

Wellness Programs in Connecticut

Employees' health issues cost U.S. employers an estimated \$225.8 billion per year [8], piquing employer interest in wellness programs. Between 2004 and 2006, the number of large firms (>500 people) offering wellness programs increased from 7% to 19% of all big employers [16]. Wellness programs, which range from free gym memberships to healthy eating classes, smoking cessation programs, and financial incentives, seek to improve employee health and prevent disease to reduce health care service costs and increase productivity. Although wellness programs are effective, wrongly-implemented programs can have adverse consequences.

The Impact of Wellness Programs

Many studies have confirmed the varied benefits of wellness programs. For example, about 25% of employers' medical costs are caused by 11 alterable risk factors: lack of exercise, alcohol use, overweight, current or former tobacco use, depression, stress, blood pressure, cholesterol, weight, and blood glucose [3]. Well designed wellness programs that address these factors can reduce sick leave absenteeism by 28%, reduce health care costs by 26%, and increase overall employee satisfaction [1, 7]. On average, the rate of return per dollar of investment in wellness programs can range from \$3 to \$15 and savings are usually realized within 12-18 months [9].

Problems with Wellness Programs

Despite their efficacy, wellness programs can put some employees at a disadvantage. Lower-income workers, for instance, may be less likely to participate in wellness programs due to barriers such as limited transportation options, longer working hours, and lack of access to child care or elder care [2, 12]. Moreover, financial penalties and rewards in wellness programs that affect the cost of employees' health insurance might raise the price until insurance becomes unaffordable for employees, potentially causing those who could benefit the most to drop coverage [2].

Employees at small firms are also at a disadvantage because nationally, small firms are less than half as likely to offer wellness programs as large employers [4,5]. Small firms have fewer financial incentives to start wellness programs because they provide fully insured plans to employees, meaning that their premiums are set by an insurance company who determines premiums based on industry and not the firm's experience [4]. Large firms, on the other hand, are more likely to be self-insured and pay for their employees' healthcare themselves. Self-insured firms benefit directly from their wellness investment with healthier employees and fewer claims. Small firms would require an industry-wide wellness effort for healthier employees for insurance companies to lower their premiums.

Women face additional obstacles in accessing wellness programs including pregnancy and family responsibilities. In 2002, 77% of single mothers, over 60% of married mothers with children under the age of 6 years, and 76.8% of married mothers with school-aged children were in the labor force [13]. Considering women's special time constraints, wellness programs will most effectively serve women if they incorporate child care, flexible schedules, and consider the health effects of pregnancy [14].

Wellness programs without any incentives may also fail because of low participation rates [10, 11]. Many studies have shown financial incentives can effectively increase participation [2].

Overcoming the Problems

The American Heart Association makes some recommendations to ensure the success of wellness programs. Financial incentives, for example, should not be attached to health care premiums or status so employees keep their coverage [2]. Also, employers should make wellness programs more accessible by providing supportive services such as child care, transportation options, flexible working schedules, and on-site gyms or dieticians [2]. Employees should have the tools to effectively attain the goals of the wellness program. To reduce smoking rates, for instance, the employer must cover smoking cessation treatment such as counseling or nicotine patches. Employers should also constantly evaluate the wellness program to pinpoint areas that need improvement.

According to the American Heart Association, effective, comprehensive wellness programs must promote the following [2]:

- Tobacco cessation and prevention- group counseling, nicotine patches, and indoor smoking bans in the workplace are the most successful methods
- regular physical activity,
- stress management/reduction
- early detection/screening of diseases
- nutrition education and promotion
- weight management
- disease management
- changes in the work environment to encourage healthy behaviors and promote occupational safety and health

Government Policies Related to Wellness Programs

The federal health reform bill, the Patient Protection and Affordable Care Act, passed in March 2010 increases the limits on wellness program incentives offered by employers. Beginning in 2014, employers can provide discounts or penalties of up to 30 percent on employee premiums [15]. The same bill establishes a five-year, \$200 billion program that will provide grants to small firms (<100 employees) to implement wellness programs [15].

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines the legal boundaries of wellness programs. It allows wellness programs that reward employees for participating in a health-promotion program without having to obtain or maintain a certain health standard [16]. It also allows wellness programs that reward employees for reaching or maintaining a health standard but sets specific criteria for fairness. For example, employees with a medical condition must be offered an alternative health goal if the general standard is unreasonable [16].

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References

- [1] Parks, Kizzy M.; Steelman, Lisa A. "Organizational wellness programs: A meta-analysis." *Journal of Occupational Health Psychology*. Vol 13(1), Jan 2008, 58-68.
- [2] American Heart Association. "Worksite Wellness Programs for Cardiovascular Disease Prevention: A Policy Statement From the American Heart Association." <http://circ.ahajournals.org/cgi/content/full/120/17/1725>
- [3] Anderson DR, Whitmer RW, Goetzel RZ, Ozminkowski RJ, Dunn RL, Wasserman J, Serxner S. "The relationship between modifiable health risks and group-level health care expenditures." *Am J Health Promot*. 2000; 15: 45-52.
- [4] O'Donnell MP. "The rationale for federal policy to stimulate workplace health promotion programs." *NC Med J*. 2006; 67: 455-457
- [5] Linnan L, Bowling M, Childress J, Lindsay G, Blakey C, Pronk S, Wieker S, Royall P. "Results of the 2004 National Worksite Health Promotion Survey." *Am J Public Health*. 2008; 98: 1503-1509
- [6] Leatherman S, Berwick D, Iles D, Lewin LS, Davidoff F, Nolan T, Bisognano M. "The business case for quality: case studies and an analysis." *Health Aff (Millwood)*. 2003; 22: 17-30
- [7] Aldana SG. "Financial impact of health promotion programs: a comprehensive review of the literature." *Am J Health Promot*. 2001; 15: 296-320
- [8] Stewart WF, Ricci JA, Chee E, Morganstein D. "Lost productive work time costs from health conditions in the United States: results from the American Productivity Audit." *J Occup Environ Med*. 2003; 45: 1234-1246.
- [9] Anderson DR, Serxner SA, Gold DB. "Conceptual framework, critical questions, and practical challenges in conducting research on the financial impact of worksite health promotion." *Am J Health Promot*. 2001; 15: 281-288
- [10] Serxner S, Anderson DR, Gold D. "Building program participation: strategies for recruitment and retention in worksite health promotion programs." *Am J Health Promot*. 2004; 18: 1-6, iii.
- [11] Healthy Workforce 2010: An Essential Health Promotion Sourcebook for Employers, Large and Small. Washington DC; Partnership for Prevention; 2001.
- [12] Heaney CA, English P. "Are employees who are at risk for cardiovascular disease joining worksite fitness centers?" *J Occup Environ Med*. 1995; 37: 718-724
- [13] Employment status of women by marital status and presence and age of children:1970 to 2002. In: The 2007 Statistical Abstract: The National Data Book. Washington, DC: US Census Bureau; 2007. Table 584.
- [14] Sloan Work and Family Network Research Network. *Policy Leadership Series: An Introduction to Work-Family Issues for State Legislators*. 2005. Available at: http://wfnetwork.bc.edu/pdfs/policy_makers.pdf.
- [15] Miller, Stephen. "Wellness Programs get a boost in Health Reform Law." Society for Human Resource Management. <http://www.shrm.org/Publications/HRNews/Pages/WellnessReformBoast.aspx>
- [16] Mello M, Rosenthal M. "Wellness Programs and Lifestyle Discrimination- The Legal Limits." *New England Journal of Medicine*. 2008; 359: 192-199.