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Workplace Wellness Programs

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Workplace wellness programs, while not a new concept, are becoming increasingly popular as many employers are implementing them as a means of providing awareness to their employees and reduce the soaring costs of healthcare, which now accounts for more than 44% of payroll expenses (Benavides & David, 2010). In an effort to reduce those costs, employers are exploring the many potential benefits of implementing an effective workplace wellness program. Employees are provided the opportunity to become educated and be supported in preventive care, stress management, financial wellness, and even in making important lifestyle changes. For the employer, when implemented effectively, this approach can result in fewer health risks, a reduction in healthcare costs and premiums, lower workers’ compensation and disability management claims expenses, and increased worker productivity (Williams & Day, 2011). It is important for employers to review valid research to fully understand that when employee wellness programs are well-designed and implemented, they can, over time, provide employers with a return on investment (ROI), indicating that these programs are effective in reducing costs and improving employee health. The purpose of this literature review is to further explore existing and new research to determine the effectiveness and implementation of workplace wellness programs by employers in an effort to reduce healthcare costs and create a healthier work culture for their employees.

**Program Implementation & Design/Ethics**

Workplace wellness programs can be designed and implemented in a variety of ways and are unique to the needs of each workplace. While my research did not investigate the specific individual elements of wellness programs, it did reveal that workplace wellness programs do need to be consistently comprehensive in nature and provide key components.
DeJoy, Dyal, Padilla & Wilson (2014) reviewed the findings from four national surveys of workplace health promotion (WHP) activities completed in 1985, 1992, 1999, and 2004. These surveys were intended to provide snapshots of WHP programming and track progress toward achieving national public health objectives. This review also provided suggestions for future surveys after the Affordable Care Act (ACA). Each of the four surveys used Dun and Bradstreet listings from which to draw nationally representative worksite samples. Sample worksites had varying numbers of employees, industry classification, and geographic location. All surveys sampled worksites instead of companies or organizations. The target respondent for each survey was either a person having direct responsibility for health promotion activities at the worksite or someone with in-depth knowledge of the programming. The surveys were completed via telephone interviews and survey content varied over time. Primary data analyses for each involved presentation of descriptive statistics and statistical comparisons emphasizing stratifying variables and each successive survey made some attempt to compare results against those of prior surveys. Overall results of the surveys showed an expansion of WHP activities over time, with larger companies offering a broader scope of health promotion activities. WHP programs made significant progress toward the Healthy People 2000 national health promotion objectives and met most of these objectives. Healthy People 2010 set an objective that 75% of employers should offer programs with five key components – health education, supportive environment, program integration, linkage to related programs, and screenings, but fewer than 7% of worksites met this objective. Due to the varying content of the surveys, it was difficult to draw conclusions across the full time span, but progress could be noted. As a result of the surveys, knowledge gaps in WHP programming were able to be identified including missing information on program effectiveness and employee perspective. While data collection could be improved in this study as
well as employee perspective information obtained, it shows that only a small percentage of program objectives are being met by these employers. It is important to note however, that progress towards these objectives is being made (DeJoy et al. 2014). This provides insight on the need for these programs and how they could be more effectively implemented to have a greater impact on a healthier work culture and work toward meeting the recommended objectives.

For many businesses, healthcare costs are consuming an enormous part of their budgets. Given this reality, the question is no longer whether a workplace wellness program is needed, but rather how to administer an effective, ongoing workplace wellness program. In 2010, Machen, Cuddihy, Reaburn, & Higgins presented a case study based on the development of a workplace wellness promotion pilot framework for the Blue Care Staff Wellness Program in Australia. Blue Care is Australia’s largest not-for-profit provider of community and residential care services with over 10,000 employees across 260 facilities in over 80 communities. This study revealed that there is a growing demand for workplace wellness programs to improve the health and well-being of employees and the potential for cost savings for the employer. The challenge that exists for organizations is not whether to have a workplace wellness program, but how a program should be designed, implemented, and evaluated to achieve optimal health and cost-effectiveness. This study was based on three sources: a review of the health and wellness promotion literature, a workplace profile, and the input of a workplace wellness steering committee. Internal Human Resources and internal Information Technology (IT) reporting systems were utilized to assess the workplace needs/resources assessment. All levels of information were gathered with permission, were service and region specific, and did not identify any individual employees. A conceptual framework was developed to visually demonstrate the process required to successfully implement a program. The key components
identified for the conceptual framework were: Develop Business Care, Create Support Network, Create Program, Deliver Program, Evaluate, and Monitor. The pilot program will provide insight into the effectiveness of this conceptual framework in promoting a comprehensive workplace wellness program. Outcomes upon the completion of this pilot program will provide a greater insight into the effectiveness of this particular conceptual framework. Similar wellness program models exist and research is ongoing. According to Machen et al., research and information on workplace wellness programs is in the infancy stage. Research, reviews and outcomes are available about effective workplace health promotion programs, however, it is lacking in translating this knowledge to business practices on how to design, implement, and evaluate these programs (Machen et al., 2010). As programs continue to be implemented, additional research should be developed on the design, implementation, and efficacy to determine areas for improvement or change for organizations of all sizes and industry.

While the case study above reviews a pilot program with outcomes not yet available, other organizations have documented success with workplace program implementation. Benavides & David (2010) reviewed research and surveys about wellness programs in the public and private sectors. They reviewed the differences between an Employee Assistance Program (EAP) and a wellness program, generally labeling an EAP as a reactive employee benefit which often has a negative stigma attached to it, and a wellness program as a proactive preventive program which seeks to mitigate problems before they emerge or become unmanageable. Benavides and David discuss wellness programs and the components that contribute to a successful program, such as physical fitness, stress management, psychological and mental health issues, nutrition and dietary related needs, and alcohol and chemical dependency programs. Return on Investment (ROI) was reviewed and we will be addressed later in this
literature review. In public employment, wages tend to be lower, but a more comprehensive benefits package has historically closed that gap. The rising cost of healthcare puts those benefits at risk in public employment. However, the implementation of a successful wellness program and a high ROI could save employers money offsetting some of those costs due to improved employee health and better preventive care management. Benavides & David go on to discuss wellness programs in the Dallas Forth Worth Metroplex as that area was ranked by Men’s Fitness magazine as the seventh fattest city in the United States. To directly impact declining health, City governments implemented employee wellness programs as a means to reduce their rising healthcare costs. At the time of this study, the programs were less than two years old so ROI figures were not available, however a reduction in healthcare costs was noticed (Benavides & David, 2010). Results of this study showed that wellness programs empowered employees to make healthier choices, improve their health, morale, happiness and stress levels, and encouraged them to perform better and work harder.

One area of research that will be increasingly prevalent as workplace wellness programs develop is the moral issues and personal choice that organizations are faced with and must be aware of when delivering their programs and the impact they have on why employees choose to not participate in the programs. Little research exists on how employees view employer involvement in individual employee health and wellness. Thus, in 2012, Robroek, van de Vathorst, Hilhorst, & Burdorf conducted a study to ascertain the opinions of employees with respect to the employer sponsored health promotion programs and why they do or do not choose to participate. Employees from five companies were invited to participate in a workplace health promotion (WHP) program. Both participants (513) and non-participants (205) in the program filled in a questionnaire on individual characteristics, lifestyle, health, and opinions regarding
WHP. Nonparticipants were asked why they did not participate, with multiple responses possible. Both participants and nonparticipants were then asked to indicate on a 5-point scale ranging from “totally disagree” to “totally agree” to what extent they agree with five statements addressing their opinion on WHP programs. Participants and nonparticipants were also asked demographic information as well as questions about lifestyle behaviors (physical activity, smoking, and alcohol intake). Body Mass Index was measured by asking for weight and height. Self-perceived health was dichotomized into “poor or moderate” and “good to excellent”. The opinion of participants and non-participants regarding WHP programs was compared using a chi-square test. Logistic regression analyses were used to analyze the relation between individual characteristics and health-related factors with having problems with employer interference concerning employees’ health. There were several reasons nonparticipants provided for not participating in the program with the top being “I am healthy”, and 9% indicating they were already being treated for health problems. Approximately 13% of nonparticipants expressed some objections to workplace wellness programs because it was their opinion that work and private life be kept separate. Ninety percent of participants and nonparticipants found a healthy lifestyle important, and most participants and nonparticipants agreed that that their lifestyle is a personal matter. This opinion did not lead, however, to many concerns regarding WHP programs, with a majority of participants and nonparticipants agreeing that it is good an employer try to improve employee health. It was noted in the study that older employees are more likely to resist employer interference with their health. The main limitation in this study was the low response among nonparticipants which may induce bias (Robroek et al. 2012). Moral issues concerning employer involvement in individual health is important to consider, and
developing research should provide insight on program design and outreach to bridge that gap and increase employee participation.

**Employee Health/Behavior Change**

One of the primary goals of workplace wellness programs is to change employee health behaviors towards a healthier lifestyle. Given that workplace wellness programs are only just developing in corporate America, many studies are looking at the short term impact of these programs. Much more robust and detailed research remains to be discovered as the success of sustained lifestyle changes continue to be measured in the years to come.

Current studies show promising results in healthy behavioral changes. LeCheminant & Merrill (2012) looked at the workplace wellness program and health behavioral change connection in a two year study. Two hundred sixty-seven (267) individuals were employed by the company used in this study from 2009 through 2011. Each had the option to complete a personal health assessment (PHA) and participate in a wellness program provided by Wellsteps aimed at selected behavioral change activities. Program involvement was defined by participation in the baseline PHA and any of the 6 behavior change campaigns each year. To complete a task, the employee had to finish behavior change requirements during the specified week. The three year wellness plan created by Wellstep followed a behavioral change framework with incentives for completion. Frequencies, means, and standard deviations were used to describe the data. A repeated measures design using a mixed (random effects) model was used to assess change in health behaviors through 12 and 24 months. Results of this study showed that out of 267 eligible employees, 229 completed a PHA at baseline, 170 employees completed a PHA at 12 months, and 174 completed a PHA at 24 months. 116 employees completed a PHA at all three times points. For the 116 employees who completed the PHA at each period, the largest
improvements tended to occur during the first year. The number of people who requested health coaching significantly increased at the end of 24 months compared to 12 months and baseline. Healthy behaviors did significantly increase over the period of the study, particularly with increased participation in regular exercise and daily consumption of fruits and vegetables as result of the worksite wellness program and continued through 24 months without noticeable health decay. It is notable that strengths of this study were attributed to the components of the worksite wellness program, length of the intervention, and its comprehensive nature (LeCheminant & Merrill, 2012). This study was limited by a lack of a comparison group and possible bias due the self-selecting participation and self-reported assessment. While behavioral changes were clearly noted in this study over a period of two years, follow up research on these participants would be beneficial to determine if these behavioral changes were sustained beyond the study duration. Similar long term studies on other workplace wellness programs and the sustainability of these changes will be of great interest to organizations creating a healthier work environment for their employees as well as return on investment.

Reduced Employer Healthcare Costs/Return on Investment

Healthcare costs continue to increase and consume large portions of employer payrolls. In attempt to control some of those costs many employers are implementing workplace wellness programs and seeing savings. While the impacts of these savings are not experienced immediately, a well-developed, comprehensive program can, over time, reduce costs and provide the employer with a return on investment.

Research is providing more insight into what components are necessary in a workplace wellness programs to obtain savings. In a recent study, Hangsheng, Mattke, Harris, Weinberger, Serxner, Caloyeras, & Exum (2013) examined the impact of PepsiCo Inc.’s (PepsiCo) comprehensive wellness program on medical costs and utilization during the period of 2004-
Two years of cost and utilization data prior to program implementation were used to address possible regression to the mean effects. There were further controls for non-wellness programs such as disease management, case management and a nurse advice line. The hypothesis in this study was that wellness program participation is associated with fewer inpatient admissions and emergency room visits, as well as lower medical costs. PepsiCo implemented their wellness program in 2004 with all members of their self-insured health plan eligible to participate. Other nonwellness programs were implemented during the study period such as disease management, case management and nurse advice line. Cash incentives were offered for participation. Data sources were 2004-2007 program eligibility and participation data, as well as medical and prescriptions claims data. The study excluded members under age eighteen and over age sixty-four. All included members had at least one intervention year and two years of baseline data. Members who participated in disease or case management programs at baseline were excluded, but were then included during the intervention years. 15,587 members were eligible for the wellness program in at least one intervention year. Program participants were matched based on propensity score with members who were eligible but did not participate. Independent variables included age, gender, DxCGrisk score, indicators for chronic conditions, and baseline costs and utilization. DxCG risk score is an index for predicting a member’s medical cost based on demographics and clinical diagnoses. The final sample consisted of 7,200 wellness program participants and 8,101 eligible nonparticipants, with 6,623 participants matched to nonparticipants. Program participants had slightly lower costs and utilization, but differences were not statistically significant. Notable, however, is that the wellness program defined in this study did not include disease management. In a separate study using the same data, disease management was shown to be effective in reducing medical costs and utilizations.
Other studies showing savings on medical costs and return on investment included disease management in their wellness programs (Hangsheng, et al., 2013). This study demonstrates the importance of including disease management in wellness programs to see optimum savings. Another limiting factor in this study could be that it takes three or more years to realize program benefits, thus the analysis period for this study may not have been sufficient. Moving forward, studies beyond three years of implementation may show even greater cost savings and return on investment.

Variety in programming can further enhance medical costs savings. The addition of a web-based wellness program can produce cost saving and reduce utilization as evidenced in a study by Williams & Day (2011). A quasi-experimental study conducted by Highmark, Inc. compared data compiled from 643 employer-based wellness programs in Pennsylvania from 2003 to 2007. Forty-seven employers were engaged in the web-based wellness programs and 596 employers were not engaged. Each group contained 10,463 matched wellness participants. Participants were required to have worked for their employer during the study period and maintained Highmark’s health plan coverage across all five years. Additionally, on the non-participating group side, only employees who never used the program were included in the pool for selection in the matching process. Participating and non-participating employee comparisons were made using generalized linear mixed models to study changes in costs and utilizations. In 2004, Highmark began offering a variety of web-based wellness services addressing many health topics and providing web-based health education tools. Claims data was extracted for service dates from 2003-2007 from the Highmark data warehouse for use in the calculation of outcome variables. All health care expenditures calculated were inflated to 2007 values using the medical care component of the Consumer Price Index. Models compared the baseline year (2003) to the
fourth year of the availability of web-based wellness offerings (2007). Results of this study suggested that medical care costs increased at a slower rate for employees participating in the wellness program than they did for the employees in the matched nonparticipant group. The change in medical costs over time was $332 per employee lower for wellness program participants. Those active in the program sought more preventive services which may further impact future savings (Williams & Day, 2011). This research provides evidence that wellness programs, including web-based resources, can result in savings after a few years of consistent employer involvement in health promotion. Due to differences in how the programs were implemented and the variety of employers and worksites, return on investment data was not able to be obtained.

Other studies have determined that there is return on investment for workplace wellness programs, but some controversy exists on the accuracy of the methodology used to measure such returns. To address this issue, Baxter, Sanderson, Venn, Blizzard, & Palmer (2014), conducted a study for the purpose of determining the relationship between return on investment (ROI) and quality of study methodology in workplace health promotion programs, using higher methodological quality studies.

For the purposes of this study, “quality” was defined as the quality of economic evidence of studies (methodological quality). This study examined the impact such quality has on ROI, and accomplished this through a systematic review of comparative health economic evaluations in workplace health promotion (WHP), the assessment of methodological quality of the evidence, and examination of the relationship between quality, key study characteristics, and ROI. The main hypothesis in this study was that higher methodological quality economic evaluations demonstrate smaller financial returns. The review was performed following
Campbell and Cochrane Economics Methods Group (CCEMG) guidelines to incorporating economic evidence in reviews, the National Institute of Health and Clinical Excellence (NICE) guidelines manual, and the Centre for Reviews and Dissemination (CRD) guidance for undertaking reviews in health care. Studies included were articles written in English or German reporting cost(s) and benefit(s) and single or multicomponent health promotion programs on working adults. Return to work and workplace injury prevention studies were excluded. The ROI was calculated as \[ \text{ROI} = \frac{\text{benefits} - \text{costs of program}}{\text{costs of program}}. \]

Baxter, et al. compared their study to others who have demonstrated a higher ROI for WHPs but believe their methods provided a higher confidence which provides employers an empirically sound basis from which to scrutinize WHP financial outcomes. This study reinforced a positive ROI; however, using higher methodological quality studies, evidence showed those financial returns may be smaller. This financial analysis tested extensive existing research on ROI and expanded on how these results were calculated to provide more accurate results so employers can fully understand the outcomes of their programs in relation to their bottom line (Baxter, et al., 2014).

Even with the higher methodological quality studies indicating a smaller ROI, it is clearly evidenced that workplace wellness programs are effective in producing an ROI at some level and supports the implementation of these programs for the purpose of reducing costs and utilization and providing employers with a return on their investments overall.

**Regulatory Agencies Governing Workplace Wellness Programs**

Workplace wellness programs must be designed and implemented not only to meet the needs of the employees, but to also comply with various regulatory agencies, laws, and guidelines. It is imperative that programs not be discriminatory and that they provide opportunities for all employees to participate. The Affordable Care Act (ACA) imposed new
rules on wellness programs. Anne E. Moran, in the *Employee Relations Law Journal*, discussed some of the new standards and regulations of the ACA which prohibit discrimination due to health status and how employers can avoid violating those rules (Moran, 2013). The basic rules that describe permissible employer incentives are found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA, group health plans and group insurance issuers cannot discriminate against participants with respect to eligibility, benefits, or premiums based on a health factor. One exception allows premium discounts or rebates or similar rewards for persons who participate in programs of health promotion and disease prevention. The three agencies responsible for implementing HIPAA are the Departments of Labor, Health & Human Services, and the Treasury (the “Departments”). The Departments published rules governing such programs and essentially divided wellness programs into two categories – Participatory, and Health-Contingent. Because of the growth of the wellness programs and enhanced rewards after the ACA, new regulations were issued by the Departments in June 2013 to provide comprehensive guidance to general wellness program requirements. Participatory programs do not provide a reward and are not required to meet the more specific rules that apply to health contingent wellness programs. Health-Contingent programs are subject to more scrutiny and must meet five specific requirements to avoid being discriminatory on the basis of health factors. Those five requirements are: (1) opportunity to qualify (2) limits on amount of any reward, (3) reasonable design, (4) uniform availability and reasonable alternatives, and (5) notice of availability of alternative standard (Moran, 2013). Other laws that impact wellness programs include the Americans with Disabilities Act (ADA), Title VII of the Civil Rights Act, the Internal Revenue Service (IRS) Code, the Employee Retirement Income Security Act of 1974

Employee participation in workplace wellness programs is essential in order to obtain the desired results. Many employers offer financial incentives to employees for their participation in the workplace wellness program. It is imperative that employers be well versed in the laws, policy, and ethics when offering these incentives to their employees.

In 2011, Madison, Volpp & Halpern reviewed employers’ use of financial incentives in conjunction with health promotion programs and the role of law, policy, and ethics in those programs. Employer-sponsored programs are potentially the most rapidly growing type of health incentive program and many are tying financial incentives to those programs. Research suggests these programs will increase rapidly. The Patient Protection and Affordable Care Act (ACA) promotes growing interest in employer incentive programs but it is not without controversy. Three controversies with respect to the ACA’s support for employer incentive programs are: (1) many people question the effectiveness of incentive programs in improving health, regardless of the identity of their sponsor, (2) some people argue that it is not appropriate for employers to take such a significant role in influencing their employees’ health, and (3) many critics view financial incentive programs as coercive or as potential tools for discrimination (Madison, et al., 2011). Madison, et al, argued that while potential exists that financial incentives can be successful, there is mixed evidence on the effectiveness of financial incentives; that employers can be key partners in improving public health; program design can mitigate possible ethical issues relating employer sponsored wellness programs; the ACA may fall short in protecting individuals against discrimination and undue inducement; and further research is needed on programs’ effectiveness and on programs’ unintended consequences. Madison, et al. discussed
potential program design flaws of incentive based programs that could discriminate against both healthy and less healthy individuals and the various aspects of financially incentivized programs and how employees could feel coerced into participation, or if the programs constitute undue inducement.

The ACA and HIPAA primarily govern employee workplace programs and provide regulations against discrimination when designing programs. According to Madison, et al., the current incentive ceiling is inadequate, and they have called on more systematic evaluation of incentive program effects in the future. They concluded that appropriately structured incentive programs may be able to improve public health, but that it is important to remain cognizant of the risks that incentive programs pose. By engaging in more systematic evaluation of incentive programs, a better understanding can be developed of how best to improve health and how to design regulations to minimize undue inducement, prevent discrimination, and maximize equity. Future research on the regulation of these incentives will provide important information on the efficacy of incentivizing these programs. Some researchers have suggested having employers submit certain incentive data to a central pool permitting third party analysis and requiring employers to contribute a small sum (possibly 1% of wellness program costs) to fund these evaluations. This kind of reporting could discourage employers from participation in programs, due to the reporting being overly burdensome, while fees and centralized databases could slow or cease the development of incentive programs. Continued and expanded research on wellness programs in general is essential to provide a larger picture of how effective these programs are as well as the long term effects they have on employee health and employer gain.
Summary

Workplace wellness programs are being implemented by more and more employers in an effort to reduce healthcare costs, improve employee health and morale, reduce absenteeism, and increase productivity. While research is still relatively new in this area, it has shown that workplace wellness programs can be effective and accomplish these objectives. Federal and state assistance may be available in addition to private organizations and health insurers to assist with the creation and implementation of these programs. Web-based programs are also available and can be an effective tool in delivering a successful program. Applicable laws and incentive regulations need to be carefully reviewed and considered when designing workplace wellness programs. One obstacle that employers are struggling to overcome is employee participation rates in these programs. Employees who choose not to participate have expressed violation of privacy concerns when employers get involved with employee health. There is some discrepancy in the research as to the methodology for collecting data samples and calculating return on investment (ROI), but overall, employers who implement comprehensive programs do tend to have success in achieving their goals and see a positive ROI.

More standardized sampling and methodology guidelines are needed for more accurate research on what the efficacy of these programs is in saving employer costs on healthcare. While research has shown that there are, in fact, healthcare savings, the discrepancy exists in just how much savings they provide. Additional research needs to be developed as workplace programs expand to a wider variety of employers, both public and private. This will provide more information on the longevity of the programs and long term effects they may have on employer costs as well employee participation, health, morale, absenteeism, and productivity. Workplace
wellness programs may soon be an essential part of organizations’ benefit packages as the demand for healthier work cultures grows.
References


