

## Editor's Notes

### **Making the Impossible Possible: Engaging the Entire Population in Comprehensive Workplace Health Promotion Programs at No Net Cost to Employers or Employees**

Sec. 2705 ("Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status") of the Patient Protection and Affordable Care (PPAC) Act includes a provision that allows employers more flexibility in setting health plan premiums based on employees' meeting health standards.<sup>1</sup> This mechanism has the potential to do what seems intuitively impossible: drive participation in workplace health promotion programs to nearly 100%, and fund the full cost of a comprehensive health promotion program at no additional cost to the employers or employees as a group. This provision was developed by Safeway, not Health Promotion Advocates,<sup>2</sup> but Health Promotion Advocates strongly endorsed it and generated more than 11,000 letters to members of Congress to support it. I predict that financing health promotion programs using this mechanism will become the norm among major employers in the next few years.

#### **Provision Details**

Prior to passage of the PPAC Act, regulations allowed employers to offer a health plan premium differential of up to 20% based on employees' meeting health standards such as not smoking, reaching recommended weight levels, or having normal blood pressure, cholesterol, glucose, triglycerides, etc. However, these provisions were in regulation vs. statute form, and most employers did not take advantage of them because they were concerned the regulations might change at any time. Sec. 2705 has seven important provisions related to this issue: (1) The primary purpose of this section is to prevent group or individual health plans from limiting eligibility based on health status, medical conditions, claims experience, utilization, medical history, genetic information, or evidence of insurability (including domestic violence), disability, and other factors. This is the much-applauded provision that prevents discrimination against 39 million in the United States who have preexisting conditions that make it difficult for them to obtain affordable health insurance. (2) It codifies in statute existing regulations that allow employers who are paying for a portion of health plan premiums to charge a differential premium based on meeting health standards. It also specifies that the same differential can be applied to spouses and other dependents, and that people with medical conditions that prohibit them from participating in programs will receive a waiver. (3) It increases the maximum amount of the differential tied to meeting health standards from 20% to 30% in 2014. (4) It directs the Secretaries of Labor, Health and Human Services, and Treasury to issue a report by 2013 based on employer data on the (a) effectiveness of wellness programs in improving health and preventing disease, (b) impact of programs on access to care and affordability of coverage for participants and nonparticipants, (c) impact of premium based and cost-sharing incentives on changing health behavior, and (d) effectiveness of different

types of rewards. (5) It allows the Secretaries of Health and Human Services and Treasury to increase the maximum differential from 30% to 50% if they "determine that such an increase is appropriate." (6) It allows premium discounts to be offered to employees who participate in health promotion programs. (7) It authorizes a 10-state pilot in 2014 allowing health insurance companies to provide similar premium differentials in the individual health insurance market, and expansion of this pilot to additional states in 2017 if the 10-state pilot "is effective."

#### **Opposition From Patient Advocacy Groups**

These provisions were opposed by patient advocacy groups who believe the provisions violate the core purpose of this part of the legislation ... to make it possible for people with preexisting conditions to secure affordable health care coverage. They were also concerned that there were no requirements to offer comprehensive health promotion programs.<sup>3</sup> My personal opinion is that these concerns are unfounded, especially in the context of workplaces in which all employees are eligible for health insurance regardless of preexisting conditions, and the employer is paying a large portion of the cost. I do not agree with their concern that charging employees who do not meet health standards or participate in programs is unfair. On the contrary, I believe it is unfair to force employees who do everything possible to practice healthy lifestyles to subsidize health plan premiums for those who are unwilling to at least try to improve their health by participating in a health promotion program. Medical costs tied to lifestyle factors are significant. For example, smokers<sup>4</sup> and people who are overweight<sup>5</sup> have higher medical costs, and employees with a cluster of heart disease risk factors (stress, tobacco use, overweight, inactivity, high blood pressure, high cholesterol, poor nutrition, and excess alcohol use) have costs 3.28 times higher than employees who do not have these risk factors.<sup>6</sup> This translates to average annual medical costs of \$3000 for employees with none of these risk factors and \$9840 for employees with these risk factors, a difference of \$6560.<sup>3</sup>

Patient advocacy groups do make an argument I agree with, that additional safeguards need to be built into the rules that guide the implementation of premium differentials in the individual insurance market (provision 7 above) because it is much more difficult for an insurance company to provide a comprehensive health promotion program than an employer. Workplace health promotion programs are effective because people spend a huge portion of their waking hours at work, and great health promotion programs are able to create social cultures and physical environments that make healthy choices the easiest choices. Health insurance companies may be able to provide access to excellent skill-building programs, but are not likely to be effective in shaping the workplace culture or environment.

#### **Impact on Health Promotion Programs**

Overall, I am very excited about the provisions in Sec. 2705 because it has the potential to push participation in workplace health promotion programs to close to 100%, and to provide a mechanism to fully fund comprehensive health promotion programs at no net cost to employers or employees. It is also important to recognize that health improvement will

*Am J Health Promot* 2010;24(6):iv-v

DOI: 10.4278/ajhp.24.6.iv

Copyright ©2010 by American Journal of Health Promotion

result from participating in programs, not the financial incentives. I will review each of these points.

**Full Participation.** Recent studies have shown that participation rates in health risk assessment (HRA) questionnaires are reaching and surpassing 90% when programs are supported by top management, marketed well, and tied to incentives of \$200/person that are integrated into the health plan.<sup>7,8</sup>

**Improving Health Behavior.** There is very little evidence that financial incentives directly improve health behaviors.<sup>9,10</sup> As such, we expect health behaviors to improve when people participate in health promotion programs.

**Full Funding for Comprehensive Programs.** My experience has shown that comprehensive health promotion programs cost about \$250/eligible employee/year, or \$250,000 for a program offered to 1000 employees. As a separate line item, it might be difficult to secure this level of program budget. However, in the context of an annual health plan budget, which is probably on the order of \$5750/covered life, or \$5,750,000 for 1000 lives, \$250,000 seems relatively small. In fact, it is less than 5% of that amount ... less than the typical annual increase in the health plan budget. In this context the amount is more palatable, especially when employee premiums would cover a portion of the total. Tying the health promotion program budget into the health plan budget thus makes it less difficult to secure.

**No Cost to Employer or Employees.** The initial premium differential is cost neutral to the employer because premiums are raised for employees who do not qualify to cover the reduction for employees who do qualify. The health promotion program is cost neutral to the employer and employees as a whole because the program should save as much as it costs if it is well designed. In fact, the average medical cost savings reported from two systematic reviews of the literature is more than \$3 saved for every \$1 invested.<sup>11,12</sup> I still find this level of return to be remarkable, and even questionable, but after decades of seeing these kinds of savings in well-designed programs, I am convinced that the savings in medical costs are at least equal to the program costs. Employees who meet the health standards or participate in programs should see their premiums go down. Employees who refuse to participate in programs will see their premiums increase, but even they will benefit by the overall cost savings produced by the health promotion program.

### How Should This Be Set Up?

I recommend keeping this simple so employees understand it and data management is not too cumbersome. I recommend focusing on three to four health standards that can be measured objectively. Health standards might be (1) no tobacco use, (2) body mass index (BMI)  $\leq 27.5$  or passing a fitness test, and (3) biometrics in the normal range, including blood pressure, cholesterol, triglycerides, and glucose. Values for all of these standards would need to be measured through screenings, not self reported. Given the current law, I would award a 5.0% premium discount for each health standard met, and 5.0% for participating in the screening, for a total maximum of 20% premium discount. I would use the 27.5 BMI level instead of 25.0 to provide slack for those who are moderately overweight. I would allow passing a fitness test as an option to qualify for those who are overweight because compelling research has shown that lack of fitness is a more important predictor of mortality than being overweight.<sup>13</sup> For those who do not meet the health standard, I would offer 3% for each health area addressed through participation in a health promotion program. For example, smokers could earn a 3% discount by participating in a quit-smoking program. People who are overweight could earn 3% by participating in a weight control program that includes fitness and nutrition. People who have abnormal biometrics could earn 3% by having medical supervision for their condition and participating in at least one relevant lifestyle change program. So if the health plan cost \$5750/year/covered life and the health promotion program cost \$250, the total annual cost would be \$6000/person; 3% of that would be \$180 and 5% of that would be \$300. Discounts would be \$1200 for those who participated in the screening and met all three standards, \$900 for two, \$600 for one, and \$300 for zero. For those not meeting the health standards, but participating in screening and programs, discounts would be \$840 for participating in programs to meet three standards, \$660 for two, \$480 for one, and \$300 for just participating in the screening. The actual premium per employee would be dependent upon how many employees qualified

for each level of discount, but in the simplified case in which total utilization remained flat, half of employees participated in the screening and met all three health goals, and the other half did not participate in the screening or any programs, participants would have premiums of \$1200 and nonparticipants would have premiums of \$2400. (In 2014, I would increase the incentive for achieving each health goal from 5% to 7.5%, for a total possible discount of 30%, and increase the incentive for participation from 3% to 5%. In the simplified case, premiums for participants would be \$900 and for nonparticipants would be \$2700.)

### Conclusion

I predict it will take employers several years to fully embrace this concept, but when they do, most large employers will use it, participation rates in programs will increase from an average of 20% to more than 90%, and program budgets will increase from an average of \$60 per year to \$250 per year. Tens of millions more people will participate in well-funded and effective health promotion programs, and the health of the working population will improve dramatically. This may be the most important development of the decade for workplace health promotion.

*Michael O'Donnell*

Michael P. O'Donnell, PhD, MBA, MPH  
Editor in Chief

### References

1. Patient Protection and Affordable Care Act, HR 3590. Title I—Quality, affordable health care for all Americans. Subtitle C—Quality health insurance coverage for all Americans. §2705. Prohibiting discrimination against individual participants and beneficiaries based on health status. §1201. Amendment to the Public Health Service Act.
2. Health Promotion Advocates website. Available at: <http://www.HealthPromotionAdvocates.org>. Accessed April 30, 2010.
3. O'Donnell MP. Integrating financial incentives for workplace health promotion programs into health plan premiums is the best idea since sliced bread. *Am J Health Promot.* 2010;24(4):iv–vi.
4. Fellows JL, Trosclair A, Adams EK. Annual smoking-attributable mortality, years of potential life lost, and economic costs—United States, 1995–1999. *MMWR Morb Mortal Wkly Rep.* 2002;51:300–303.
5. Finkelstein E, Fiebelkorn IC, Wang G. The costs of obesity among full-time employees. *Am J Health Promot.* 2005;20:45.
6. Goetzel RZ, Anderson DR, Whitmer RW, et al. The relationship between modifiable health risks and health care expenditures: an analysis of the multi-employer HERO health risk and cost database. *J Occup Environ Med.* 1998;40:843–854.
7. Taitel MS, Haufle V, Heck D, et al. Incentives and other factors associated with employee participation in health risk assessment. *J Occup Environ Med.* 2008;50:863–872.
8. Seaverson ELD, Grossmeier J, Miller TM, Anderson DA. The role of incentive design, incentive, value, communications strategy, and worksite culture on health risk assessment participation. *Am J Health Promot.* 2009;23:343.
9. Matson Koffman D, Lee JW, Hopp JW, Emont SL. The impact of including incentives and competition in a workplace smoking cessation program on quit rates. *Am J Health Promot.* 1998;13:105–111.
10. Cahill K, Perera R. Competitions and incentives for smoking cessation. The Cochrane Collaboration: Cochrane Reviews. Updated April 29, 2008. Available at: <http://www.cochrane.org/reviews/en/ab004307.html>. Accessed December 24, 2009.
11. Aldana SG. Financial impact of health promotion programs: a comprehensive review of the literature. *Am J Health Promot.* 2001;15:296–320.
12. Baicker K, Cutler D, Song Z. Workplace wellness programs can generate savings [published online ahead of print January 14, 2010]. *Health Aff (Millwood).* 2010;29:304–311.
13. Sui X, et al. Cardiorespiratory fitness and adiposity as mortality predictors in older adults. *JAMA.* 2007;298:2507–2516.

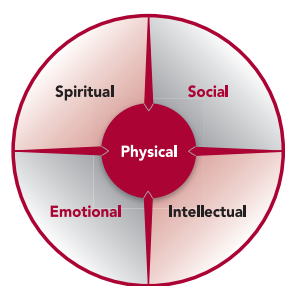
Online  
subscriptions  
now available

Volume 24, Number 4  
March/April 2010

# Your Best Source for the Latest Research and Best Practices in Health Promotion

## Definition of Health Promotion

“Health Promotion is the art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health, and supporting them in changing their lifestyle to move toward a state of optimal health. Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of learning experiences that enhance awareness, increase motivation, and build skills and, most important, through the creation of opportunities that open access to environments that make positive health practices the easiest choice.”



**DIMENSIONS OF OPTIMAL HEALTH**

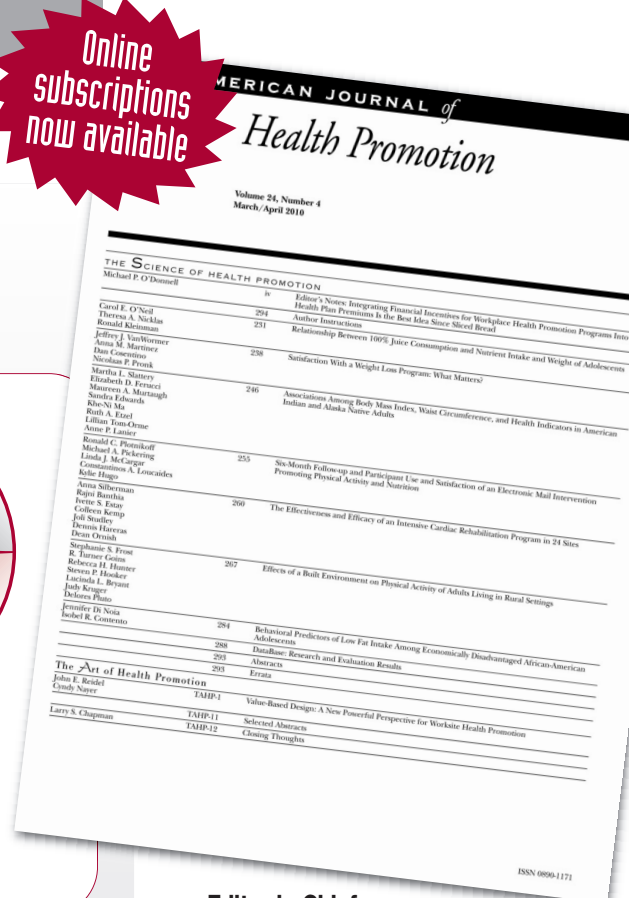
(O'Donnell, *American Journal of Health Promotion*, 2009, 24,1,iv)

“The *American Journal of Health Promotion* provides a forum for that rare commodity — *practical and intellectual exchange between researchers and practitioners.*”

**Kenneth E. Warner, PhD**  
*Dean and Avedis Donabedian Distinguished University Professor of Public Health School of Public Health, University of Michigan*

“The contents of the *American Journal of Health Promotion* are *timely, relevant*, and most important, *written and reviewed by the most respected researchers in our field.*”

**David R. Anderson, PhD, LP**  
*Senior Vice President & Chief Health Officer, StayWell Health Management*



*Subscribe today...*

ANNUAL SUBSCRIPTION RATES: (Available 1/1/10. Good through 12/31/10)

|                   | INDIVIDUAL     |       | INSTITUTION |                |
|-------------------|----------------|-------|-------------|----------------|
|                   | Print & Online | Print | Online      | Print & Online |
| U.S.              | \$139          | \$177 | \$359       | \$359          |
| Canada and Mexico | \$148          | \$186 | \$359       | \$368          |
| Other Countries   | \$157          | \$195 | \$359       | \$377          |

Call 800-783-9913 (U.S. only) or 818-760-8520

**Check out our new online format:**

<http://www.HealthPromotionJournal.com/online.htm>

**Editor in Chief**  
Michael P. O'Donnell, PhD, MBA, MPH

**Associate Editors in Chief**  
Margaret Schneider, PhD

Jennie Jacobs Kronenfeld, PhD

Shirley A. Musich, PhD

Kerry J. Redican, MPH, PhD, CHES

**SECTION EDITORS**  
**Interventions**

**Fitness**  
Barry A. Franklin, PhD

**Medical Self-Care**  
Lucy N. Marion, PhD, RN

**Nutrition**  
Karen Glanz, PhD, MPH

**Smoking Control**  
Michael P. Eriksen, ScD

**Weight Control**  
Kelly D. Brownell, PhD

**Stress Management**  
Cary Cooper, CBE

**Mind-Body Health**  
Kenneth R. Pelletier, PhD, MD (hc)

**Social Health**  
Kenneth R. McLeroy, PhD

**Spiritual Health**  
Larry S. Chapman, MPH

**Strategies**  
**Behavior Change**  
James F. Prochaska, PhD

**Culture Change**  
Daniel Stokols, PhD

**Population Health**  
David R. Anderson, PhD, LP

**Applications**  
**Underserved Populations**  
Antronette K. (Toni) Yancey, MD, MPH

**Health Promoting Community Design**  
Bradley J. Cardinal, PhD

**The Art of Health Promotion**  
Larry S. Chapman, MPH

**Research**  
**Data Base**  
Troy Adams, PhD

**Financial Analysis**  
Ron Z. Goetzel, PhD

**Measurement Issues**  
Shawna L. Mercer, MSc, PhD