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Reconsidering the Advisability of Workplace Wellness

BY AL LEWIS JD

Expanding workplace wellness, which is already nearly ubiquitous in larger corporations,[1] has become a major bipartisan initiative under the Affordable Care Act. The Business Roundtable has made it a top priority,[2] and a Senate committee held hearings in 2015 titled: Employer Wellness Programs: Better Health Outcomes and Lower Costs, to explore ways to increase their uptake.[3] In order to alleviate corporate concerns about legal liability for civil rights violations,[4] the Equal Employment Opportunity Commission has proposed allowing employers to coerce employees into forking over details about their health status or else pay thousands of dollars more for their health insurance [5] and Texas became the first state to circumscribe employees' rights to sue over wellness program governance, foregone incentives, or penalties.[6]

The widely accepted premise behind these actions is that the four most common wellness interventions—health risk questionnaires, on-site biometric screenings, checkups and weight-loss programs—save money and improve health outcomes. (Smoking cessation programs are beyond the scope of this essay.) This premise, however widely accepted, needs to be especially evidence-driven and incontrovertibly beneficial because, unlike most of health care, employees are required to undertake these clinical interventions or lose money (fines or foregone incentives). Further, unlike most of health care, these clinical programs are not required to be administered by clinical trained or licensed personnel.

However, the premise lacks any support. As will be shown below, literature and guidelines find no economic value or even health benefit in any of those four activities, let alone all of them. Consequently, there has been no discernable change in health outcomes that can be traced to wellness. Perhaps most compellingly, the wellness industry's two advocacy organizations published a multi-authored document that they call a consensus study, the Population Health Alliance/Health Enhancement Research Organization Program Metrics

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[1] Pollitz K., Rae M. *Workplace Wellness Programs Characteristics and Requirements*, Kaiser Family Foundation, Issue Brief June 15, 2015. Accessed Sept. 20, 2015.

[2] Begley, Sharon U.S. CEOs threaten to pull tacit Obamacare support over 'wellness' spat (Reuters), Nov. 29, 2014. See http://tinyurl.com/nsymkua. Accessed Sept. 11, 2015.

[3] U.S. Senate Committee on Health, Education, Labor and Pensions, Jan. 29, 2015, http://www.help.senate.gov/hearings/employer-wellness-programs-better-health-outcomes-and-lower-costs. Accessed July 26, 2015.

[4] It is a violation of the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act for an employer to request information about health status or family medical history from an employee or covered family members unless the request is made in conjunction with a *voluntary* wellness program.

[5] The final regulation has not been issued.

[6] Texas Civil Practice and Remedies Code, H.B. 2390, Chapter 142A.

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and Evaluation Guide[7] (''HERO Guide''), supporting a conclusion that outcomes improvements are at best modest and money is certainly being lost.

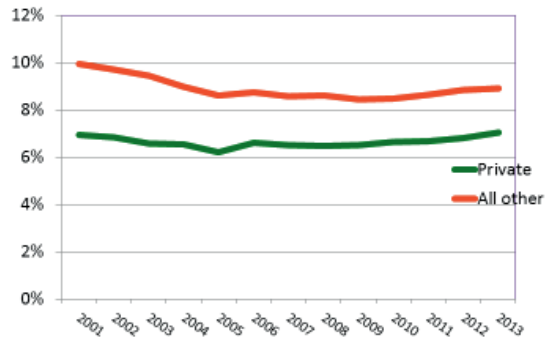
First, the literature and guidelines do not find benefit but do find possible harms in required annual checkups,[8] or corporate weight-loss programs[9] (which are likely aiming at the wrong target anyway, according to the most recent research[10]) and annual blood screenings in asymptomatic working-age adults.[11] Seth Serxner, a senior executive at UnitedHealthcare's wellness subsidiary (Optum), acknowledges substantial overscreening but blames employers for insisting on annual screens despite the potential for harm due to overdiagnosis and overtreatment.[12]

Further, many vendors have taken advantage of the lack of governmental oversight and employee recourse to sell screens that are rated ''D'' by the United States Preventive Services Task Force. In the guise of wellness, one health plan [13] markets controversial obesity drugs [14] [15] that the Journal of the American Medical Association has published a ''special communication'' against.[16]

Second, consider the endpoint of health outcomes to be the avoidance of admissions for events potentially preventable by wellness. This endpoint is advocated by the advocacy document noted above, which also specifically states that wellness ''increase[s] the use of preventive services, certain chronic medications, outpatient visits and [possibly] ER and urgent care visits.''[17] Along with this consensus document, the only book on wellness outcomes measurement (written by an author of this paper) recommends a similar outcomes endpoint,[18] as does the Intel-GE Validation Institute, the industry's sole outcomes validation organization.[19]

Using the Healthcare Cost and Utilization Project database compiled by the Agency for Healthcare Research and Quality, Figure 1 tracks admissions data for the privately insured population (containing essentially 100% of the population exposed to workplace wellness) against the remaining U.S. population, over the 13-year period in which the wellness industry has grown dramatically. The measurement is the rate of primary-coded admissions rate of the cardiometabolic diagnoses listed in the HERO Guide. Those include hypertension and stroke (ICD-9 401 to 405, 430 to 438), heart attacks (410), and diabetes (250). Those admissions are tracked versus the admissions rate for everything else. The rate of these targeted diagnoses should be trending far more favorably in the exposed population (even though not every privately insured person has access to wellness) than in the reference population, meaning that if the privately insured population trends flat, the reference population would increase significantly, or if the reference population trends flat, the privately insured population rate would decrease significantly. Instead, both lines trend flat, meaning that applying workplace wellness to the privately insured population has no discernable impact.

Wellness-related ICD9s as percentage of total admissions, nationwide (privately insured vs. all other admissions)



Source: Healthcare Cost and Utilization Project

One could argue that the number of people exposed to/participating in wellness is a fluid figure, with definitional inconsistency, and hence wellness may be successful but affecting too few employees to influence the overall trendline. However, that argument meets an insurmountable mathematical hurdle: spending on these wellness-sensitive admissions overall is $11.3 billion (using the Guidelines estimate of $22,500 per admission).[20] The industry size is estimated at $8 billion.[21] If the number of employees exposed to wellness—and hence the number of corresponding admissions preventable by wellness—is too low to bend the trendline, it is also so low that the industry size would exceed addressable costs, making savings impossible.

Indeed, the wellness industry's own data supports that impossibility observation, on an employer-specific basis. Experts say wellness programs should cost at

[7] Program Measurement and Evaluation Guide: Core Metrics for Employee Health Management http://populationhealthalliance.org/publications/program-measurement-evaluation-guide-core-metrics-for-employee-health-management.html. Accessed Aug. 28, 2015.

[8] http://www.choosingwisely.org/patient-resources/health-checkups. Accessed Sept. 20, 2015.

[9] Lewis A., Khanna V., Montrose S. Employers Should Disband Employee Weight Control Programs Am J Manag Care. 2015; 21(2):e91-e94.

[10] Ann Intern Med. Published online Nov. 10, 2015. 015 doi:10.7326/M14-2525.

[11] U.S. Preventive Services Task Force A and B Recommendations http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations. Accessed Sept. 21, 2015.

[12] ''The Great Wellness Debate,'' Population Health Alliance (Washington, D.C.) Nov. 2, 2015.

[13] Aetna Press Release Jan. 14, 2014, ''Aetna Promotes Personalized Weight-Loss Options.'' https://news.aetna.com//news-releases/aetna-promotes-personalized-weight-loss-options/.

[14] ''Dr. Aetna Will See You Now,'' The Health Care Blog, Jan. 15, 2014.

[15] ''Dr. Aetna Will See You Now,'' They Said *What*? July 15, 2014.

[16] JAMA Intern Med. 2014; 174(4):615-619. doi:10.1001/jamainternmed.2013.14629.

[17] HERO Guide, p. 22.

[18] Lewis A. *Why Nobody Believes the Numbers: Separating Fact from Fiction in Population Health Management* (John Wiley & Sons, 2012).

[19] http://www.validationinstitute.com/rules/rules-validation. Accessed July 18, 2015.

[20] HERO Guide, p. 23.

[21] Corporate Wellness Services in the US: Market Research Report IBISWorld, March 2015.

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least $100/employee,[22] while the HERO Guide measures addressable cost at only $59/employee.[23] The HERO Guide itself estimates only $1.50 per employee per month in vendor fees alone[24] (the remainder of their list of other expenses[25] is not counted, and no explanation is given for the low vendor fee) and savings of $0.99 per employee per month, yielding a net loss exceeding $6 per employee per year.

Third, others have reached similar conclusions about economic impact, based on case studies or meta-analyses of case studies. Using an analysis of wellness-sensitive medical events similar to that advocated by the HERO Guide, Gowrisankaran *et al.* [26] found that wellness-sensitive admissions declined at Barnes Hospital but not by enough to save money, despite an original admission rate of 23 per 1000 (yielding ample room for reduction) versus 2.62 in the HERO Guide. [27] [28] A RAND analysis of PepsiCo showed a loss on health promotion.[29] The RAND Corp. also recently released a report concluding that employee participation in workplace wellness programs does not reduce health-care utilization or cost.[30] The few health economists who have studied wellness oppose it.[31] An entire website is devoted to deconstructing and invalidating outcomes claims made by wellness vendors.[32]

On the other hand, the only meta-analysis finding savings, a 2010 analysis [33] later challenged by RAND and others[34], was not confirmed by a 2015 meta-analysis concluding that ''randomized control trials exhibited negative [returns on investment].'' [35] By contrast, all the studies in the original meta-analysis were of the participant/non-participant design. In wellness—owing to what RAND calls the ''unobservable differences between program participants and nonparticipants, such as differential motivation to change behavior,'' [36]—that design has been noted, as part of a peer-reviewed award process, to create a favorable separation (savings) of 9% in Year One and 18% in Year Two, both in the absence of a program.[37] A study by Aetna released in October elegantly confirmed that substantial mock ''savings'' could be generated in one year in a population healthy to begin with, even if there was no change in overall health of the study population versus the control, simply by using that study design.[38] [39]

In conclusion, there appears to be no strong evidence in support of a pro-wellness federal policy, either prescriptively or descriptively, for financial outcomes or even health outcomes. Indeed the evidence appears to show the opposite on a national basis for both types of outcomes, while case-study evidence in favor of wellness is based on invalid study design. Especially recognizing that health-care interventions that involve financial forfeitures and unlicensed providers should be held to a high standard of necessity and effectiveness due to their financial coerciveness, risk of deliberate or accidental data release,[40] and potential for discrimination[41], workplace wellness should be reconsidered both as a national priority and as corporate policy. At a very minimum, regulations, oversight, and licensing should be implemented, as wellness is the only significant health-care intervention which has none.

And, most urgently, existing EEOC employee protections under the ADA and the Genetic Information Nondiscrimination Act, should be strengthened, rather than loosened as is now being considered.

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[22] Wellsource Website http://media.hypersites.com/clients/1185/filemanager/docs/Free-Resources/Worksite-Wellness/How_Much_Should_a_Wellness_Program_Cost.pdf. Accessed Sept. 19, 2015.

[23] HERO Guide, p. 22-23. Calculation: 2.62 wellness-sensitive admissions per 1000 times $22,500 cost/admission.

[24] HERO Guide, p. 15.

[25] HERO Guide, p. 10-11.

[26] Gowrisankaran et al. *Health Aff* March 2013 32:477-485; doi:10.1377/hlthaff.2012.0090.

[27] Gowrisankaran G et al. *Health Aff* March 2013;32:477-485; doi:10.1377/hlthaff.2012.0090.

[28] ''Wellness Programs and Cost Reduction,'' Letter to the Editor, Al Lewis, doi: 10.1377/hlthaff.2013.0277 *Health Aff* June 2013 vol. 32, no. 6, 1172.

[29] Caloyeras J. et al. *Health Aff* January 2014 33:124-131; doi:10.1377/hlthaff.2013.0625.

[30] RAND Abstract released May 11, 2015. Website accessed June 28, 2015. http://www.rand.org/pubs/research_reports/RR724.html.

[31] Incidental Economist, Dec. 2, 2014; http://theincidentaleconomist.com/wordpress/workplace-wellness-programs-dont-save-money. Accessed Sept. 27, 2015.

[32] http://www.theysaidwhat.net accessed Sept. 27, 2015

[33] Baicker K., Cutler D., Song Z. Workplace Wellness Programs Can Generate Savings *Health Aff* February 2010 vol. 29, no. 2, 304-311.

[34] Mattke S., The Real Professor Baicker, The Health Care Blog, Jan. 5, 2015. http://tinyurl.com/nadf5nw. Accessed July 26, 2015.

[35] Baxter S., Sanderson K., Venn A., Blizzard L., Palmer A. The Relationship Between Return on Investment and Quality of Study Methodology in Workplace Health Promotion Programs *American Journal of Health Promotion* 2014 28:6, 347-363.

[36] Mattke A. et al. Workplace Wellness Programs Study: Final Report. Santa Monica, CA: RAND Corporation, 2013. http://www.rand.org/pubs/research_reports/RR254. Also available in print form. Accessed Aug. 26, 2015.

[37] Lewis A., Khanna V., Montrose S. Workplace Wellness Produces No Savings. Health Affairs Blog, Nov. 25, 2014, http://tinyurl.com/oc97zlu. Accessed Aug. 25, 2015.

[38] Steinberg, Gregory MB, BCh; Scott, Adam MBA; Honcz, Joseph MBA; Spettell, Claire PhD; Pradhan, Susil MS Reducing Metabolic Syndrome Using a Personalized Risk Program J Occ Medicine October 2015 (epub ahead of print).

[39] Aetna Accidentally Invalidates the Wellness Industry's Savings Model. http://tinyurl.com/pp4f63b. Accessed Nov. 5, 2015.

[40] ''Workplace Wellness Programs Put Employee Privacy at Risk,'' Kaiser Health News, Sept. 28, 2015, http://tinyurl.com/ojaga46. Accessed Sept. 28, 2015.

[41] Horwitz J., Kelly B., DiNardo J. Wellness Incentives In The Workplace: Cost Savings Through Cost Shifting To Unhealthy Workers Health Aff, March 2013, vol. 32, no. 3, 468-476.