Care Continuum Alliance

701 Pennsylvania Ave. N.W., Suite 700
Washington, D.C. 20004-2694 (202)
737-5980 • (202) 478-5113 (fax)
info@carecontinuumalliance.org
www.carecontinuumalliance.org

May 23, 2013

The Honorable Jacqueline Berrien
Chair
U.S. Equal Employment Opportunity Commission
131 M Street, N.E.
Washington, D.C. 20507

The Honorable Constance Barker
Commissioner
U.S. Equal Employment Opportunity Commission
131 M Street, N.E.
Washington, D.C. 20507

The Honorable Chai Feldblum
Commissioner
U.S. Equal Employment Opportunity Commission
131 M Street, N.E.
Washington, D.C. 20507

The Honorable Victoria Lipnic
Commissioner
U.S. Equal Employment Opportunity Commission
131 M Street, N.E.
Washington, D.C. 20507

The Honorable Jenny Yang
Commissioner
U.S. Equal Employment Opportunity Commission
131 M Street, N.E.
Washington, D.C. 20507

The Honorable P. David Lopez
General Counsel
U.S. Equal Employment Opportunity Commission
131 M Street, N.E.
Washington, D.C. 20507

Re: Wellness Programs and Incentives

Dear Sir or Madam,

The Care Continuum Alliance (CCA) welcomes this opportunity to comment on the discussion at the May 8th EEOC public meeting on "Wellness Programs Under Federal EEOC Laws" in Washington, D.C. We are a non-profit association of almost 200 companies. CCA convenes all stakeholders in the population health management industry. Our members design and provide services, programs and tools to better coordinate care for all patients along the continuum, from the healthy to those with chronic conditions. Through advocacy, research and education, we advance strategies that increase quality in the health care system while reducing costs.

CCA appreciates your thoughtful consideration and careful attention to the value of worksite wellness programs and incentives. We observed in your meeting that a significant portion of the discussion revolved around the "voluntary" aspect of workplace wellness programs. Jointly-issued 2006 final regulations on *Nondiscrimination and Wellness Programs* by the Department of Labor, Department of the Treasury and Department of Health and Human Services expressly identify the five-prong Health Information Portability and Accountability Act (HIPAA) standard as the appropriate metric for evaluating the "voluntary" aspect of worksite wellness programs.[1] The EEOC also referenced this standard in its

[1] 45 CFR Part 146 §146.121(f)(2)(i)-(v), Department of the Treasury, Department of Labor, Department of Health and Human Services, *Nondiscrimination and Wellness Programs in Health Coverage in the Group* Market, Federal Register vol. 71 No. 239 (Dec. 2006): 75052.

2008 final rule, acknowledging that Title II of the Genetic Information Nondiscrimination Act allows covered entities to offer incentives for participating in wellness programs.[2]

The HIPAA five-prong test states that wellness programs offering rewards based on achieving a particular health status are voluntary if: (1) the reward does not exceed 30 percent of the cost of the individual's health coverage or 50 percent in relation to tobacco; (2) the program is reasonably designed to promote health or prevent disease; (3) individuals have the opportunity to qualify for the reward at least once annually; (4) the reward is available to all similarly situated individuals; and (5) disclosure of a reasonable alternative standard if the terms of the program are described.[3,4] Please also note the useful Wellness Program Analysis and Checklist provided by the Department of Labor to clarify application of the existing HIPAA standard.[5]

CCA supports this HIPAA standard as the appropriate metric. We encourage the EEOC to adopt this standard and issue such guidance to employers. This will alleviate confusion and concern regarding the possibility of additional regulatory hurdles for worksite wellness programs.[6] Confusion often leads employers to simply withdraw or abstain from offering even well-designed evidence-based wellness and incentive programs. The HIPAA standard aligns with CCA's and the EEOC's shared goal of promoting and improving health, while prohibiting discrimination in an employee's eligibility or ability to participate in wellness programs.[7] Furthermore, applying the standard to worksite wellness programs offers compelling advantages over forging new compliance requirements. Using this standard in the context of worksite wellness programs would be a natural extension from its current application with group health plans, ensuring consistent and streamlined regulatory requirements around wellness programs in the health industry. Also, many employers with well-received and successfully implemented wellness programs currently use the five-prong HIPAA standard. This indicates that the standard operates as a strong functional basis for future EEOC guidance.

We are providing you with a current literature review and case studies that demonstrate advancements in worksite wellness programs. The literature shows that incentives can facilitate behavior change to increase patient engagement in wellness programs. It also positively indicates that appropriate incentive and wellness program design can produce cost savings for employers. Finally, the literature reinforces that the value of incentives in wellness programs extends beyond direct healthcare cost savings. As one component of an organizational culture of health, incentives in wellness programs can produce additional positive outcomes such as workforce productivity.

We are also including a joint consensus paper by the Health Enhancement Research Organization, the American College of Occupational and Environmental Medicine, the American Cancer Society and American Cancer Society Cancer Action Network, the American Diabetes Association, and the American Heart Association entitled, "*Guidance for a Reasonably Designed, Employer-Sponsored Wellness Program Using Outcomes-Based incentives*". This paper offers valuable insights on wellness program and

[2] 29 CFR Part 1635, Equal Employment Opportunity Commission, *Regulations Under the Genetic Information Nondiscrimination Act of 2008*, Federal Register vol. 75 No. 216 (Nov. 2010):68923 n.13.
[3] 45 CFR Part 146 §146.121(f)(2)(i)-(v) at 75052.
[4] §1201, Patient Protection and Affordable Care Act, H.R. 3590 (2010).
[5] Employee Benefits Security Administration, U.S. Department of Labor, *Wellness Program Analysis*, Field Assistance Bulletin No. 2008-02 (Feb. 2008) 1-5.
[6] 45 CFR Part 146 §146.121(f)(2)(i)-(v) at 75052.
[7] Id.

incentives design for your consideration. It outlines elements of a reasonably designed wellness program and provides guidance on devising reasonable alternative standards.[8] The paper notes that incentives in wellness programs should be designed with flexibility to incent meaningful progress toward health goals and not just ideal targets.[9] It also advises employers to incorporate options that allow employees to earn any given incentive in multiple ways, promoting behavior change through individual choice.[10]

CCA looks forward to continuing this dialogue and would be glad to serve as a resource. Please feel free to contact us with thoughts or questions.

Thank you,

Frederic S. Goldstein
Interim Executive Director
Care continuum Alliance

Victoria Shapiro
Director of Government Affairs
Care Continuum Alliance

[8] Health Enhancement Research Organization, the American College of Occupational and Environmental Medicine, the American Cancer Society and American Cancer Society Cancer Action Network, the American Diabetes Association, and the American Heart Association, *Guidance for a Reasonably Designed, Employer-Sponsored Wellness Program Using Outcomes-Based Incentives*, Journal of Occupational and Environmental Medicine, Vol. 54 (July 2012).
[9] Id. at 894
[10] Id.

Literature Review

As program innovation continues, a growing body of research positively indicates that incentives can, in some cases, facilitate behavior change to increase patient engagement in wellness programs.

- Evaluations of incentive programs indicate that they are likely to have a positive effect, but results vary considerably. The reasons for variation and ways to avoid misguided incentive programs are two of the questions that are currently being researched by several organizations and research houses. (Care Continuum Alliance, 2012)
- Serxner (2013) recently proposed an applied framework approach that accounts for incentives as extrinsic motivators and emphasizes the importance of shifting to intrinsic motivation for long-term sustained behavior change. Combining the framework with motivational levers provides context for incentive design. The goal is a balanced approach of extrinsic and intrinsic motivational levers in these programs.
- The Mercer National Survey of Employer Sponsored Health Plans (2010) offers insight into the types of incentives that are prevalent in the industry. Among large employers providing incentives for health risk assessment, disease management program, or behavior modification, cash is the most used incentive type. Other incentives also include lower premium contributions and contributions to an employee's HSA or FSA.
- Incentives, when applied within the context of the communications, climate and culture of an organization, can impact long-term engagement. Workplace culture is closely connected to the impact of incentives on employee behavior (Grossmeier 2010). History shows that the right combinations of culture change, communications and policy-related incentives have been necessary for most major social changes: use of seat belts, recycling behavior, and reduced tobacco use (Terry, 2011).
- There is also research that suggests factors that contribute to the success of incentive programs. Seaverson et al (2009) offers insight into the specific factors that can lead to increased participation in a health risk assessment completion. When all factors were included in the model, incentive value and communications strategy were significantly associated with HRA participation.
- Another challenge—an opportunity for additional research—is a better understanding of the amount of incentive needed to yield the desired action. Research conducted by Taitel et al (2008) suggested specific dollar amounts that may yield certain levels of participation. The study further suggested that the level of communication and organizational commitment factor into participation at a given incentive value.

Appropriate incentive and wellness program design can produce cost savings for employers without any cost shifting to less healthy employees.

- In 2012, the Care Continuum Alliance released a whitepaper that discussed the considerations of incentive design. Efforts and decisions made to control health care costs have become an executive level issue for most organizations. As organizations explore the use of incentives, key areas of consideration include: program budget, desired outcomes, impact on motivation, and incentive sustainability. Responsible design of the incentive or wellness program can impact health care costs and need not resort to cost shifting to demonstrate savings.
- Schwartz et al (2010) studied the economic impact of the Hawaii Medical Service Association's health promotion/disease prevention program using a retrospective analysis and adjusted analyses between participants and non-participants using propensity score matching method

and/or covariates. The study of more than 166,000 members over a 4-year period found that program participants incurred consistently lower costs.

- The Healthways Process Excellence Group (2009) analyzed lifestyle management programs to determine variables that influence enrollment. This study of 98,945 individuals found multiple factors, including demographics, risk level, call timeframe, number of call attempts, and incentives. The most significant predictor of increased enrollment was the offer of a participation incentive, and the absolute dollar value needed to effectively incent a specific group varied based on socioeconomics, communications and organizational support.
- Serxner et al (2013) reviewed studies on worksite health management (WHM) programs to evaluate study methodologies, the financial impact and the overall quality of evidence. Overall, studies demonstrated positive outcomes and modest cost-savings. They note that results from any WHM study should be evaluated within the context of the nature of a WHM program and methodology used. Otherwise, assessments of studies on worksite health management programs can be very misleading.
- Case Example: A wellness program vendor provides a health and wellness program to over 1,400 employers nationally. In order to measure the effectiveness of this outcomes based program, an independent consulting group analyzed medical claims data over a multi-year period to compare medical costs of employers using the program versus those who did not. The consultants also measured the financial impact of the program on individual client's medical costs and productivity. Results show an overall positive trending and reduction in medical spend for employers in the program. It also demonstrated a significant trend reduction in medical costs versus 2010 forecasts across all clients studied with even greater projected savings in 2011. Program participants had lower claim costs and returned to work sooner versus those who chose not to participate.

The value of wellness programs extends beyond direct healthcare cost-savings. As one component of an organizational culture of health, wellness programs can produce additional positive outcomes such as workforce productivity, aside from short-term Return On Investment.

- Employers now recognize that health is a strategic asset in achieving improved productivity and a sustained competitive advantage, as opposed to the former way of thinking of health as a cost to be controlled (Parry et al, 2012). In a Hewitt 2008 survey, 65% of employers responded that keeping employees healthy to improve productivity was one of their top three business issues.
- In a meta-analysis of worksite health promotion programs, Chapman (2012) concluded that these programs represent one of the most effective strategies an employer can use to reduce absenteeism as well as medical costs. He asserts the importance of future research to provide a better understanding of their impact on productivity as the average age of American workers increases.
- Loeppke et al. (2008) evaluated the impact of an integrated population health enhancement program on employee health risks, health conditions, and productivity. Their findings demonstrate sustained behavior change and improved absenteeism.
- Case Example: An analysis of a large cohort within a wellness program vendor's book of business demonstrates significant health improvement. The data set includes participants engaged in plans with incentives of all sizes and shapes. The majority of the plans administered contain financial incentives. The results from this study highlight the benefits of financial incentives when facilitating behavior change to improve health outcomes. More than 40% of people who had high blood pressure in their first screening were within normal ranges the following year. Additionally, 55% of those with high LDL cholesterol in their first screening did not have high LDL

cholesterol the following year. Of those who were in the obese range in their first screening, 7.2% were not obese one year later. Lastly, 7.8% of nicotine users were negative for nicotine in one year.

- Case Example: A customized, end-to-end wellness program included specific biometric targets, defined financial incentives and a turn-key screening vendor. The program produced significant positive health outcomes for a company's employees. Among employees in the program for three years, 11% of smokers stopped smoking. Of the 26% of employees with LDL cholesterol above 130 at baseline, after three years only 20% were above 130. Net cost savings averaged $120 per employee per year, taking into account discounts offered to those employees who passed all biometric targets and fees paid to the program vendor. For employees who participated, claims per employee fell by 3.4% from year 1 to year 2, while claims for those who did not participate in the program increased by 26.8%.
- Case Example: Participants in an employer's wellness program have the chance to win significant incentives simply for engaging in the program. The employer is in the fourth year of the program and sees high participation rates in excess of 95%. This program is focused on three steps: awareness, responsibility, and activity. Employees have the opportunity to take part in a free comprehensive on-site biometric screening, health evaluation, and receive a personalized health score. Employees may also take an unlimited number of one on one telephonic health coaching sessions with a health professional. Employees can participate in a vigorous walking program that provides free pedometers and offers a variety of challenges among colleagues. The number of tobacco users dropped 15% between 2011 and 2012, and one third of all employees are logging an average of 8,000 steps daily.
- Case Example: An employer implemented a wellness program that included biometric targets, defined financial incentives, and a screening program to improve employee health and reduce cost trend. Smoking and obesity were found to be major drivers of health costs so the program included higher rewards for non-smokers and non-obese individuals. The program was securely integrated into the organizational culture, which links quality of life together with productivity costs. Participation reached 99% in all 3 years of the program. 7.6% of participants stopped smoking in the third year; and 16.4% had a BMI reduction of 2 or more points in the third year. Additionally, there was a net savings of $124 per employee per year allowing continued investment in wellness programs.
- Case Example: In 2008, an employer launched a comprehensive program, including health risk assessments, professional health screenings, on-line health coaching, and consistent communication. The program has expanded to include wellness incentives that have increased year to year. In 2010, the employer offered employees a non-tobacco incentive. Also, the employer offered an opportunity for employees to wear jeans and sneakers and get fit by walking. The employer offers healthy food choices at the on-site cafeteria and revamped its vending machine selections to provide healthy alternatives. There is an on-site Weight Watchers program, a personal health coach, monthly newsletters, lunch & learns, and access to a personal nutritionist. Since 2009, the employer has seen several improvements in the health of their employees and family members, including 15% reduction in high glucose, 32% reduction in high cholesterol, 20% reduction in the risks associated with obesity, 43% improvement in the number of employees and family members involved with regular fitness and exercise, and18% reduction in metabolic syndrome.

References

Care Continuum Alliance. Outcomes Guidelines Report, vol. 5. Washington, DC: Care Continuum Alliance, 2010.

Care Continuum Alliance. Participant Engagement and the Use of Incentives – Considerations. Washington, DC: Care Continuum Alliance, 2012.

Chapman LS. (2012). Meta-Evaluation of Worksite Health Promotion Economic Return Studies: 2012 Update. The Art of Health Promotion, March/April 2012; 26(4): TAHP-1-TAHP-11.

Ford ES, Zhao G, Tsai J, and Li C. Low-risk lifestyle behaviors and all-cause mortality: findings from the National Health and Nutrition Examination Survey III Mortality Study. American Journal of Public Health, August 2011; 101(10).

Grossmeier J, Terry PE, Cipriotti A, and Burtaine JE. (2010). Best practices in evaluating worksite health promotion programs. American Journal of Health Promotion, January 2010; 24(3): TAHP-1-TAHP-12.

Healthways Center for Health Research. Incentives for Health and Wellness Programs: Strategies, Evidence and Best Practices. Outcomes & Insights in Health Management, June 2009; 1(3).

Hewitt Associates. Wellness and Beyond: Employers Examine Ways to Improve Employee Health and Productivity and Reduce Costs. August 2008. Available at http://www.aon.com/attachments/thought-leadership/Wellness_and_Beyond.pdf.

Hill RK, Thompson JW, Shaw JL, Pinidiya SD, and Card-Higginson P. (2009). Self-reported health risks linked to health plan cost and age group. American Journal of Preventive Medicine, June 2009; 36(6): 468-74.

Loeppke R, Nicholson S, Taitel M, Sweeney M, Haufle V, Kessler RC. (2008). The Impact of an Integrated Population Health Enhancement and Disease Management Program on Employee Health Risk, Health Conditions, and Productivity. Population Health Management, 2008; 11: 287-296.

Mercer National Survey of Employer-Sponsored Health Plans. 2010. Available at http://www.mercer.com/ushealthplansurvey

Neville BH, Merrill RM, and Kumpfer KL. (2011) Longitudinal outcomes of a comprehensive, incentivized worksite wellness program. Evaluation & Health Professions, March 2011; 34(1): 103-23.

Osilla KC, Van Busum K, Schnyer C, Larkin JW, Eibner C, and Mattke S. (2012). Systematic review of the impact of worksite wellness programs. American Journal of Managed Care, 18(2): e68-e81.

Parry T, Sherman B. (2012). A Pragmatic Approach for Employers to Improve Measurement in Workforce Health and Productivity. Population Health Management, April 2012; 15(2): 61-4.

Pelletier KR. (2011). A Review and Analysis of the Clinical and Cost-effectiveness Studies of Comprehensive Health Promotion and Disease Management Programs at the Worksite: Update VIII 2008 to 2010. JOEM, November 2011; 53(11): 1310-31.