another challenge for wellness. Most health care management strategies target a subset of the population, but wellness could apply to every employee. Table I shows the approximate portion of people in various care categories for a typical employer-sponsored program.

Disease management efforts identify and focus on high-cost and chronically ill people. The vast majority of people who are the focus of wellness are not targets of disease management—They are mostly healthy and/or low cost even though they may currently exhibit risky behaviors. Improving the behavior of these people can make them healthier in years to come, which can reduce long-term costs (but perhaps increase short-term costs, since those who are currently healthy may need to catch up on preventive services.)

Table II on the next page shows how typical PMPM spending for disease management or wellness is concentrated on target people.

Tables I and II suggest that if wellness programs can truly shift the health status of a lot of people, they are a remarkable bargain. An alternative interpreta-

tion is that, to be effective, wellness programs need to dramatically change the behavior of a few imminently high-risk people in order to be successful.

ELEMENTS OF SUCCESS AND FAILURE

Much of the advice about any successful corporate culture change applies to wellness. Companies that have gone through merging corporate cultures or changing from a traditional to an entrepreneurial culture will recognize the key elements of a successful wellness program:

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TABLE II
TYPICAL PMPM SPENDING FOR DISEASE MANAGEMENT OR WELLNESS,
INITIAL VS. FINAL TARGET POPULATION

Program	Initial Target Population			Final Target Population	
	Typical PMPM Fee for Total Population	Portion of Total Population	Annual Cost per Adult	Portion of Total Population	Annual Cost per Final Target Person
Disease management ¹	\$3	7%	\$500	2%	\$2,600
Wellness ²	\$1	100%	\$12	33%	\$36
Comprehensive smoking cessation program ³	\$.50	16%	\$38	1%	\$600
Total health benefits ⁴	\$300	100%	\$3,600		

Notes:

1. Assumes all disease management fees are spent on highest acuity patients, which are 2% of the population (20% of the disease management population).
2. Assumes all wellness fees are spent on half of the adults.
3. Assumes about 6% of smokers will enter a formal smoking cessation program in a year. Twenty-four percent of adults who smoke are the equivalent of 16% of members. The \$400 is per program entrant; the per quitter cost is higher. The authors have calculated that intense, medically-oriented smoking cessation programs spend more than \$1,000 for each quitter (Fitch, Iwasaki and Pyenson, "Covering Smoking Cessation as an Employee Benefit," American Legacy Foundation, December 2006 (available at www.milliman.com)).
4. PMPM for health benefits vary greatly. Adults make up about 65% of members.

- Visible executive leadership and championship
- Effective communication
- Consistent messaging and policies
- Sufficient resources.

As with other aspects of corporate culture, incentives (rewards or penalties) are important motivators for most people. And sometimes, spending a bit more can be the difference between success and failure. More intensive approaches to certain programs (e.g., smoking cessation) are more successful—And they cost more.⁸ The cost of meeting goals may not necessarily be the wellness benefit but may be the cost of adding medical benefits. For example, an employer may need to add specific medical coverage for behavioral health counseling, pharmacotherapy, nicotine replacement therapy, etc., for a smoking cessation program. With an obesity initiative, the cost may include medical benefits for nutritional counseling, behavioral health counseling or weight loss pharmacotherapy—in addition to the more traditional membership cost of gyms or weight loss programs, refurbishing space for an on-site gym, etc.

Many of the integration and measurement problems seen with health benefits in general also apply to wellness. These problems include:

- **Integration with other health management pro-**

grams. Integrating disease management with medical management, or integrating behavioral health with prescription drugs and medical care, has been a persistent problem with health benefits. Poor integration can be a huge obstacle for wellness. Does it make sense to offer a wellness program for smoking cessation if the medical benefit does not pay for antismoking prescription drugs? Or to offer obesity programs if the medical benefit does not cover nutritional counseling or weight loss prescriptions?

- **Measuring value.** For many health insurers and employers, timely and accurate measurement of aggregate health care spending is a major actuarial challenge. In today's changing health care system, trying to measure the cost impact of wellness on that spending can be almost impossible.

The following factors add to the difficulty of measuring the "hard" impact of wellness:

- Wellness targets people who are at risk but not sick. Their costs tend to be low and it may take years for the risk to materialize (if it ever does).
- Employee turnover will dilute any impact.
- Changes in medical practice, disease management and public education make it difficult to isolate the impact of wellness programs.

FIRST MEASURED STEPS

As with any new venture, wellness advocates and champions want to prove success, and objective measurements offer the best way to do that. The Disease Management Association of America (DMAA) (Outcomes Guidelines Report, Volume 2, 2007) has offered four domains of impact for outcomes measurement:

1. **Process measures**
Contact frequency, duration and type
Participation rates
Type and number of contacts
2. **Behavior change for modifiable risk factors/unhealthy lifestyle choices**
Proper nutrition
Weight loss
Regular exercise
Medication adherence
Obtaining preventive screening services, immunizations
Screening cholesterol, blood pressure, blood glucose, BMI
Improved motivation, readiness to change
3. **Productivity/quality of life**
Absenteeism
4. **Utilization and medical costs**
Medical claims
Short- and long-term disability
Absentee days
Workers' compensation.

The DMAA guidelines note expected time frames for various impacts. According to DMAA, it may take years (or even decades) to see changes in medical costs, workers' compensation offsets or long-term disability. In the shorter term (months or years), doctor visits and laboratory tests may increase due to more appropriate adherence to recommendations for screening and preventive services. In the moderate term (months or years), reductions may be seen in emergency room visits or outpatient procedures.

Having an idea about what to measure is a helpful first step. From a benefits perspective, the long time it takes for behavior change to reduce utilization makes process measures more believable than economic measures.

Body mass index (BMI) is a number calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems.

- Participants in wellness programs may self-select. That is, people who are most likely to change behavior on their own may be the ones who participate; those least likely to change may not participate.
- The intent is to reach and touch the total population, making it difficult to identify a comparable control group.

Many of the published articles and anecdotes claiming savings from wellness programs have not addressed these factors.

A 2007 survey⁹ of major U.S. employers found that 88% of employers with wellness programs used some type of incentive for participation in the wellness pro-

gram, with premium reductions being the most common incentive. Yet the challenge for health management programs most commonly cited by the respondents had to do with maintaining employee motivation over time. The second biggest challenge identified was the ability (or inability) to assess program costs and effectiveness. Only 14% of the companies that used incentives indicated they had been successful at measuring a return on investment for the health management program.

HOW TO THINK ABOUT THE VALUE OF WELLNESS

The health cost crisis has spawned a thriving cost-

control industry that offers an ever-growing number of “solutions.” The authors encourage employers to go back to the basics in evaluating these offerings, including their wellness policies and programs. In particular, think about the impact of any program on:

- **Demand side: members and patients.** These actions shift responsibility, choice or cost to members and include efforts to improve the health of a population so that demand for medical care will decline.
- **Supply side: hospitals/physicians and other providers.** These actions affect how providers practice medicine, how much they are paid or which providers a member can use. The intent is to pay only for medically necessary evidence-based care.

Demand- and supply-side actions will, of course, influence one another. For example, paying providers for health coaching can increase the supply of providers offering and recommending these services and will increase member demand for coaching services.

The enthusiasm and claims of wellness advocates (and vendors) prompts the authors to recommend thinking about savings in two ways:

1. **Hard savings**, the amounts the corporate accountants would feel comfortable booking (such as shifting to a lower cost supplier). Net savings from claims audits or nonpayment for “never events” (such as wrong-side operations) are examples of hard savings.
2. **Soft savings**, which might be real (or not) but are hard to connect through cause and effect, such as increased worker productivity and decreased turnover. (Most chief financial officers will not be sympathetic to using soft savings in financial forecasts.)

Wellness affects the demand side; it attempts to change the patient, not the providers. The results of wellness are best considered soft savings, because it is difficult or impossible to directly link wellness programs and changes in medical cost. Wellness’ combination of demand side/soft savings contrasts sharply with some of the more typical and muscular benefit changes employers consider:

- Benefit increases or cuts, or shifting to value-based purchasing
- Paying (or not) for waste, inefficiency and medical errors
- Open access or economic/quality credentialing of providers (pay-for-performance initiatives).

In a time of health benefit cuts, perhaps it is ironic that some employers are interested in spending more on wellness. Adding a basic wellness program might seem relatively inexpensive but will not solve increasing costs or make up for the drastic cuts in medical benefits that some employers are being forced to make. But approaching wellness with an attention to the evidence base, meaningful outcomes metrics and the particulars of a given workforce may justify the investment. ◀

Endnotes

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