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Value-Based Wellness Programs: Are We There Yet?



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Worksite wellness programs are becoming increasingly popular among U.S. employers. In 2011, 74 percent of employers offered health benefits and some form of worksite wellness programs, including weight-loss programs, gym membership discounts, on-site exercise facilities, smoking cessation programs, personal health coaching, classes in nutrition or healthy living, or wellness newsletters.¹ As more employers implement wellness programs, and broaden them each year, the evaluation of these programs is vital. Currently, few reports examine what types of information employers use to evaluate programs and if the evaluation of a program affects benefit design. As evaluation should be a feedback tool to improve and re-

¹ *Employer Health Benefits 2011 Annual Survey*, Kaiser Family Foundation/Health Research & Educational Trust.

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fine the program, we examined whether employers' overall benefit plan designs were set up such that they supported what the employers claimed they were trying to accomplish.

This article utilizes findings from a regional employer survey to explore how benefit designs differ by companies that evaluate their wellness programs as well as what they evaluate. In fall 2011, the Maryland Institute for Policy Analysis and Research, University of Maryland, Baltimore County and RCM&D conducted a survey of employers in the Mid-Atlantic Region (Maryland, Pennsylvania, Virginia, and Washington) to assess their progress with healthy workforce programs. Employers surveyed included members of the MidAtlantic Business Group on Health, the Lancaster County Business Group on Health, the Lehigh Valley Business Coalition on Health Care, the Maryland Healthcare Human Resources Association, employers participating in the Healthiest Maryland Businesses initiative, and employers unaffiliated with these listed organizations.

Responses were received from 162 employers. Thirty-eight percent of the responding employers had 500 or more employees, 13 percent had 250 to 499, 12 percent had 100 to 249, and 37 percent had fewer than 100 employees. The largest industry sector represented was the health care industry (27 percent), but a variety of industry sectors participated in the survey. All employers participating in the survey provide some form of worksite wellness program or benefit plan design to promote a healthy workforce.

Value-Based Program Design

Before diving into the survey results, we need to consider the concept of value-based plan design and its linkage to benefit plan and wellness plan design. The concept of value-based plan design for health plan design began in the 1990s with research conducted at the University of Michigan and has continued to evolve since then.² The Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148) includes incentives to promote value-based insurance design. The theory behind value-based plan design is that total health plan costs are linked to the quality of health care provided.

² A.M. Fendrick, D. Smith, M. Chernew, and S. Shah (2001). *A Benefit-Based Copay for Prescription Drugs: Patient Contribution Based on Total Benefits, Not Drug Acquisition Cost*. *The American Journal of Managed Care*, 7, 861-867.

When a health plan drives participants toward the highest quality care, improved health outcomes and lower health plan costs naturally follow.³

A health plan using value-based design will align health plan out-of-pocket costs, copays, and premiums with the value of the medical and prescription services covered through the plan. In other words, lower out-of-pocket costs will be applied to the highest value care. Preventive care is an example of high-value care. The value is the health benefit produced by the health care service. That value is not defined by cost of the care, but lower cost is an outcome of high-value care.

With a value-based program design, participants are provided incentives to engage in higher value medical treatments or services by lowering out-of-pocket costs for those services. An example is high blood pressure treatment. Most cases of high blood pressure can be successfully treated with a low-cost medication, if that medication is taken consistently as directed. If high blood pressure is left untreated or medication adherence is poor, it can lead to any number of high-cost and physically debilitating cardiovascular complications. In a value-based program, blood pressure medication is a high-value, low-cost form of care. Hospitalization and ongoing treatment for stroke or other serious, high-cost, cardiovascular disease can be averted.

A low or zero copay for blood pressure prescriptions will incentivize medication adherence. Consistent medication adherence reduces high cost-low value claims for medical care to treat out-of-control blood pressure, including emergency room visits and hospitalizations. This strategy reduces the participant's cost for the high-value, low-cost service—i.e., blood pressure management—driving higher utilization of that service. The outcome is lower overall plan costs and higher health status through reducing the high cost-low value care to resolve an episode of out-of-control blood pressure.

Incentives are an important piece of wellness programs, as they drive participation and behavior change. Incentives have become such an important part of programs that PPACA mandates certain incentives to promote worksite wellness.⁴ Employers can apply the value equation to their worksite wellness programs. Employers can encourage participation in high-value and high-quality health-related activities by lowering benefit plan cost-sharing for participants.

For example, completion of a health risk assessment (HRA) and biometric screening is assessed as a high-value program versus attending a health fair. While attending a health fair may be enjoyable and provide some health education, the outcomes are not measurable and do not necessarily meet the specific health needs of the individual participant or the group. HRA completion and biometric screenings are higher value because they provide participants with concrete information about their own health status compared to age- and gender-norms. Using value-based methodology, an employer would provide higher incentives for completing an HRA than for attending a health fair.

Employers ideally would use data collected during an HRA or biometric screening to develop personal goals

for the participant, and can use data in the aggregate to develop appropriate interventions and goals for the wellness program. Employers can use lower cost-sharing to encourage participants to complete HRAs and get biometric screenings. For example, employers can offer incentives such as enhanced employer contributions to employees' health savings accounts or health reimbursement arrangements.

Data Collection

Data collection is a key step in the process of building an effective, value-based wellness program. Data collected will show employers which areas should be the focus of their wellness programming. In the survey, we looked at three discrete types of data employers collected while developing their wellness programs. These types of information fall into the broad categories of organizational data, employee data, and environmental health and safety data (EHS).

Within these categories, the information is used for the following purposes:

- to identify health risks to determine the focus of wellness programs,
- to develop incentives to drive participation,
- to link benefit plan design to wellness objectives, and
- to evaluate the impact of wellness programs.

Benefit plan data include medical, pharmacy, and disability plan information. Employee data include HRA responses, employee interest surveys, and biometric screenings. EHS data include workers' compensation claims, safety reviews, and worksite environmental assessments.

Organizational Data

Benefit plan claims, which include data from employers' medical, pharmaceutical, and disability plans, provide organizational data. Additional information is taken from data on workers' compensation claims and absenteeism.

These data sets are important as they provide insight into prevalent medical conditions occurring within the employee group and opportunities for the wellness program to address those conditions. A brief review of the data should provide information on manageable chronic diseases, such as diabetes, hypertension, heart disease, and many cancers.

Medical plan and pharmacy data in particular can provide a wealth of information for developing an effective wellness program. Gaps in preventive care and compliance rates for health screenings can be easily identified within the medical and pharmacy plan data. For example, because most cancer screenings have very specific screening schedules, an employer can identify whether plan participants are receiving age- and gender-appropriate cancer screenings.

Within the pharmacy plan data, medication adherence is an important metric to identify how well diabetes, hypertension, and other common chronic diseases are controlled. Are participants refilling their medications on a timely basis? If not, poor medication compli-

³ University of Michigan, School of Public Health, Center for Value-Based Insurance Design, <http://www.sph.umich.edu/vbidcenter>.

⁴ PPACA, Section 10408.

ance may lead to a worsening of chronic medical conditions.

Another important output of careful analysis of medical and pharmacy plan data is optimal plan design. Are the plan provisions aligned to encourage preventive care and medication adherence? High copays for maintenance medication or preventive care drugs can be a cause of poor medication adherence.

An analysis of disability plan data typically provides insight into the diseases that are causing the longest duration and most costly claims. Which diseases are causing those claims? Are the disability claims resulting from the same chronic diseases seen in the medical plan? For example, poor personal health management can result in missed workdays, which impacts productivity.

Workers' compensation data can be reviewed through the same lens as other plan data. Identify the most frequent and costly causes of workers' compensation claims: What are the injuries that produce workers' compensation claims with the longest duration? Many common workers' compensation claims, such as back pain, can be addressed within a wellness program.

Employee Data

HRAs, employee interest surveys, and biometric screenings provide the employee data that should be assessed. They are considered a high-value data set because they provide important insight into participants' levels of health literacy, lifestyle practices, and perceived health needs, so that appropriate programming can be developed. In particular, HRAs function both as a tool to collect information and as an opportunity to provide health status information to individual participants.

Since an effective wellness program should include education, it is important that employers have a snapshot of what employees think about their own health needs and their readiness for change. An HRA is usually conducted as a campaign. Typically, employees are required to participate or are provided an incentive for participation. In addition to encouraging employees to think about their health status, employers also have as a goal to encourage the largest number of participants so that the data collected will represent the employee population as accurately as possible. Employers conducting the HRA campaigns are typically provided an aggregate report of all employee responses.

In addition to data to be used for program development, an HRA campaign is an initial education opportunity for participants. HRA questions will help identify whether employees "know their numbers," which means educating employees about their blood pressure, cholesterol levels, or, for diabetics, their hemoglobin A1c numbers, all of which are key metrics of health. Employees who complete HRAs typically receive reports that identify how their scores compare with national health benchmarks.

In the survey, we found that only 45 percent of surveyed employers offered an HRA and, of that percentage, 73 percent offered them annually. Thus, a majority of employers are missing an opportunity to use data to strategically plan benefits and wellness programs to address future needs.

Employers are starting to conduct biometric screenings. These screenings will typically consist of a series

of tests, including for blood pressure, cholesterol levels, body fat or body mass index, and blood sugar levels. Some employers include a brief consultation with a health coach to review biometric screening results and to discuss nutrition, exercise, or other lifestyle factors impacting health. In our survey, only 31 percent of employers indicated that they offered biometric screenings, again with a majority (74 percent) offering them annually. Yet only 53 percent said they offered financial incentives to encourage participation in biometric screenings. While employers are beginning to use biometric screening, this value-based approach to wellness programming still has room to grow.

Environmental Data

The physical environment in which employees live and operate has an impact on their health status. Environmental assessments are conducted to consciously review areas within the work environment that support or detract from good health. Safety reviews are a common source of environmental data as they identify physical hazards within the work environment that lead to injuries or workers' compensation claims. Yet in our survey, only 16.5 percent of employers indicated they used workers' compensation or disability claims to evaluate their wellness programs.

Other environmental areas to review are:

- Is the work environment tobacco-free?
- Are cafeterias or vending machines offering healthy selections?
- Are there safe and well-lit areas in which employees can walk or exercise?

Using worksite tobacco as an example, we would consider not just whether smoking occurs at the worksite but where people smoke and whether nonsmokers must walk through secondhand smoke on the worksite. How easy or difficult is it to smoke at the worksite?

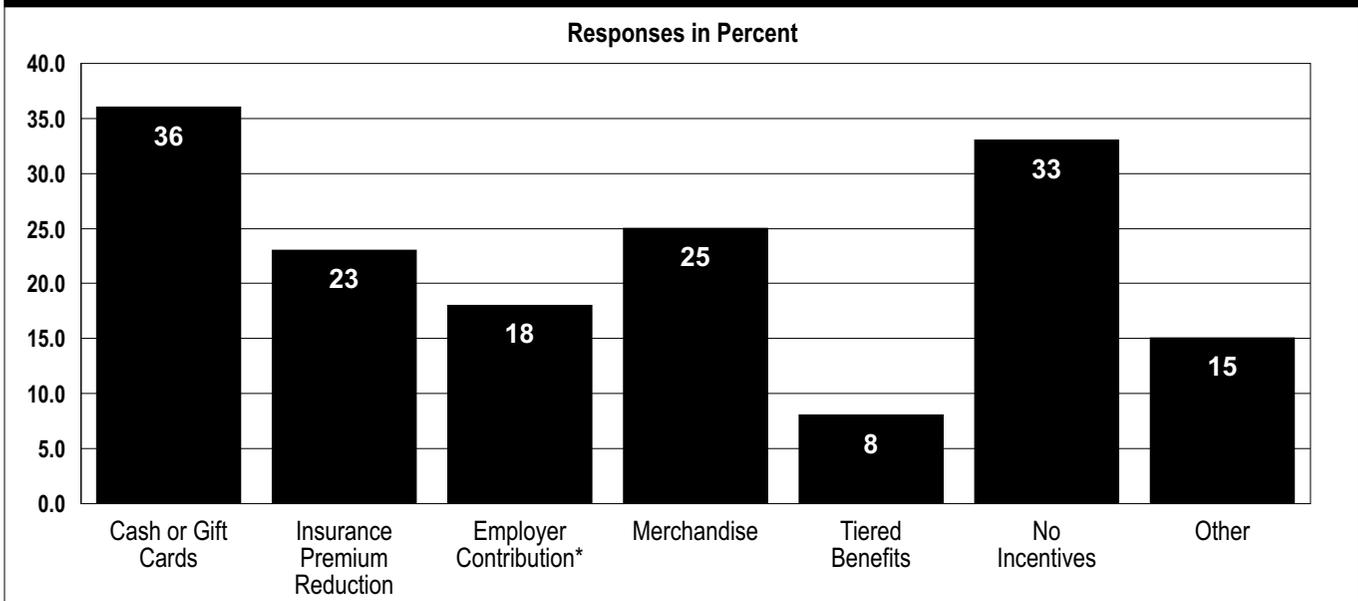
An environmental data assessment should look at opportunities to remove barriers to healthy lifestyles and opportunities to enhance existing healthy worksite environments. Our survey found that only 58 percent of employers offered a tobacco-free worksite, 56 percent offered healthy choices in their vending machines, and only 42 percent offered a safe walking area.

Benefit Plan Design

The survey questions regarding benefit plan design focused on value-based plan provisions. Value-based benefit plan design grew out of the belief that various health care services have different value and that plan design should encourage the use of high-value, high-quality health care services.⁵ Our questions explored whether employee out-of-pocket costs were designed to encourage preventive care and compliance in the use of preventive or maintenance medications. In our survey, 78 percent of the employers reported that they aligned their employee benefit plan out-of-pocket costs (copays, coinsurance, and limits) to encourage preventive care,

⁵ A.M. Fendrick and M. Chernew (2006). *Value-Based Insurance Design: A "Clinically Sensitive" Approach to Preserve Quality of Care and Contain Costs*. The American Journal of Managed Care, 12, 18-20.

Chart 1: Which of the Following Incentives do You Use to Promote Participation in Your Wellness Program?



Source: 2011 MidAtlantic Healthy Workforce Survey

*Employer contributes to either a Flexible Spending Account or Health Savings Account.

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yet only 28 percent indicated they covered maintenance or preventive care drugs with little or no cost-sharing. Thus, again, we see a need for more value-based designs in worksite benefits.

We also asked whether plan design steered participants to high-performance (high-quality) providers or networks. A high-performance provider is a medical provider or network of providers that produces high-quality outcomes, coordinates care, and has the capability to share information with a patient's other medical providers. Clearly, technology plays into a provider's ability to be designated a high performer. High performers will have an electronic medical record (EMR) system in place. To achieve a high-performance designation, these providers must have the capability to demonstrate high-quality health outcomes within their patient base. EMR enables these providers to track patients' care, provide timely follow-up care, and analyze and remediate gaps in care that occur within their practice.

Health plan provider directories will identify when a provider has met the requirements for designation as a high performer. Health plan carriers have developed branded designations such as Aetna's Aexcel® designation for specialists, Cigna's "Care Designation," and UnitedHealthcare's "Premium Designation." In the provider directory, the designation is listed next to the provider's name in an effort to drive care to those providers. In our survey, only 34 percent of employers reported that they steered employees to these high-performing networks in their health benefit plans.

Incentives

Incentives used to promote participation were broken out into two broad categories in the survey—gifts of cash, gift cards or other merchandise and value-based benefit plan-related incentives.

Cash, gift cards, and merchandise are commonly used to drive participation in wellness activities and events. For example, an employer will use a drawing for gift cards or merchandise to promote attendance at wellness events such as health fairs. Entry into a drawing can create a sense of urgency to complete an HRA. Typically, an HRA campaign will last for several weeks, and participants completing the assessment will be entered into a weekly drawing for a gift card or some specific wellness-related merchandise.

Our survey found that most employers provide incentives for participation in wellness programs, with 67 percent of employers offering some type of incentive. For those that offered incentives, most offer gift certificates (36 percent) or merchandise (25 percent).

Employers also are beginning to utilize value-based incentives. For example, in our study, 23 percent of the employers said that they lowered premiums for participation in wellness programs, and more than 18 percent said they contributed to health FSAs or HSAs.

Evaluation

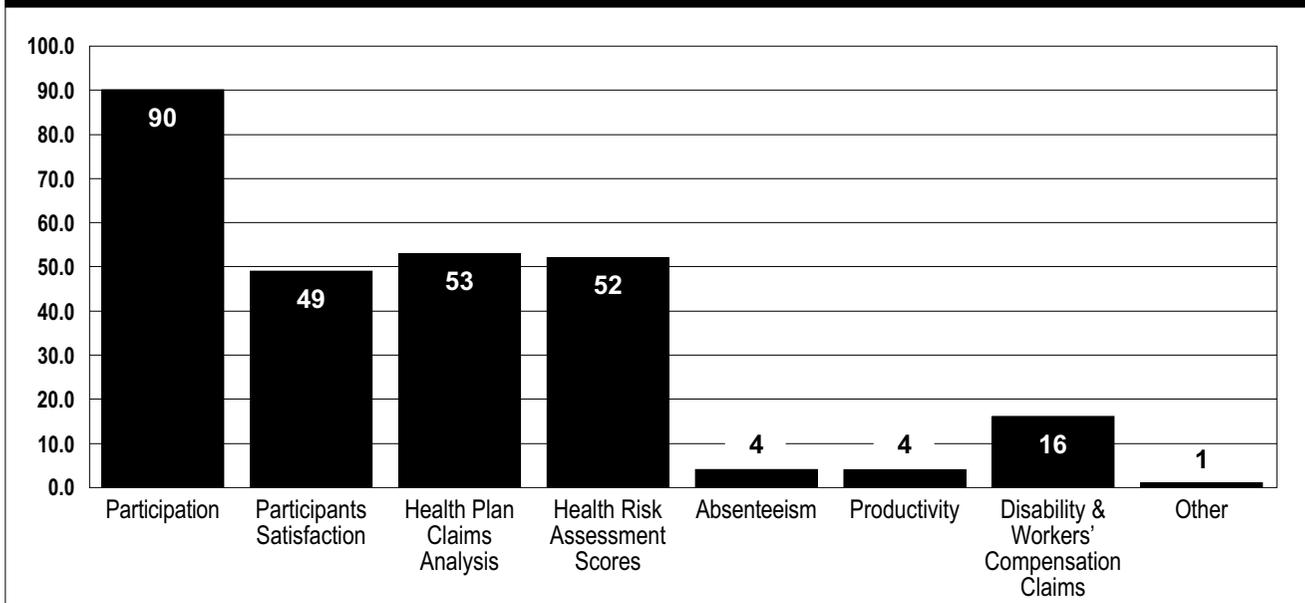
In the survey, we looked at whether employers evaluated the results of their wellness initiatives and, if so, what evaluation methods were used. Evaluation methods were aligned into two broad categories: 1. participation and participant satisfaction, and 2. outcomes.

Outcomes were defined as claims savings (health, disability and workers' compensation plan claims), HRA scores, absenteeism, and productivity.

While a majority of employers (65 percent) evaluated their worksite wellness programs, most (90 percent) simply evaluated their program by participation. However, many also examined health claims (53 percent), with very few having used more advanced measures such as absenteeism (less than 5 percent) or disability and workers' compensation claims (16 percent).

Chart 2: Which Evaluation Methods Are Used to Evaluate Your Wellness Program?

Responses in Percent



Source: 2011 MidAtlantic Healthy Workforce Survey

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The use of the evaluation results was also mixed, with only 55 percent of employers saying that they had senior leadership review the evaluation of the wellness plan and even fewer (44 percent) saying that they shared wellness evaluation with their employees.

To further examine the differences between employers that evaluate their wellness programs, we examined whether employers that perform such evaluations have different benefit designs. We found that employers that evaluate their worksite wellness programs appear to provide benefits that align with worksite wellness goals. A majority of those evaluating their wellness programs align their benefit plan design so that participant out-of-pocket costs encourage preventive services (68 percent), drive consumers to high-performing provider networks (72 percent), and offer consumer-directed health plans (67 percent). Employers that evaluate their programs also are more likely to cover the full cost of maintenance drugs and preventive drugs such as blood pressure or cholesterol medication (71 percent).

We found a significant difference between employers that evaluated wellness programs and those that did not, particularly in the self-service resources to which they directed their employees, with evaluators having used web portals, health advocacy, and nursing lines, while nonevaluators primarily used web portals or no self-service resources. We also found that employers that evaluated their wellness programs were significantly more likely to offer incentives for participation. Eighty-six percent of employers that evaluated their programs offered some sort of incentive, while only 38 percent of nonevaluating employers used incentives in their wellness programs. The most frequently used in-

centive was cash or gift cards, followed by insurance premium reduction and merchandise.

Conclusion

The survey results show us that employers are making significant progress in developing value-based wellness programs. With 100 percent of employers responding to the survey saying that they had some form of wellness program in place, 78 percent saying that they aligned benefit plan out-of-pocket costs to encourage prevention, and 67 percent saying that they offered incentives, it is clear that employers are embracing value-based wellness programming.

There is room for growth in data collection and the evaluation of program outcomes. Since less than half of employers (45 percent) offered HRAs and less than a third (31 percent) conducted biometric screenings, there are opportunities here to improve data collection to identify the health risks within employers' populations. The 65 percent of employers that evaluated their wellness programs mostly by measuring participation can gain more specific data if they begin to review more advanced measures such as claims analysis, HRA scores, biometric screening results, absenteeism, and other productivity measures.

While we are not there yet, it is clear from the survey data that employers are moving in the right direction. By continuing to collect data to identify risks, developing value-based programming to address those risks, and continuously evaluating program outcomes, employers can achieve their stated health goals for the unique needs of their employee populations.