Wellness Program Study

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Study Briefing
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Meeting agenda

- Project overview
- Findings – Epidemiology
- Findings – Impact
- Findings – Incentive use
- Summary

The study combines four data collection and analysis components

Literature review: • Peer-reviewed literature • Non-peer reviewed literature	Employer survey: • Stratified random sample of 3000 employers • 20% response rate
CCA data analysis: • Program data and medical claims for seven employers • ~570,000 covered lives • ~1.8M employee-years	Case studies: • Five employers of various sizes, locations and industries • Expert interviews and employee focus groups

We use a thematic approach to organize study findings for the final report

"Epidemiology" of wellness programs

- What is the overall prevalence of any program use?
- How are programs configured?
- How do programs vary by factors like industry, firm size, and region?

Program impact

- To what degree are programs utilized by employees?
- What is the effect of wellness programs on medical costs and utilization, health behavior, and health outcomes?
- How long does it take for program effects to materialize?

Impact of incentives

- What are current practices of using employee incentives?
- Are incentives promoting program uptake?
- Do incentives impact participant health behavior and health outcomes ?
- Do employee incentives have any unintended consequences?

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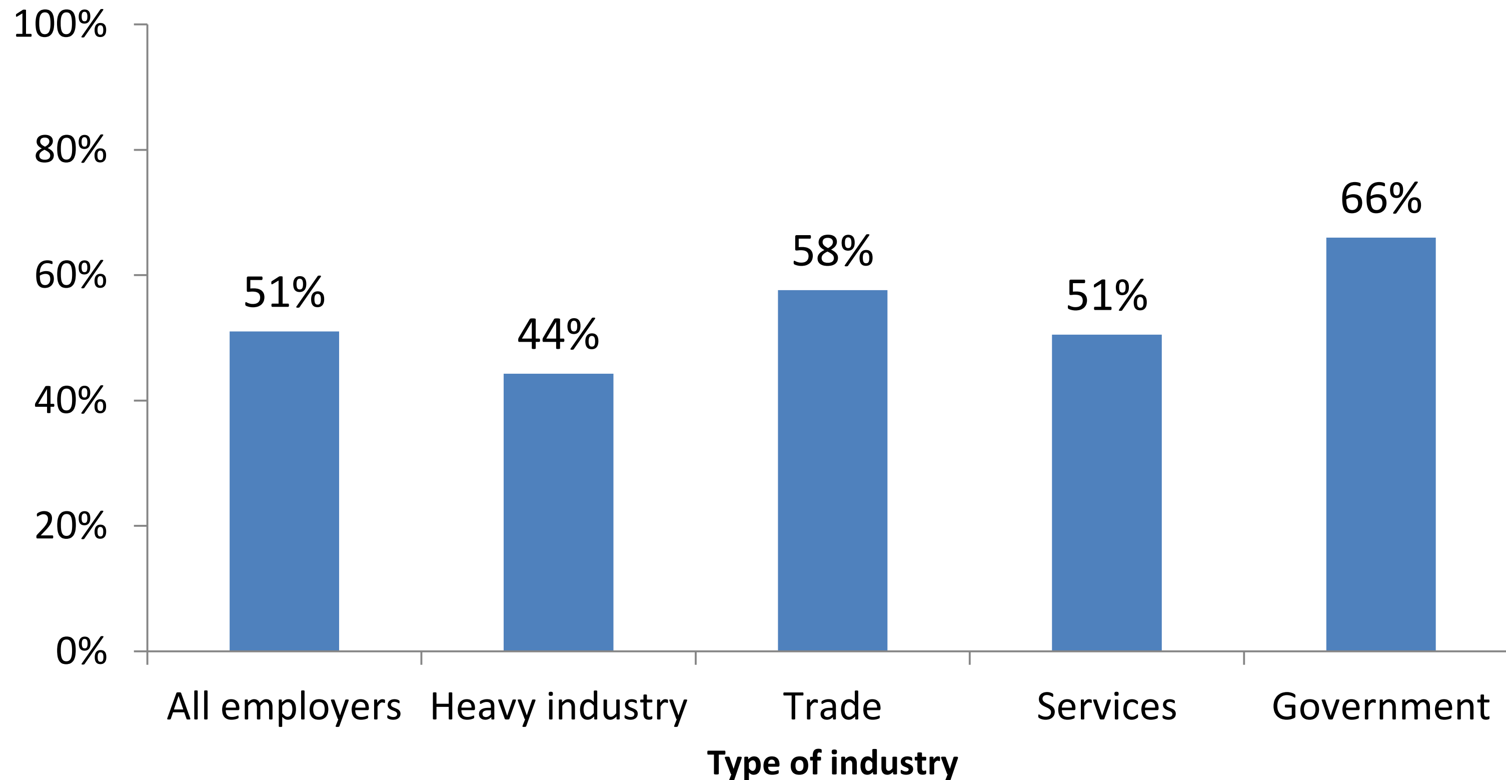
Wellness programs are offered by about half of all employers with more than 50 employees



"We want employees to be ***healthier and better informed to live a better life****, and at the same time we are doing this to* ***control costs and improve productivity****."*

Case study interviewee

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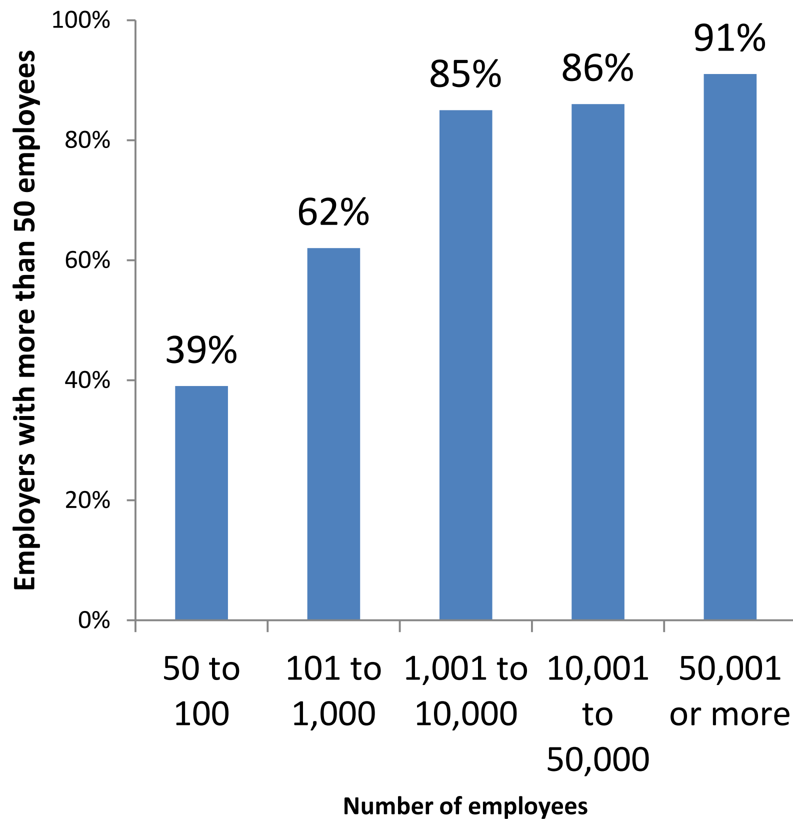
Note: $P>0.05$ for the comparison across all industry categories; $p<0.05$ when comparing government to heavy industry , or government to service industry.

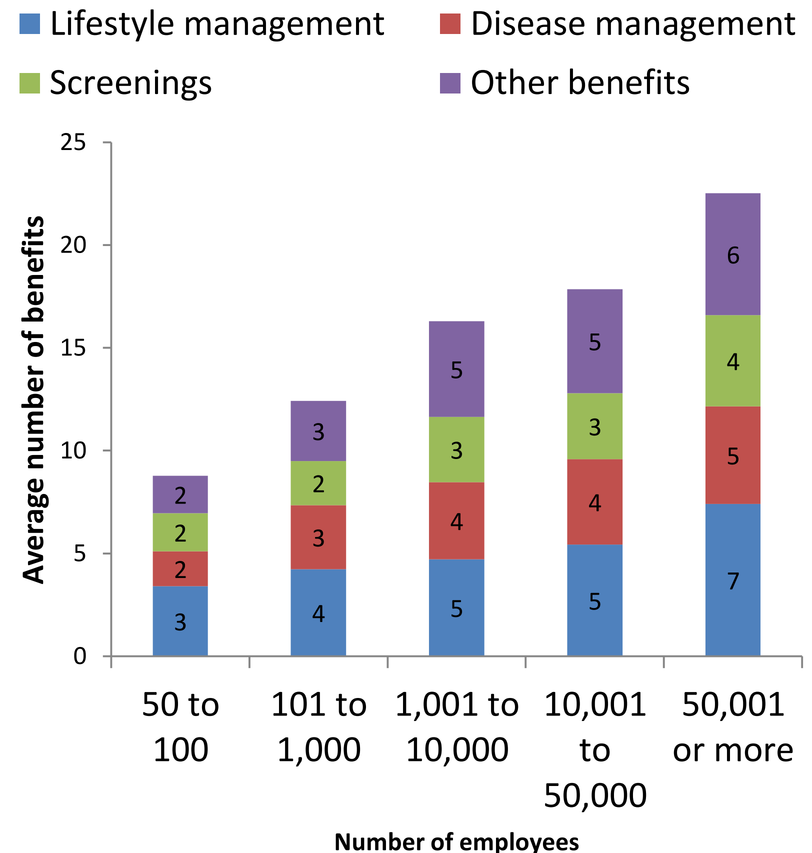
Source: RAND Employer Survey 2012

Larger employers offer more and more complex programs

Program availability increases with company size



Breadth of offering also increases with size



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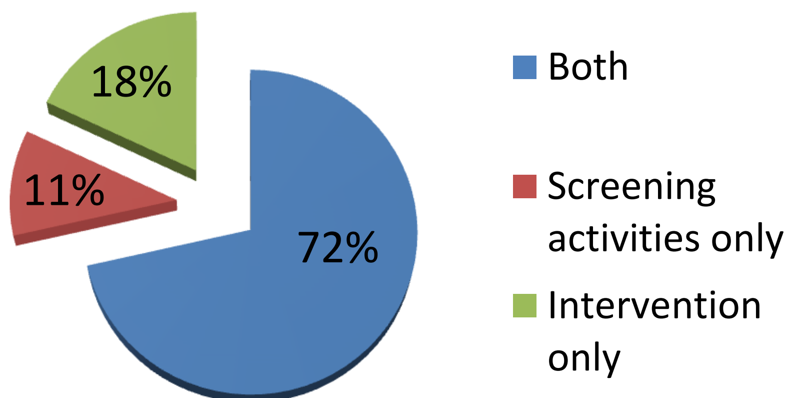
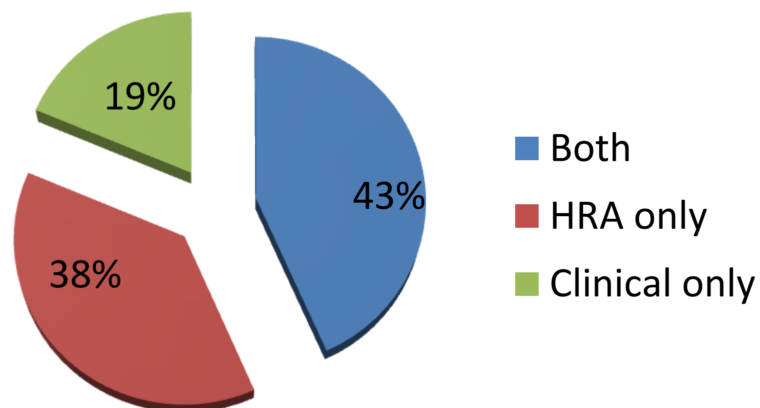
Source: RAND Employer Survey 2012

Wellness programs typically combine data collection with interventions

~90% of employers offer interventions

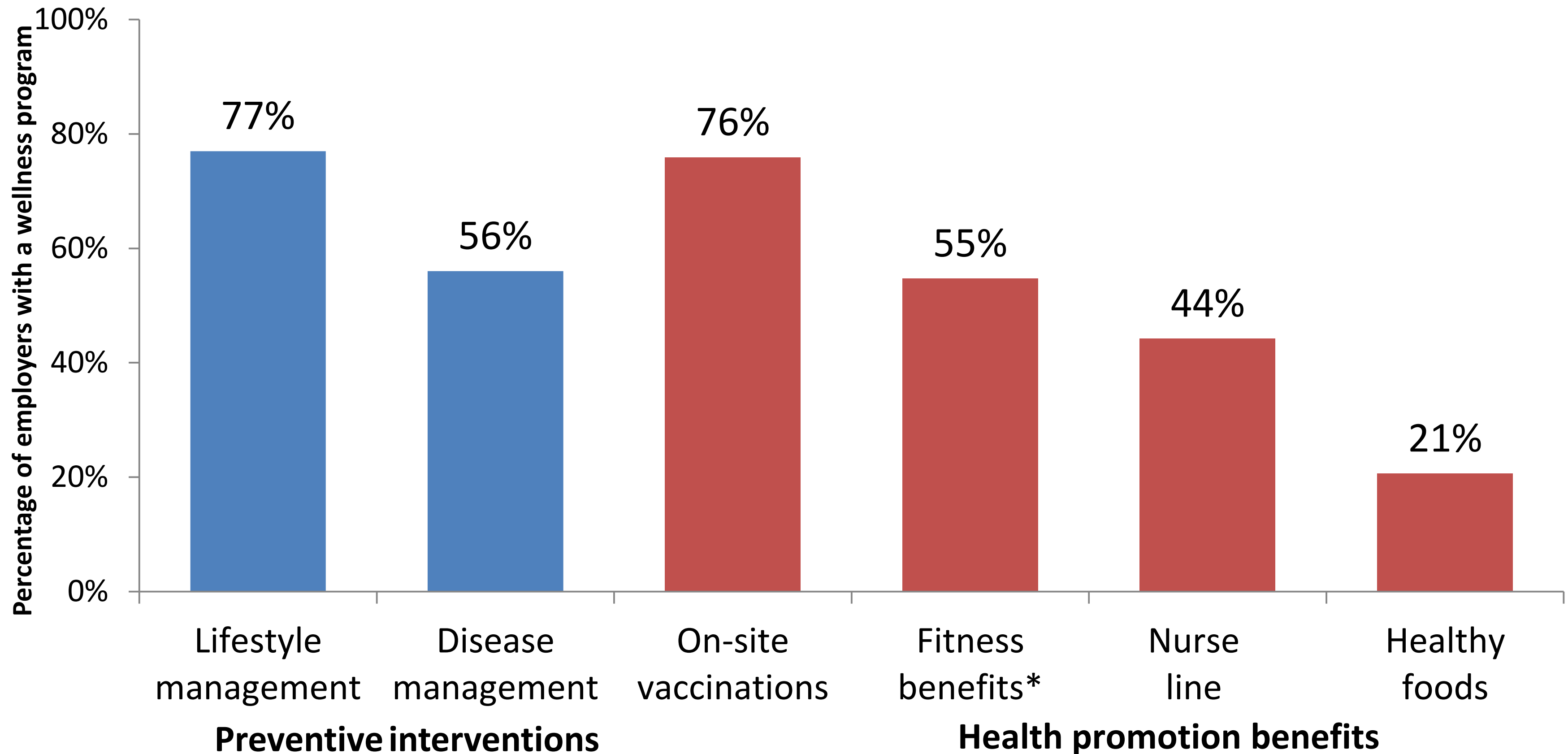
~80% of employers use HRA





Source: RAND Employer Survey 2012

A broad range of intervention components is offered



* Includes onsite facilities or discounts, fitness breaks, other exercise opportunities

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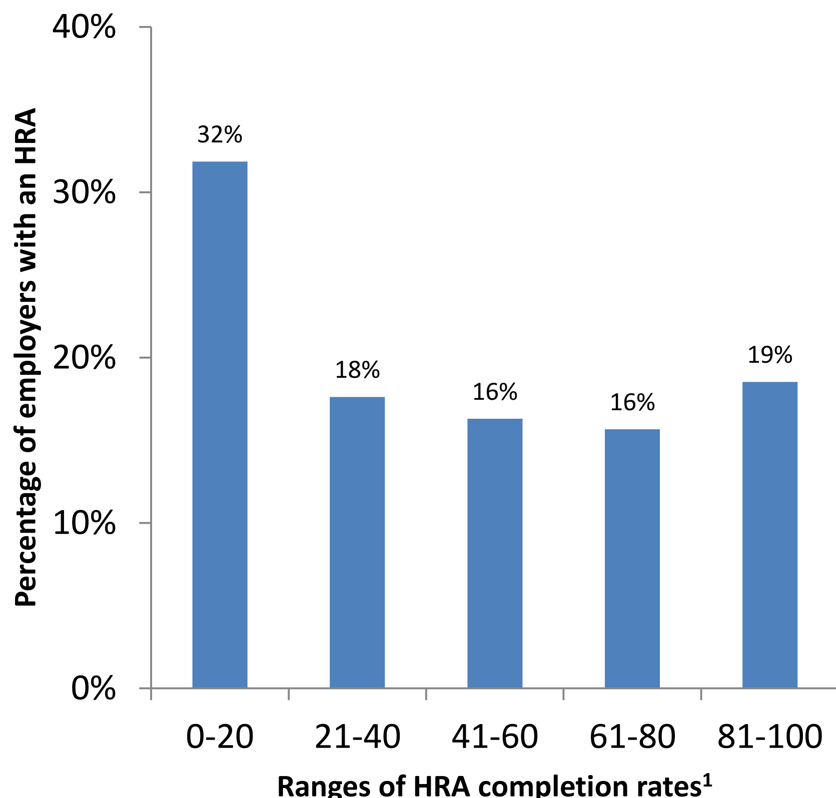
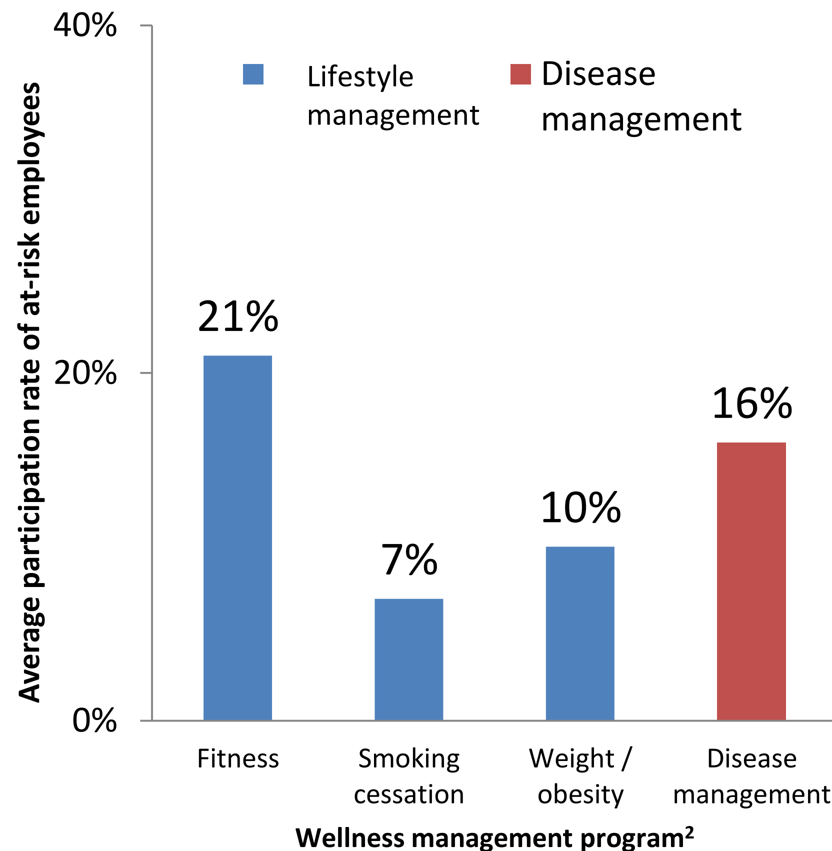
Employees are willing to undergo health screening but program uptake is limited

Nearly half of employees participate in screening programs



...but <1/5 of at-risk employees engage in interventions



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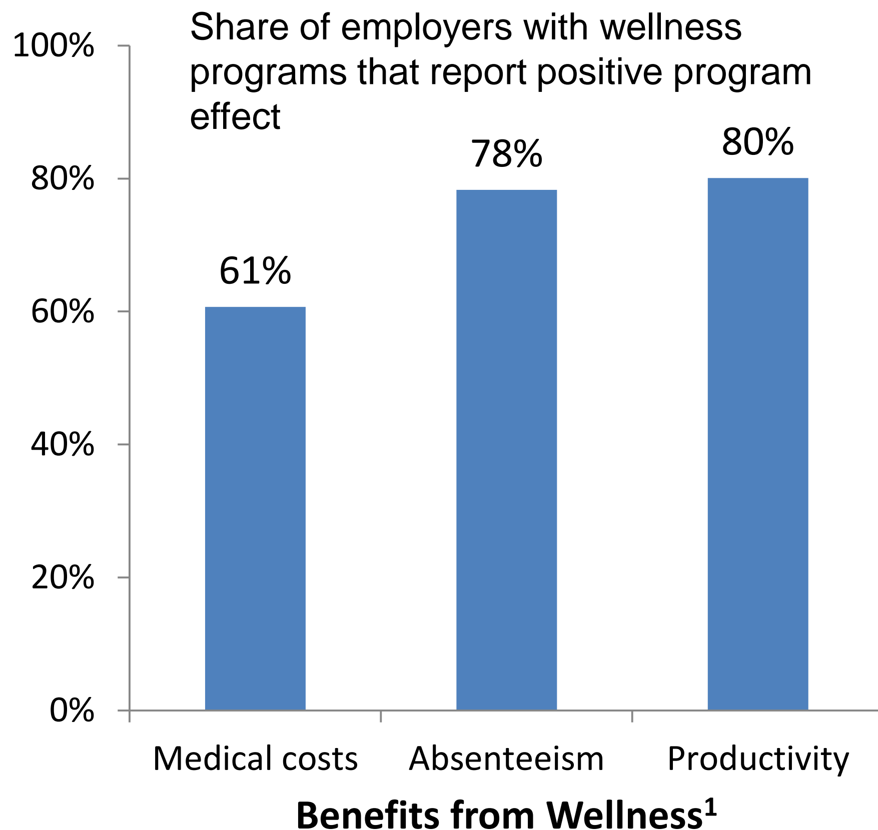
[1] Employees offered an HRA
[2] Employees eligible for a specific program
Source: RAND Employer Survey 2012

A majority of employers perceive cost savings but lack actual performance data

Many employers report positive effect of programs



But few conduct formal evaluations

- Only 2% of survey respondents reported actual data on program cost and benefits
- Case studies confirm that formal evaluations are rarely conducted

"A lot of the experts even question whether you should look at ROI. Wellness should be something like compensation or health insurance that is just something you offer to attract and retain good employees."

Case Study Interviewee

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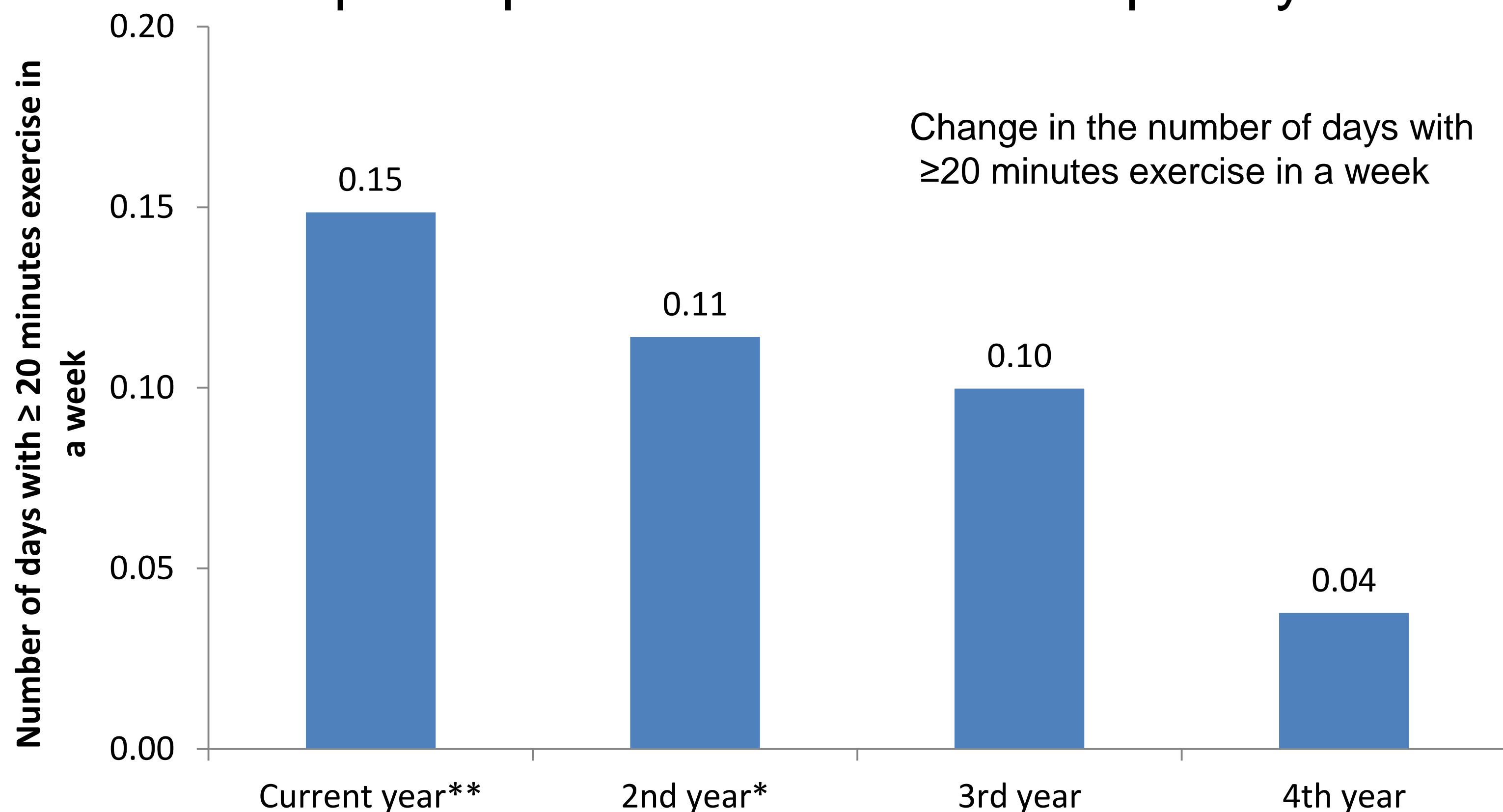
[1] Among employers with a wellness program
Source: RAND Employer Survey 2012, case study results

Evidence points to programs' ability to increase exercise rates,…



*** p<0.05; ** p<0.01**

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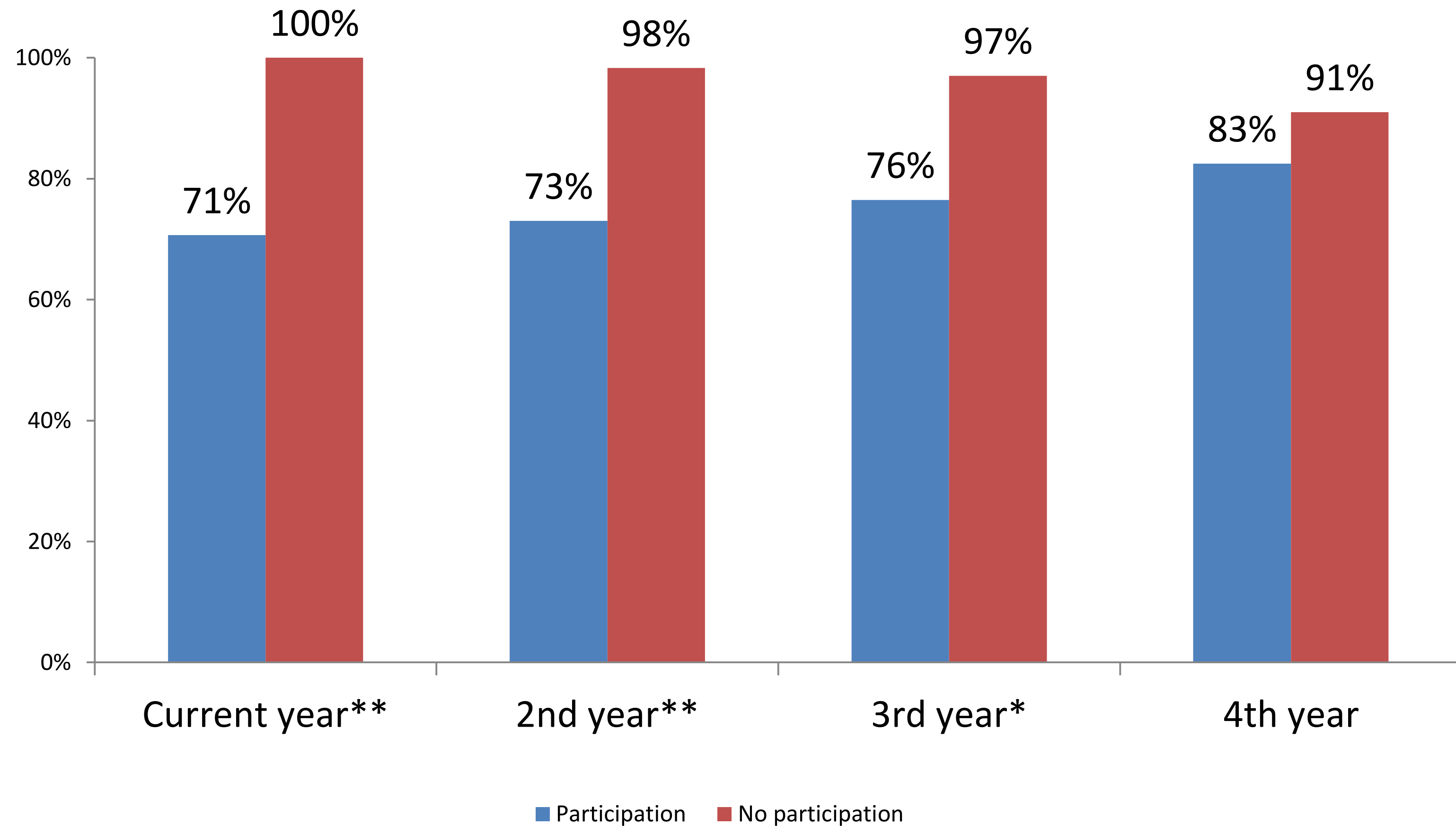
Source: RAND analysis of 2005 - 2010 CCA data for one employers (27,505 employees; 78,122 employee years).

...smoking...

Effect of current year exercise program participation on smoking rates



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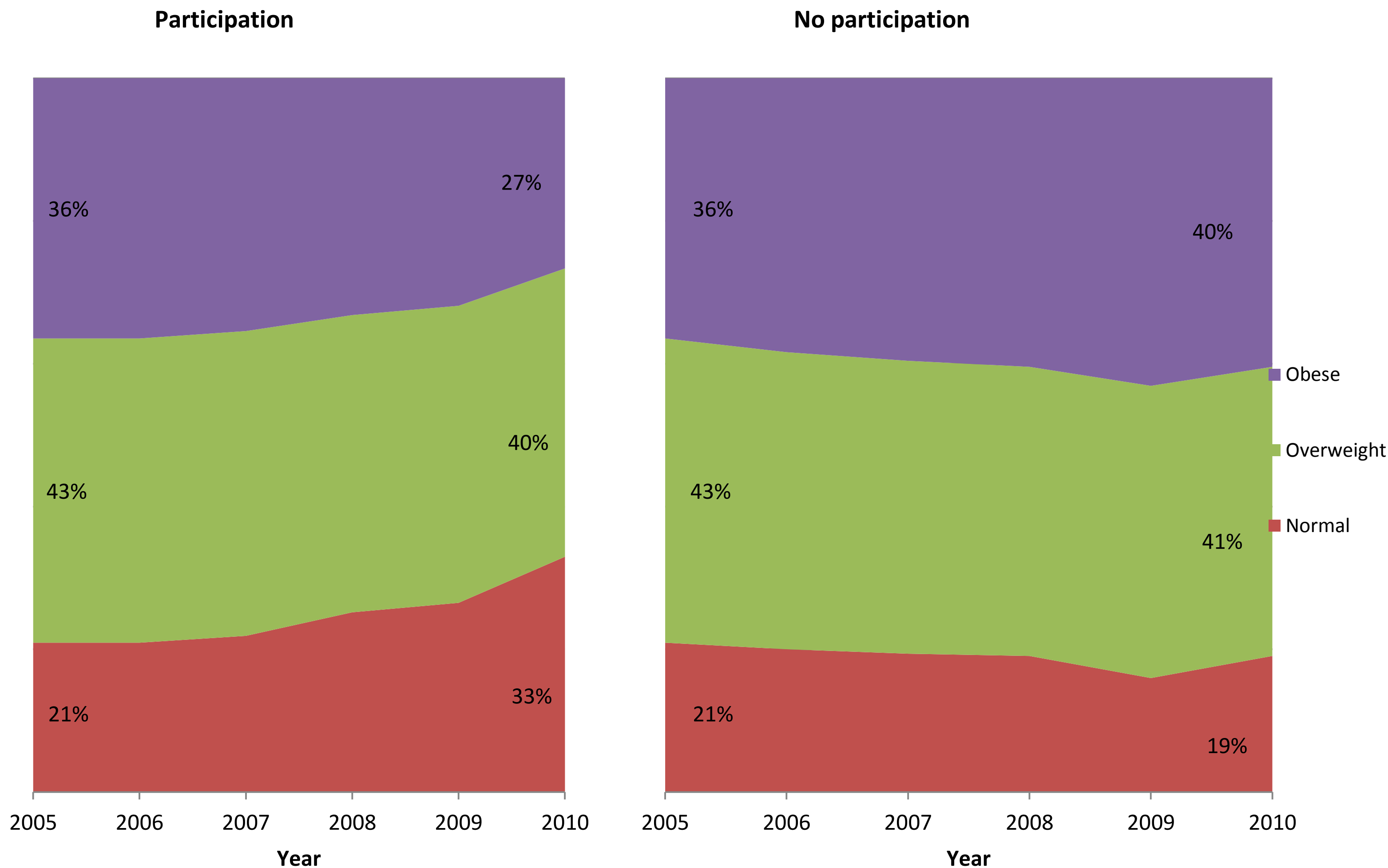
Source: RAND analysis of 2005 - 2010 CCA data for one employers (746 employees).

… and to reduce the rate of overweight and obese participants



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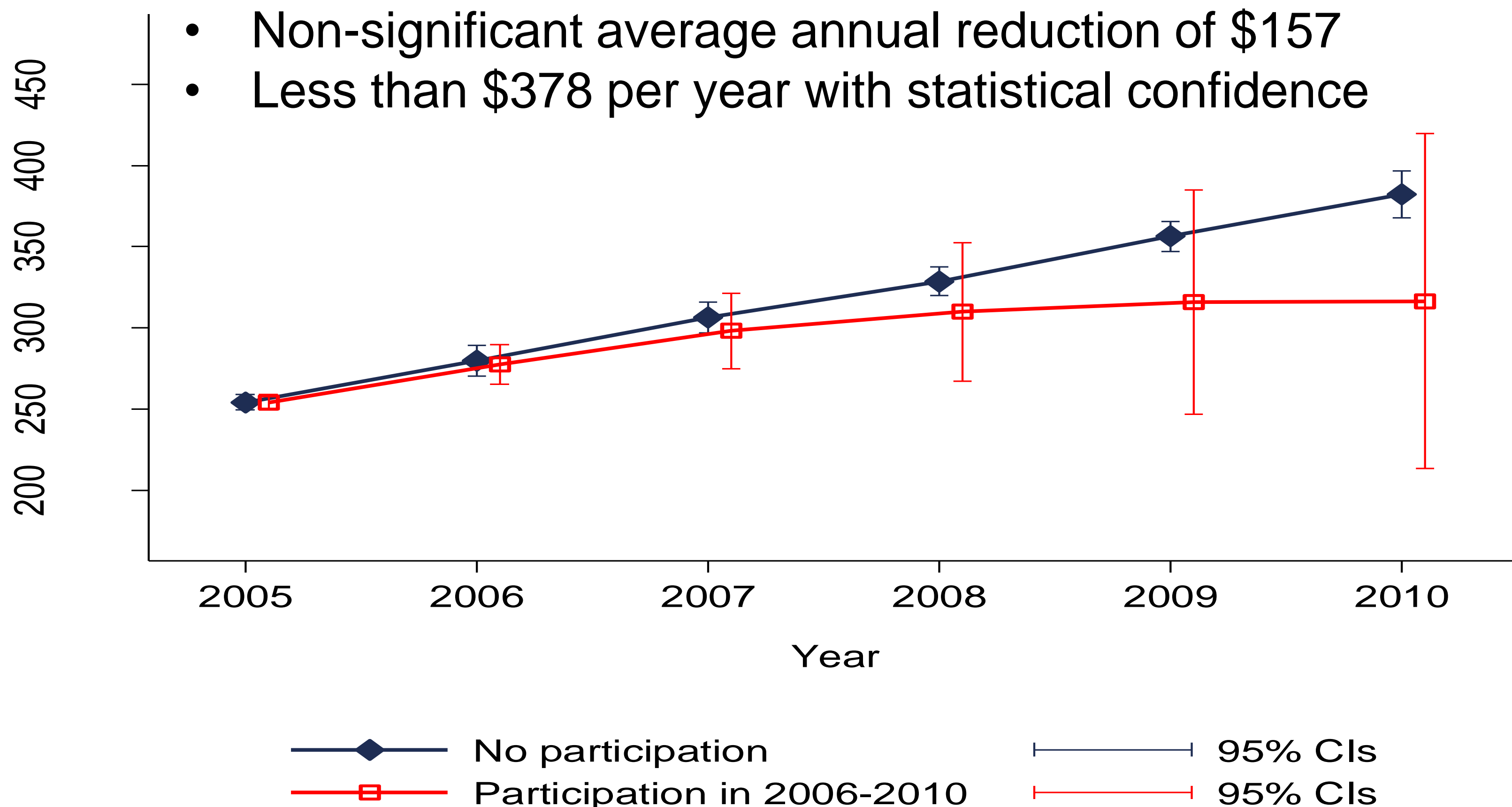
Source: RAND analysis of 2005 - 2010 CCA data for four employers (104,920 employees; 250,363 employee years).

Lower health risks translate into lower cost trend, but change is not significant

Cumulative effect of participation in any program component



Source: RAND analysis of 2005 - 2010 CCA data for three employers (173,382 employees; 615,770 employee years). P>0.05 for all years in 2006-2010.

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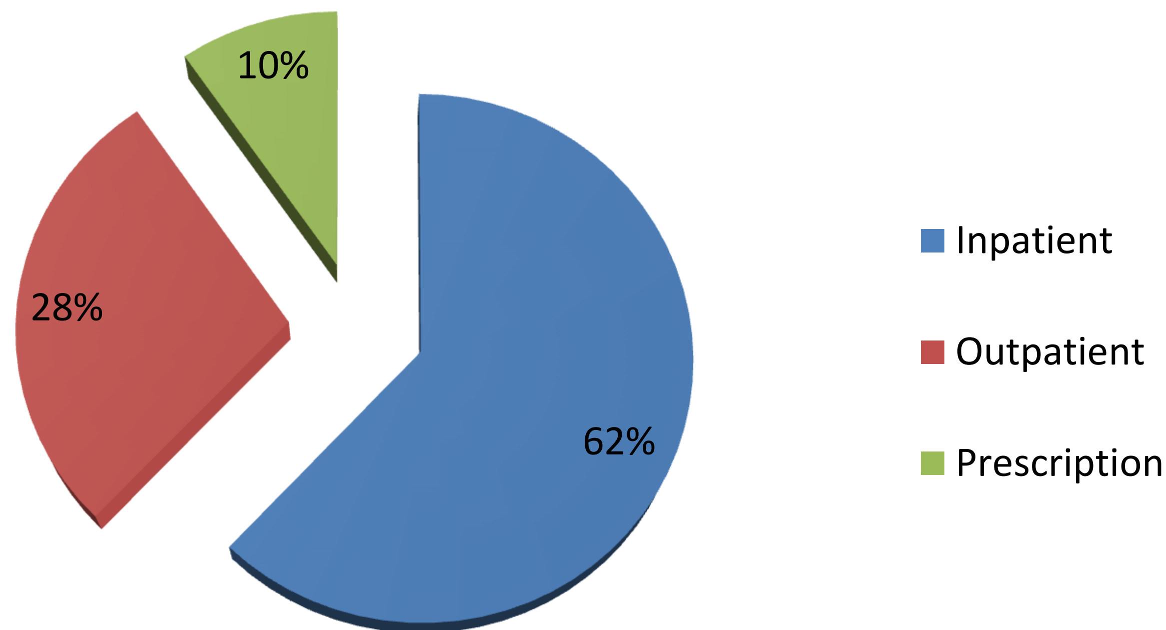
Lower cost trend is driven by reduction in hospital inpatient cost



* RAND analysis of 2005 - 2010 CCA data for three employers (173,382 employees; 615,770 employee years). The trend is not statistically significant at the 5% level ($p>0.05$). The proportions are approximated as the summation of savings are not exactly the same as the total PMPM savings.

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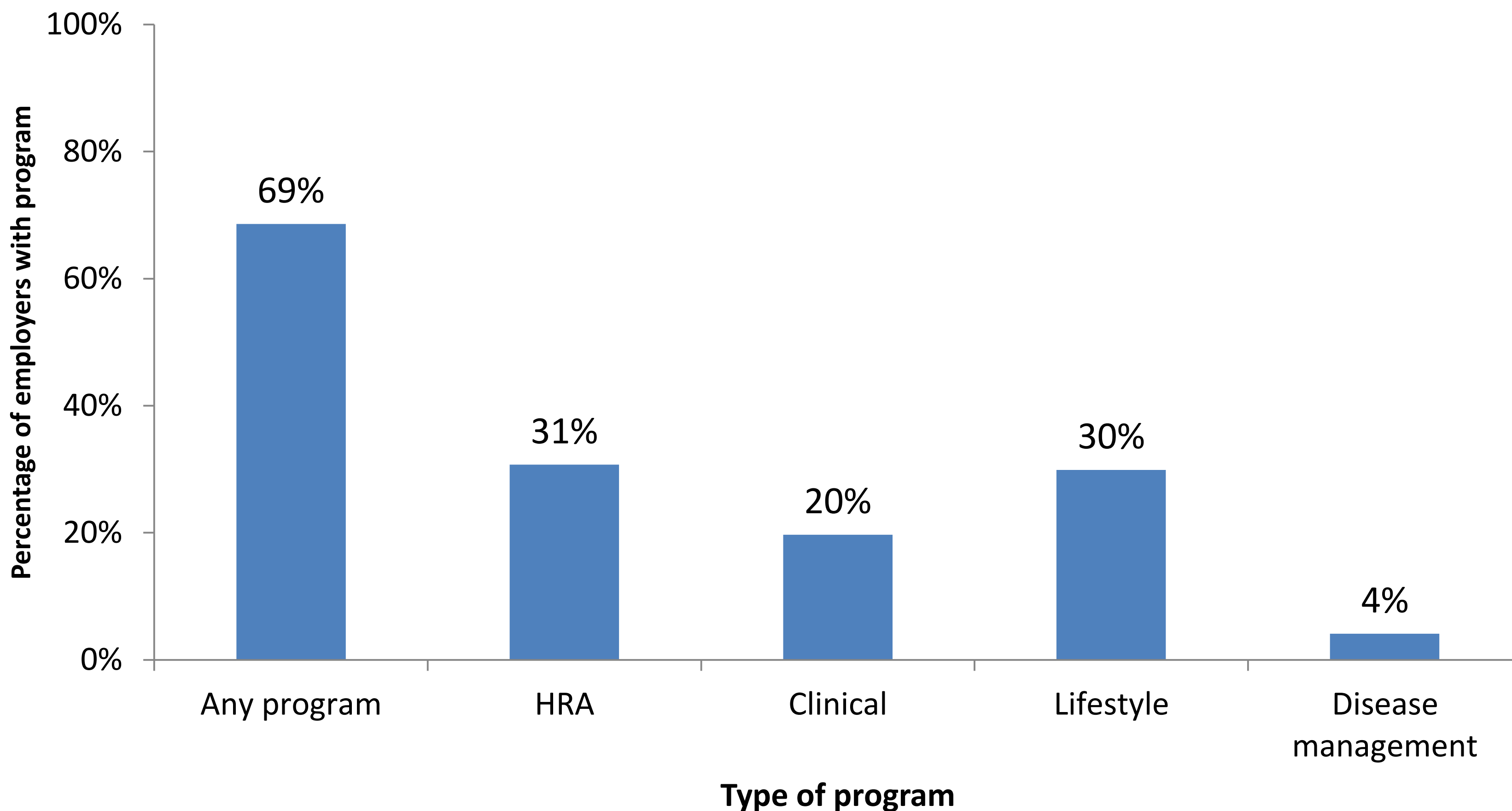
Incentives have become a common means to encourage program uptake



Median maximum payout for HRA participation is $300; for lifestyle management participation $300

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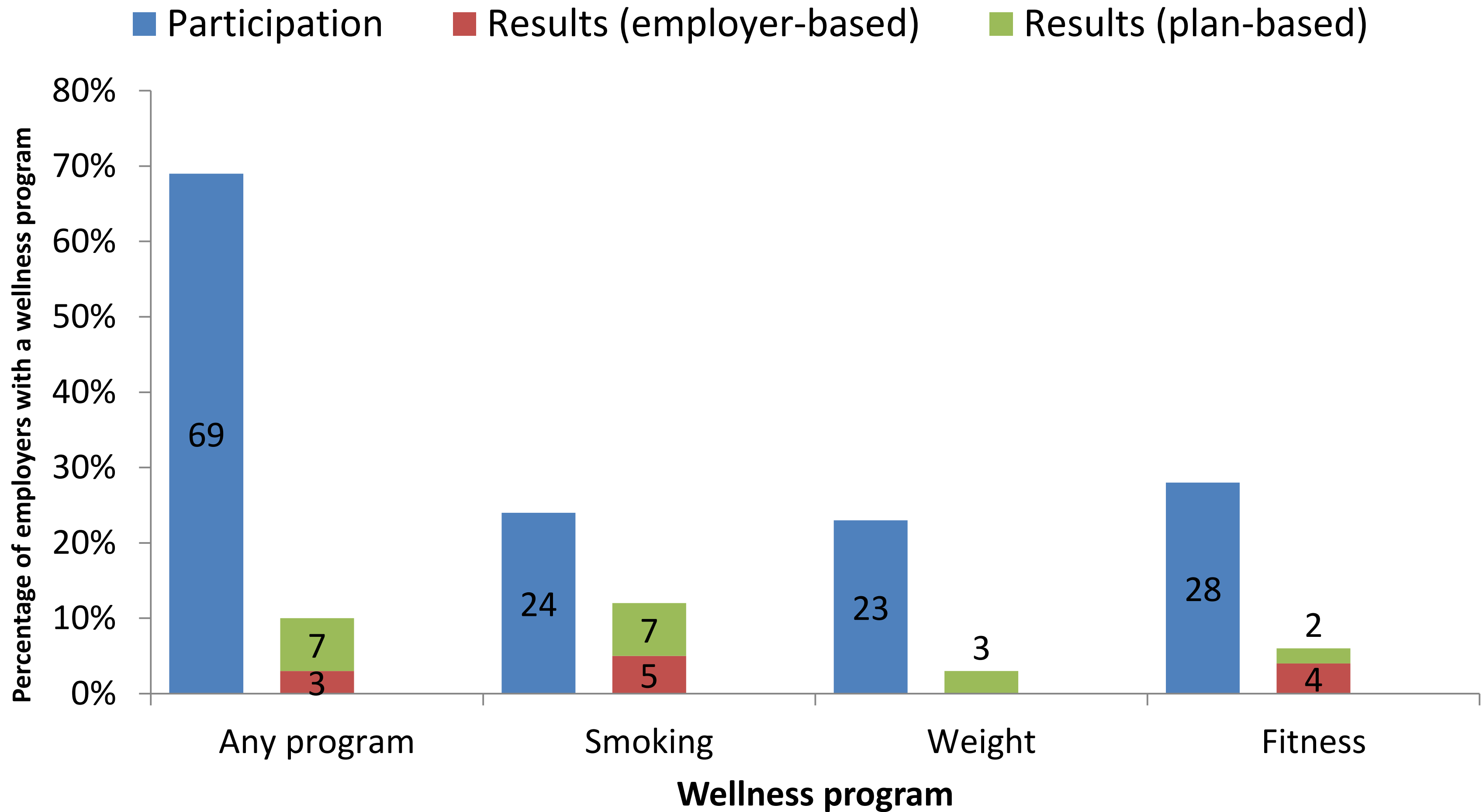
Source: RAND Employer Survey 2012

Incentives are predominately awarded for participation



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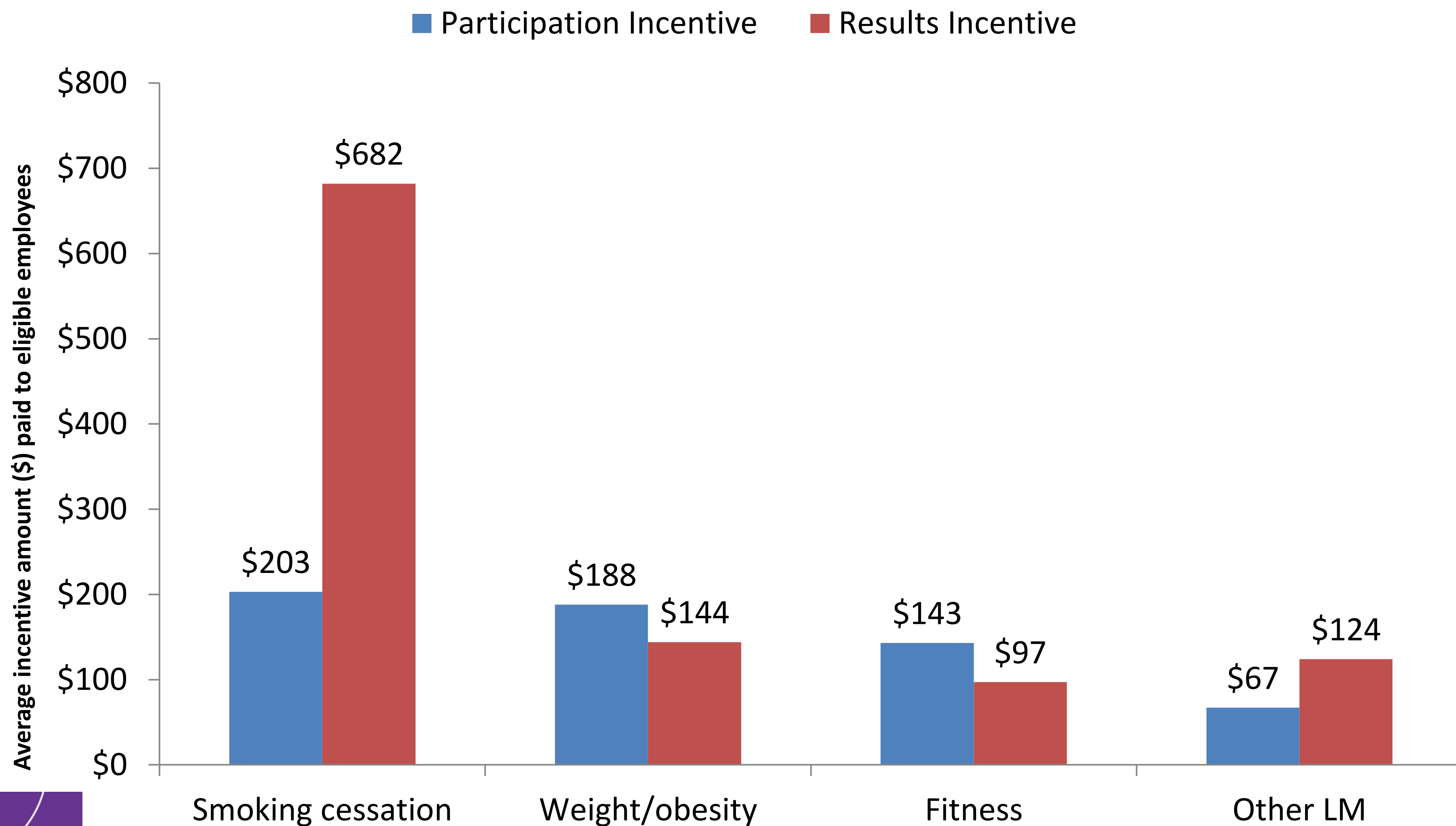
Source: RAND Employer Survey 2012

Smoking is the only behavior with higher incentives for cessation than program uptake



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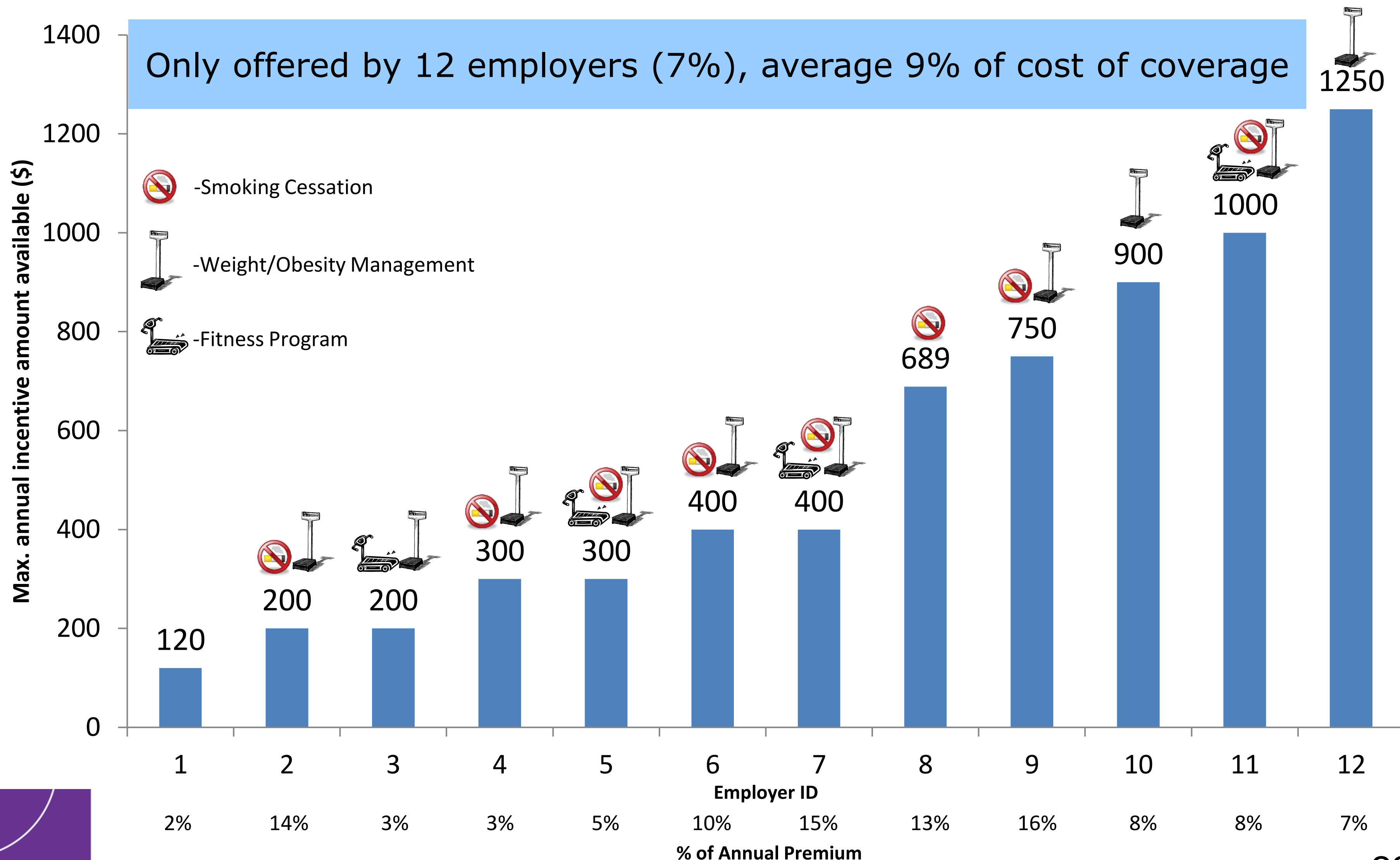
Source: RAND Employer Survey 2012

Results-based incentives under health coverage remain rare and limited in size



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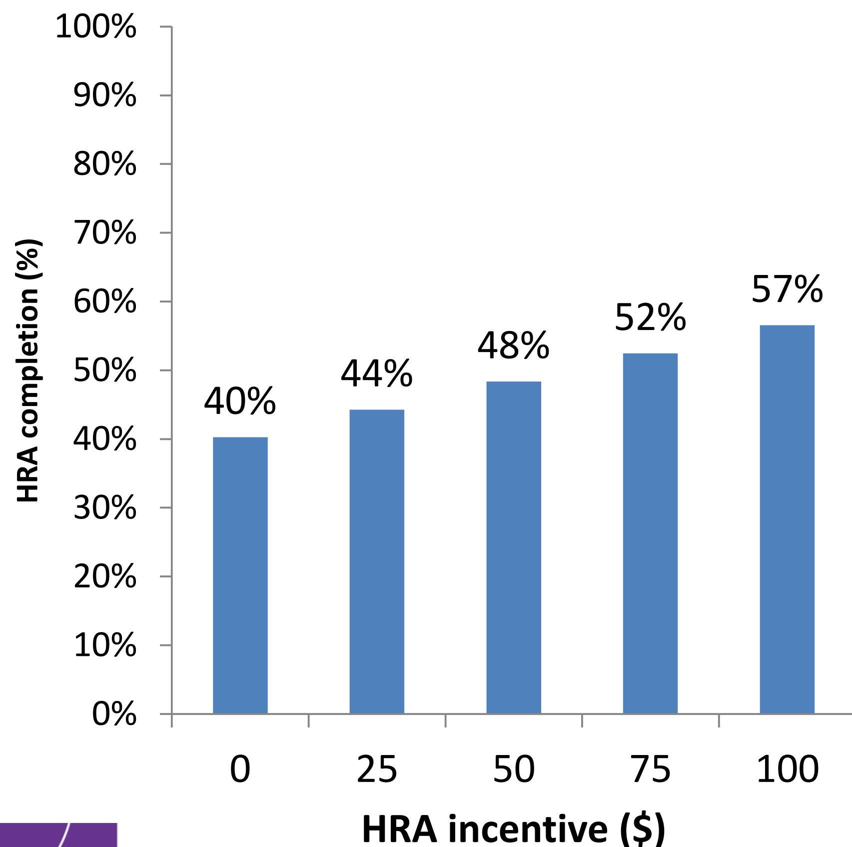
Source: RAND Employer Survey 2012

Incentives seem to have the intended effect

Incentives associated with improved HRA completion rates…



…and small effect on outcomes

- Incentives are associated with significant improvements in smoking, BMI and exercise, but not in cholesterol levels, but effect sizes are small
- Sample did not allow estimating impact on program participation
- Limited variability of incentive levels impairs out ability to detect effect

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Source: RAND analysis of 2005 - 2010 CCA data for five employers (185,604 employees; 509,974 employee years).

With limited uptake of “high-powered” outcomes incentives, definite assessment is difficult

- Only 9% of employers in our survey tie incentives to health outcomes/status
  - Majority (70%) of those employers administer results-based incentives through health plans
  - The median of maximum results-based incentives paid by health plans is $480 based on our survey
- The CCA database did not have sufficient data to provide definite insights
  - No employers used results-based incentives
  - Maximum amount for program participation per year was $200
- Concerns about results-based incentives frequently voiced in literature and by experts, but no formal evaluations exist in workplace wellness program

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Summary of findings - Epidemiology

- Wellness programs have become a common workplace benefit across regions and industries
- Larger employers are more likely to offer any and more complex programs
- Programs typically combine identification of health risks with interventions

Summary of findings - Impact

- Consistent with prior research, we find supportive evidence for program impact on health risks
  - Generalizability of the evidence is limited as it is mostly derived from a small set of programs, often run by highly committed employers
- Program participation rates tend to be low
  - Case studies point to strategies for improving participation
- Effect on healthcare cost is not significant
  - Point estimate is $157 lower cost per year in participants
  - We can rule out a reduction of more than $378 per year

Summary of findings - Incentives

- Financial incentives of around $100 are frequently used
  - -Small effect in promoting HRA completion
  - -Effect on program participation and health outcomes cannot be firmly established based on the available data
- Data are insufficient to conclude presence or absence of unintended consequences, and assess effect of “high-powered” incentives

Questions and Discussion