

EMPLOYEE HEALTH & PRODUCTIVITY MANAGEMENT PROGRAMS: THE USE OF INCENTIVES

A Survey of Major U.S. Employers

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*The results of the Spring 2008
Health, Wellness & Productivity
Programs, Incentives & ROI Impact Survey*



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EXECUTIVE SUMMARY

Most **large employers now offer health management programs** to their employees. A related trend is the **growing use of incentives as a tool to drive employee participation and engagement** in those programs. Program incentives **averaging \$192 per person per year** are part of an overall employer investment that is expected to yield a return. While most common incentives used are gift cards, premium reductions, and cash bonuses, **the use of gift cards is on the rise.**

For the second consecutive year, Health2 Resources conducted a survey of the membership of the National Association of Manufacturers (NAM) and the ERISA Industry Council (ERIC) to delve into the use of incentives in health, wellness and disease management programs.

This year's survey found that more than three out of four employers now offer health & wellness programs and almost half offer disease management programs. The results offer **new insights** into employer attitudes about health and disease management programs, including the **nuances of when, how much and what kind of incentives are being used** and how success is measured.

Key Findings:

- ▶ **Health & wellness programs continue to grow.** Currently 77 percent of employers offer formal health & wellness programs, up slightly from 2007, and more than half of those currently without programs plan to add them, many within 6 to 12 months. In 2008, 48 percent of employers offer formal disease management programs, approximately the same percentage as in 2007.
- ▶ **Incentives to promote healthy behaviors are on the rise.** Between 2007 and 2008 there was an increase in the proportion of employers offering incentives for health & wellness or disease management programs, from 62 percent of companies with programs to 71 percent in 2008. Analysis of results by type of incentives suggests that the use of incentives with health & wellness programs increased, while the use of incentives with disease management programs declined.¹
- ▶ **Gift cards are a top incentive choice.** Between 2007 and 2008 this survey found a shift in the types of incentive offered for health & wellness programs. The use of "gift cards" increased from 17 percent in 2007 to 28 percent in 2008. Premium reductions and cash bonuses as an incentive continue to be options used by major employers although results show a decline in use from 2007.
- ▶ **Employers are offering incentives to drive program participation and program completion.** For health & wellness programs, incentives were most commonly awarded to employees for "participation." When employees "complete" a program (vs. mere participation) 38 percent of employers offer incentives. If an employee achieves an outcome goal (weight loss; smoking cessation) 16 percent of employers offer incentives.
- ▶ **Value of incentives is typically between \$100 and \$300 per person per year.** Among employers offering incentives, the average incentive value was estimated to be just under \$200 per person per year. Most programs for which estimates were made involved per-person costs of between \$100 and \$300 per year.

¹ Because of differences in the way the questions were asked in 2007, separate overall incentive estimates for health & wellness programs as distinct from disease management programs could not be compared between the two years.

- ▶ **Employers are beginning to successfully measure ROI for health & wellness programs, with 83 percent of those estimating results achieving greater than 1:1 return.** The proportion of those companies successfully measuring ROI increased dramatically between 2007 and 2008 from 14 percent to 26 percent of employers with programs. Among these respondents, more than 83 percent estimated an ROI greater than break-even in 2008, up from 66 percent in 2007.
- ▶ **“Maintaining employee motivation over time” and “measuring program effectiveness” remain key challenges.** These were cited as the top challenges by employers with health & wellness programs in both 2007 and 2008.

As employers continue to experiment in ways to improve the health, wellness and productivity of their workforce, **incentives are being recognized as an important part of a health management strategy.** This solidifies their use as an attractive and cost-effective tool for unlocking the benefits of health, wellness and disease management programs.

BACKGROUND

Health care expenditures have been a growing component of employee compensation for at least 40 years. According to some studies^{2,3,4} the reason for tapering cost increases is linked to the proactive employee health and productivity management practices of leading edge employers. This investment in health promotion and risk reduction, often including the use of incentives, is paying off in better employee health and lower overall costs.

The second annual Health2 Resources study of incentive use in health, wellness, and disease management programs was conducted during April and May 2008. The employers surveyed are members of the National Association of Manufacturers (NAM) and the ERISA Industry Council (ERIC).

NAM, ERIC, and IncentOne, a company that offers incentive programs to employers, sponsored this study. The NAM and ERIC members surveyed represent major U.S. employers with a combined total of more than 15 million employees. Respondents represent some of the largest companies in the U.S.; 27 percent of respondents are listed among the Fortune 500.

The 2008 NAM, ERIC, and IncentOne survey offers new insights into employer attitudes about health & wellness programs, including the “when, how much and what kind” nuances of incentives management.

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² 2008 Health Care Cost Survey, 2008. Towers Perrin, 29 May 2008 "http://www.towersperrin.com/tp/getwebcachedoc?webc=HRS/USA/2008/200801/hcss_2008.pdf"

³ "Healthcare Cost Trends for 2008." PWC Health Research Institute, 19 June 2007. PricewaterhouseCoopers, 29 May 2008 <<http://pwchealth.com/cgi-local/hregister.cgi?link=reg/numbers2008.pdf>>.

⁴ "Building an Effective Health and Productivity Framework," 2007-2008 Staying@Work Report, Watson Wyatt Worldwide and the National Business Group on Health, 29 May 2008 http://www.watsonwyatt.com/research/de_liverpdf.asp?catalog=2007-US-0216andid=x.pdf.

INTRODUCTION

The specific goals of this survey are to:

- ▶ Determine employer adoption of incentives for health and disease management programs;
- ▶ Assess types of incentives used with health and disease management programs and the ways in which incentives are applied to activities or behaviors; evaluating the average amount paid; and
- ▶ Evaluate “if” and “how” employers are measuring ROI and program measures/outcomes for health management programs.

The 2008 survey resulted in 281 completed or partially completed surveys representing 225 major U.S. employers with 7.6 million employees. The survey instrument was expanded in 2008, although comparison with responses to the 2007 survey can be made on key questions.

Table 1. Survey Response

	Spring 2007	Spring 2008
Respondents	304	281
Respondent Companies / Organizations	240	225
Percentage Companies Fortune 500	17%	27%
# Employees Represented	6.5 million	7.6 million

Source: 2007 and 2008 Spring Surveys of NAM and ERIC membership.

INDUSTRY INSIGHTS

Employers clearly recognize the connection between individual behaviors and health care costs. Those costs are spiraling upward, and employers are responding accordingly with an approach to lower costs through improved employee health & wellness.

Health care spending tops \$2 trillion

Total health care spending in the United States grew 6.7 percent to \$2.1 trillion in 2006 — 16 percent of the nation’s gross domestic product (GDP), according to the most recent numbers from Centers for Medicare and Medicaid Services (CMS).⁵ Through 2017, growth in health care spending is expected to outpace that of the GDP by an annual average of 1.9 percentage points. Over the past 25 years, increases in national health care spending per capita have exceeded increases in the Consumer Price Index (CPI) every year.⁶

The Kaiser Family Foundation and Health Research and Educational Trust’s (HRET) *2007 Employer Health Benefits Survey* found that in just one year, premiums rose an average of 6.1 percent for employer-sponsored health insurance.⁷ That’s a lower rate than the 7.7 percent increase in 2006, but still higher than the increase in workers’ wages (3.7 percent) and it well outpaced the overall inflation rate (2.6 percent).

Health-related costs encompass considerably more than just insurance and health care spending. A study published in the *Journal of Occupational and Environmental Medicine* indicates that U.S. employers may be significantly underestimating the overall costs of poor employee health, while failing to fully assess the diseases and health conditions that drive them.⁸ Researchers found that “full cost” measures (those that include health-related lost productivity costs along with direct medical spending) were *four times greater* than measures of direct medical spending alone.

⁵ “National Health Expenditure Accounts Highlights,” Centers for Medicare and Medicaid Services, www.cms.hhs.gov/NationalHealthExpendData/downloads/highlights.pdf, NHE Fact Sheet. (www.cms.hhs.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp)

⁶ Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, <http://facts.kff.org/results.aspx?view=slidesandtopic=3>

⁷ Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007, www.kff.org/insurance/7672/index.cfm.

⁸ Loeppke, MD, MPH, Ronald, Michael Taitel, PhD, Dennis Richling, MD, Thomas Parry, PhD, Ronald C. Kessler, PhD, Pam Hymel, MD, MPH and Doris Konicki, MHS. “Health and Productivity as a Business Strategy,” *Journal of Occupational and Environmental Medicine*, 49(2007): 712-721.

Promote health, lower cost trends

The number of employers who say they will become more directly involved in managing the health of their individual employees jumped dramatically from 2007 to 2008. An April report by Hewitt Associates found that, for the first time, employers identified keeping employees healthy as one of their top business and workforce issues. Sixty-three percent said they plan to offer incentives to motivate *sustained* health care behavior change.⁹ Increased use of employer incentives for workers who adopt healthy lifestyles was echoed in recent surveys by Watson Wyatt and the National Business Group on Health¹⁰ and the Midwest Business Group on Health.¹¹

This survey of NAM and ERIC members delves more deeply than previous research into the nuances of incentives themselves. To the authors' knowledge, this survey is the first to directly ask major employers detailed questions about the types of incentives they use; the specific incentives they use for key population health management programs (e.g., disease management, health risk assessment use or general wellness); how much they pay; the challenges they face implementing these programs; and their expectations for ROI.

SURVEY RESULTS

The market is evolving and employers that offer health and disease management programs are finding unique and diverse ways to offer incentives as part of these programs.

Therefore, findings about incentive management strategies are discussed within the context of these programs.

This report is divided into four sections:

- 1. Health & Wellness Programs**
- 2. Disease Management Programs**
- 3. Employer Expectations: ROI and Program Measures for Health & Wellness Programs; and**
- 4. Challenges Employers Face With Health & Wellness Programs.**

⁹ "Survey Findings: Two Roads Diverged: Hewitt's Annual Health Care Survey 2008." Hewitt Associates, www.hewittassociates.com.

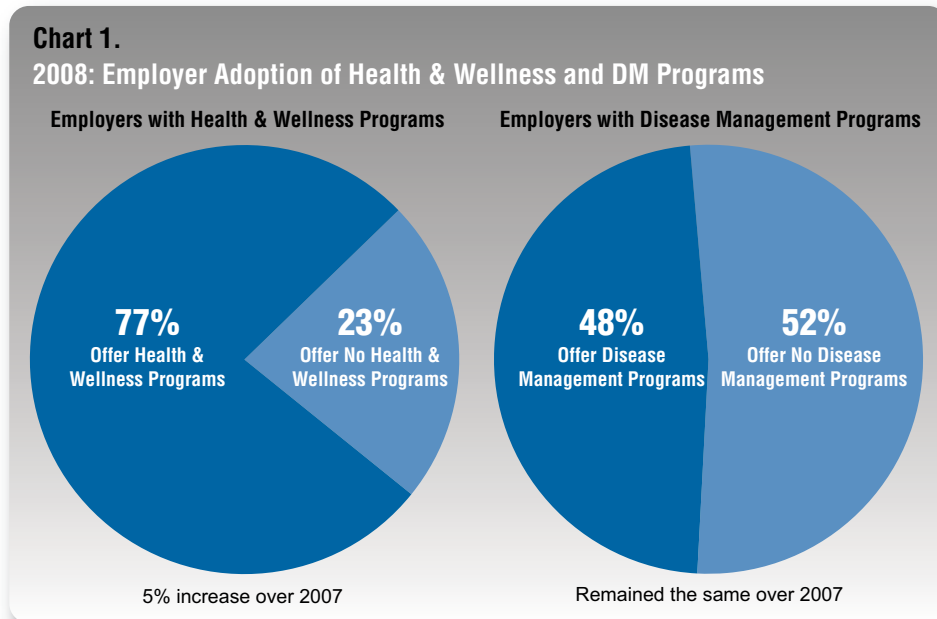
¹⁰ Watson Wyatt/National Business Group on Health 2007/2008 Staying@Work report, www.watsonwyatt.com/research/reports.asp.

¹¹ "Readiness to Change Survey," Midwest Business Group on Health, May 2008, www.mbg.org.

Health & wellness and disease management program adoption and overall use of incentives

In order to evaluate how, when and in what way employers use health incentives, it was first important to determine how broadly employers have adopted health & wellness and disease management programs and to what degree they are using health incentives.

In 2008, 77 percent of employers offer health & wellness programs and 48 percent offer disease management programs (**Chart 1**).



Although both are widely offered, health & wellness programs have become more pervasive than disease management programs among large employers. The plateau in the number of disease management programs may be linked to a number of factors. In recent years, the efficacy of telephonic disease management has been challenged as return on investment for these programs has not been convincingly documented. While some employers have invested in face-to-face disease management programs to optimize effectiveness, the cost of program administration may be a barrier to broader appeal.¹²

Health management programs, however, are still on a growth trajectory: In the 2008 survey, 77 percent offer health & wellness programs, up from 72 percent in 2007.

In **Chart 2 (next page)**, employers that offer either health & wellness or disease management programs are depicted. Adding disease management to the health & wellness offering only expands the number of employers offering programs of any type by 1 percent, to 78 percent. More than half of employers without programs have active plans to offer them in the future.

Key Finding:

Health & wellness programs continue to grow.

Currently 77 percent of employers offer formal health & wellness programs, up slightly from 2007, and more than half of those currently without programs plan to add them, many within 6 to 12 months. In 2008, 48 percent of employers offer formal disease management programs, approximately the same percentage as in 2007.

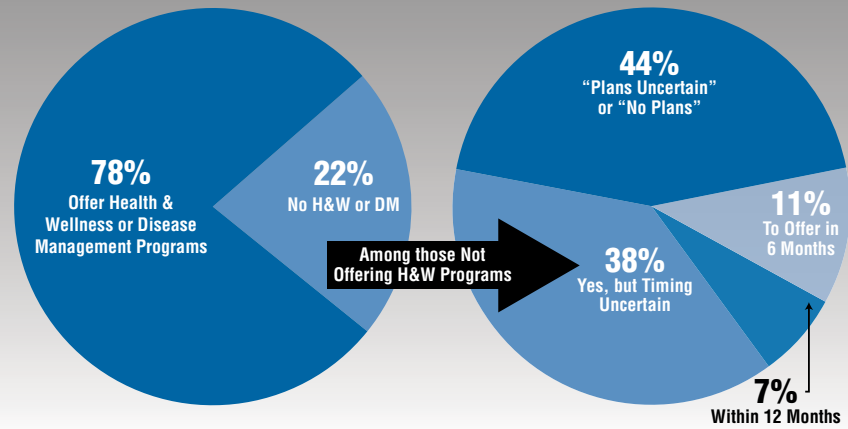
¹² Sidorov, Jaan E., and Fitzner, Karen. "Obesity Disease Management Opportunities and Barriers." *Obesity* 14:27 Jan 2006 645-649. 5 Jun 2008 <http://www.nature.com/obyjournal/v14/n4/full/oby200672a.html>.

Key Finding:

Incentives on the rise to promote healthy behaviors.

Between 2007 and 2008 there was an increase in the proportion of employers offering incentives for health & wellness or disease management programs, from 62 percent of companies with programs in 2007 to 71 percent in 2008. Analysis of results by type of incentives suggests that the use of incentives with health & wellness programs increased between the two years, while the use of incentives with disease management programs declined.

Chart 2.
2008: Employer Adoption of Health & Wellness and DM Programs



Adoption of incentives

The use of incentives as a component of successful programs is on the rise. Incentives are being used by employers for a number of activities to include employee engagement across the continuum of programs—from completing an initial health risk assessment to enrollment in lifestyle change programs.

I. FOCUS ON: HEALTH & WELLNESS PROGRAMS - USE OF INCENTIVES, PROGRAM MEASURES

Health & wellness programs are now coming into their own. More than three-fourths of employers now offer health & wellness programs, and among those offering programs 71 percent use incentives.¹³

Variety of health & wellness programs offered

Employers offer a variety of health & wellness programs that embed incentives as part of the program design. Examination of what kinds of health & wellness programs employers offer and in what way they apply incentives to encourage behaviors allows for a closer evaluation of program effectiveness.¹⁴

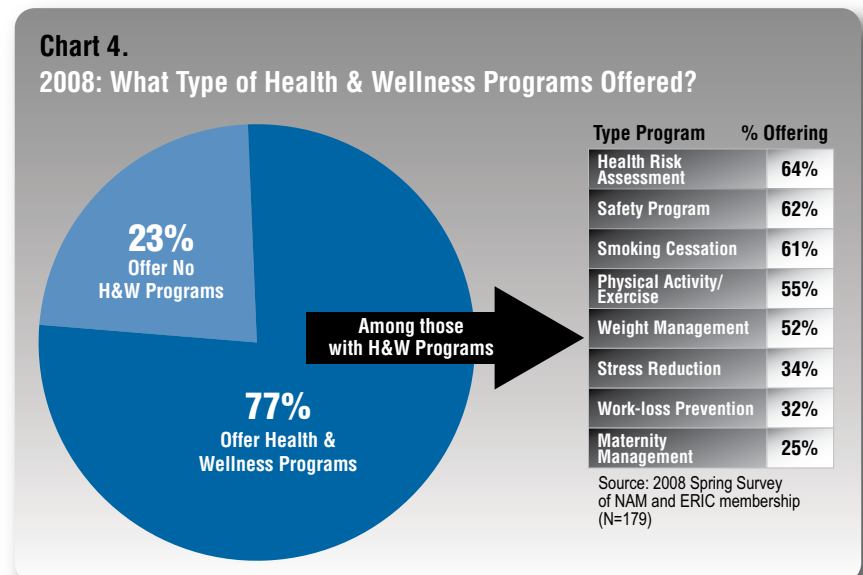
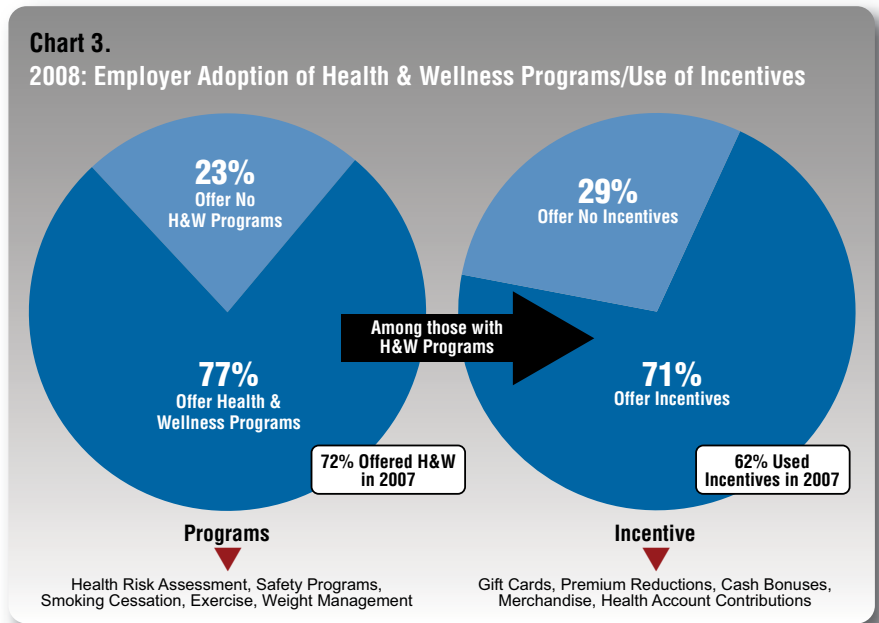
Of the responding employers that offer health & wellness programs, 64 percent of employers offered programs that involve health risk assessments. This is not surprising as the health risk assessment is most often seen as the gateway into health and disease management program placement. Safety and smoking cessation programs follow closely and more than half of the responding employers offer exercise and weight reduction programs (Chart 4).

How incentives are being used with health & wellness programs

Not all employers offer incentives as part of their health & wellness programs and when incentives are offered, they are offered for different programs and different activities within those programs.¹⁵ Incentives are most likely to be offered in association with health risk assessments. Among those programs listed, they are also likely to be offered with physical activity or exercise programs (Chart 5, next page).

What types of incentives are being used?

While a water bottle and T-shirt were reward enough for participation in health & wellness programs a decade ago, incentives now mirror the sophistication, depth and breadth of the programs they reward and the audience they are trying to motivate.



¹³ We distinguished health & wellness programs from disease management programs, and asked a series of questions about availability of health & wellness programs and the use of incentives with those programs.

¹⁴ The question allowed the respondent to check from a list of types of possible programs and then fill in additional kinds of programs using an open-ended format. Among the 22 "other" programs listed by respondents in the open-ended "other" category were various health & wellness programs (which were explored later in the survey), EAPs, nurse hotlines, occupational health, defensive driving, healthy food choices, and clarification of several of the listed programs.

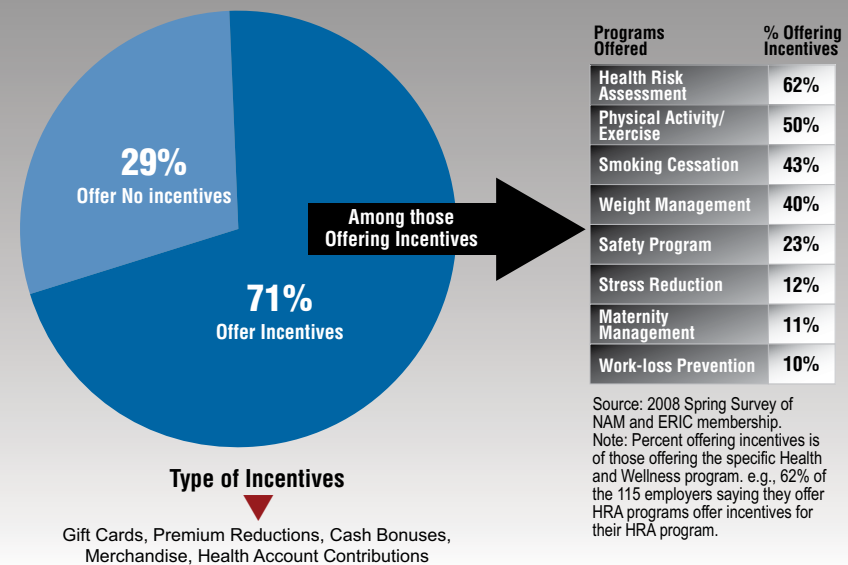
¹⁵ Respondents were asked to indicate, from the same list of common health & wellness programs, which programs used incentives.

Key Finding:

Gift cards are a top incentive choice.

Between 2007 and 2008 this survey found a substantial shift in the types of incentive offered for health & wellness programs. The use of “gift cards” increased from 17 percent in 2007 to 28 percent in 2008. Premium reductions and cash bonuses as an incentive continue to be options used by major employers although results show a decline in use from 2007.

Chart 5.
2008: Adoption of Health & Wellness Programs/Use of Incentives

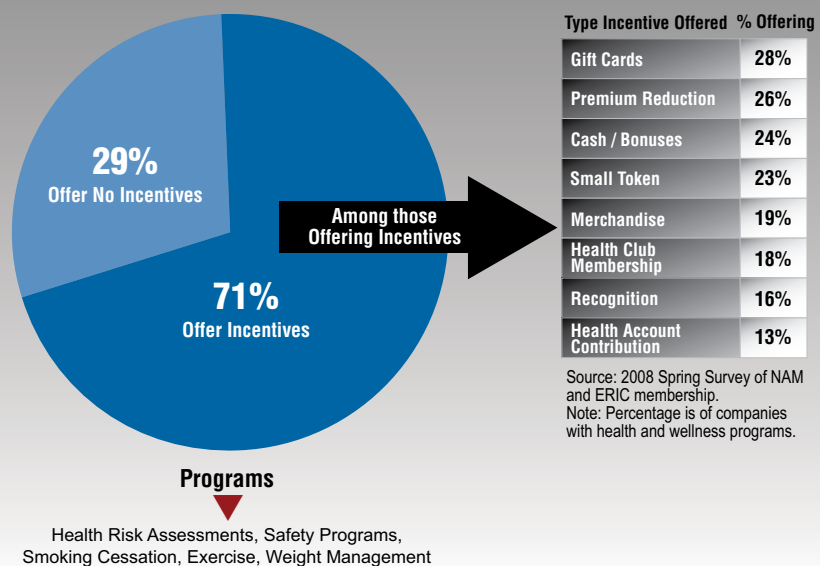


It is apparent that no single kind of incentive dominates.¹⁶ Gift cards are now the most commonly used incentive, but they are closely followed by premium reductions and cash bonuses.

Between 2007 and 2008 the types of incentives offered by employers has changed.¹⁷

Offering employees a “premium reduction,” which was the most frequently used incentive in the 2007 survey, has shown a decline over the past year. “Premium reduction” has now fallen to second place behind gift cards (which shot up sharply) in percentage of employers using the incentive. These results suggest that there isn’t yet agreement on a specific kind of incentive for broad use and employers are using a variety of incentives to shape behavior.

Chart 6.
2008: What Type of Incentives are Being Used?

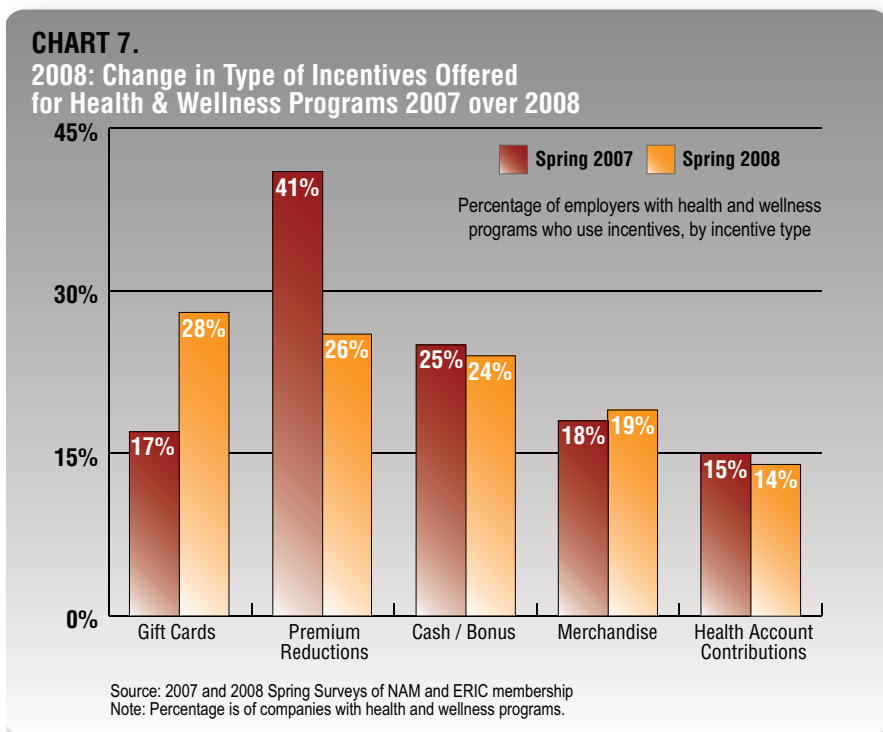


¹⁶ Respondents were asked to choose the types of incentives their organization offered from a list of commonly used incentives. The results are shown in Chart 6.
¹⁷ Respondents were provided a variety of incentives from which to select. Several choices given only in 2008 are not included in the chart.

How incentives are being used to shape consumer behavior

Intelligently designed incentive programs should appeal to diverse audiences and offer a range of options to match the company's program agenda, corporate culture and the workforce demographics.

The way in which incentives are applied to health & wellness programs to encourage key consumer engagement is essential in the successful administration of health & wellness programs. After all, if programs are offered and there are no "takers" or "completers," then there will be a significant impact on program ROI.



The most common behavior¹⁸ rewarded with incentives is "participation," but almost 40 percent offer incentives for "completing" a program. Very few employers offer incentives for goal achievement during or after completion of the program, and other kinds of behaviors are even less likely to have incentives attached. For example, less than 5 percent of employers offer incentives to encourage employees to recruit others into a program or to lead groups in program participation.

There are several reasons why employers may be choosing to link incentives more often with program enrollment, participation and completion than with goal achievement. The first and most obvious is ease of fulfillment; it is simpler to track and confirm enrollment, participation and program completion than whether participants achieved program goals.

Key Findings:

Employers are offering incentives to drive program participation and program completion.

For health and wellness programs, incentives were most commonly awarded to employees for "participation." When employees "complete" a program (vs. mere participation) 38 percent of employers offer incentives. If an employee achieves an outcome goal (weight loss; smoking cessation) 16 percent of employers offer incentives.

¹⁸ Survey respondents were given a list of commonly rewarded behaviors and asked to choose which behaviors their employers used incentives to reward. The results are illustrated in Table 2.

**Key Finding:
Value of incentives is typically between \$100 and \$300 per person per year.**

Among employers offering incentives, the average incentive value was estimated to be just under \$200 per person per year. Most programs for which estimates were made involved per-person costs of between \$100 and \$300 per year.

A second reason may be employer concern to steer clear of regulatory caps on monetary incentives for health & wellness programs proscribed by HIPAA. While HIPAA regulations place no limit on incentives for participation-based health & wellness programs, they do limit incentives for programs that require participants to meet a health-related standard. Although the HIPAA regulations are broad enough to allow fairly generous goal achievement incentives (up to 20 percent of total cost of coverage), employers may find it simpler to link incentives to enrollment, participation and program completion than try to meet HIPAA's five-point regulatory burden.¹⁹

Table 2.

What Consumer Behaviors Earn Incentives Through Health & Wellness Programs

Behaviors Earning Incentives - 2008 Only	% Using Incentives For Listed Behavior
Participation In Program	48%
Completing a Program	38%
Signing Up For / Enrolling in Program	25%
Achieving Outcomes / Goals During Program	16%
Achieving Outcomes / Goals After Program	12%
Maintaining Outcomes / Goals After Program	6%
Leading Groups to Participate in Program	2%
Recruiting Others Into Program	1%

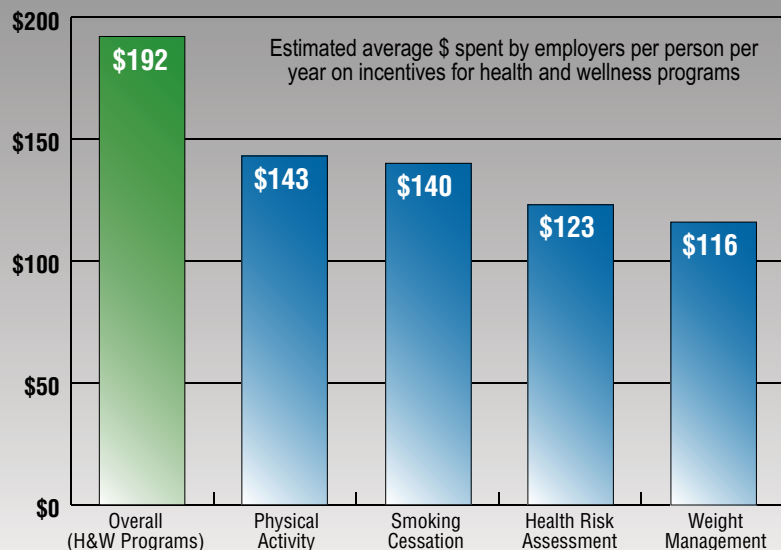
Source: 2008 Spring Survey of NAM and ERIC membership. (N=138)

How much is being spent?

Most programs offering incentives provide dollar amounts per participant per program ranging from approximately \$100 to \$300.²⁰ Overall, about half of respondents indicated a monetary incentive in that range, and one-third indicated their average incentive was below \$100. Only one in five respondents indicated that their company spent more than \$300 per person on incentives overall.

Chart 8.

How Much is Being Spent Per Person Per Year (PPPY) in Incentives for Specific Health & Wellness Programs?



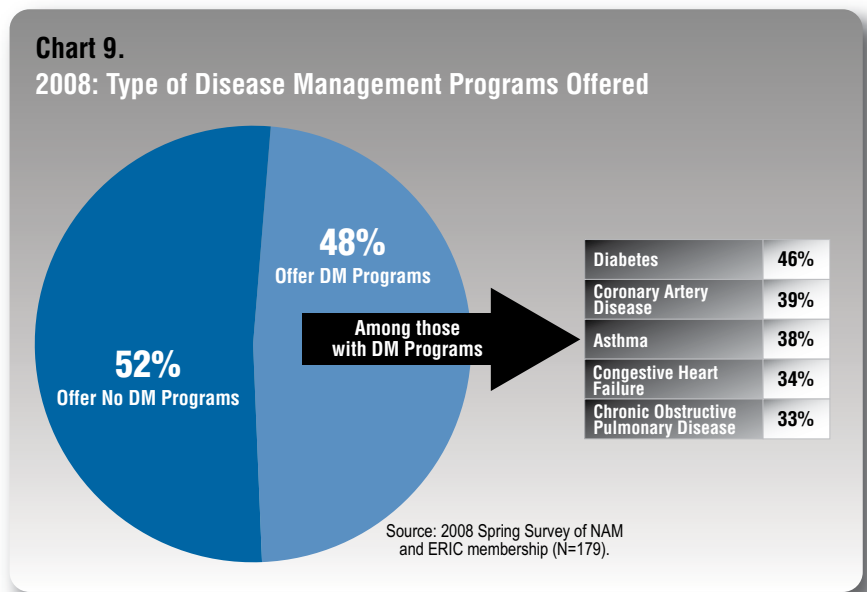
Source: 2008 Spring Survey of NAM and ERIC membership
Note: There were 22 estimates above \$1000 per person per year that were eliminated, due to ambiguity as to whether the estimate was in aggregate or per person.

¹⁹ Alvarez, Frances P., et al. "Final HIPAA Nondiscrimination Regulations Spur Employers to Review Workplace Wellness Programs." Preventive Strategies and Positive Solutions for the Workplace. 14 Dec 2006. Jackson/Lewis. 5 Jun 2008 <<http://www.jacksonlewis.com/legalupdates/article.cfm?aid=1040>>
²⁰ A number of respondents (19 of 87 providing estimates) provided estimates that were thought to be outside of a reasonable range, and were presumed to be providing a total dollar amount spent rather than dollars per person (some of these responses were in the millions of dollars). Also, some respondents who provided an overall estimate appeared to "sum" the estimate for each of their different health & wellness programs rather than "average the estimate" for each of their programs. For those that appeared to sum the estimate (five respondents), their overall estimate was recalculated as an average of the estimates for their different programs. In the chart, the estimates are ordered from left to right based upon the number of respondents making an estimate.

II. DISEASE MANAGEMENT PROGRAMS - TYPE OF PROGRAMS OFFERED/USE OF INCENTIVES

Disease management program offerings

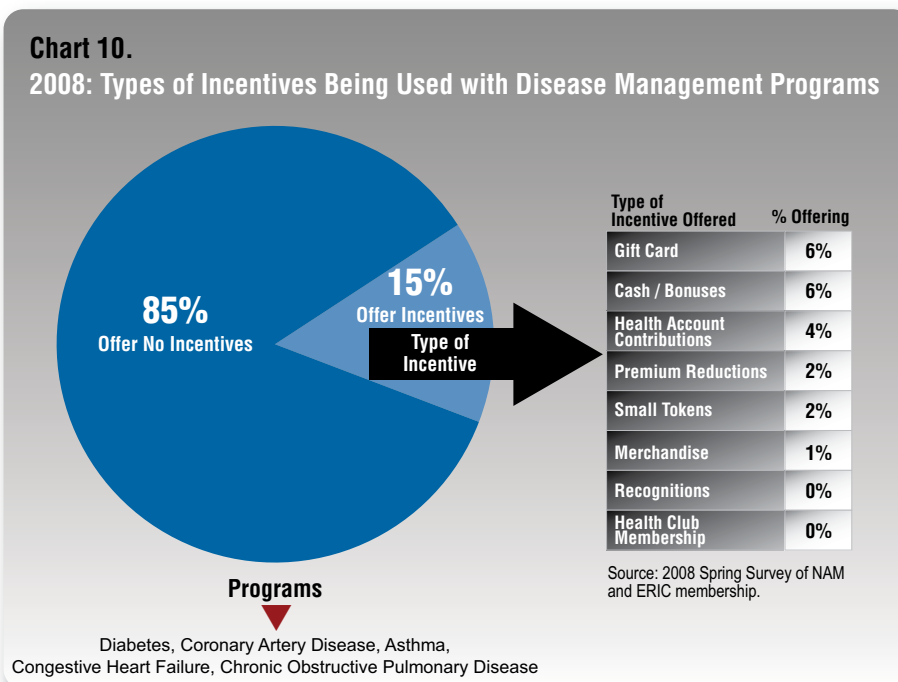
Traditional, standalone disease management programs have been in use for some time. The trend in health management programs, however, is to address the needs of the total employee population along the care continuum—from those currently in good health, to those at risk for developing chronic disease, and those already filing claims for illnesses such as diabetes and high blood pressure. The line between traditional disease management and total population health management is blurring, and as a result, this survey found little change in the prevalence of standalone disease management programs between 2007 and 2008.



In general, employers were somewhat less likely to offer disease management programs²¹ than they were to offer health & wellness programs, and the percentage of employers offering incentives for disease management programs was much lower. As a result, adoption of disease management programs is less robust than that of health & wellness programs.

Type of disease management programs offered

We were interested in determining which types of disease management programs were most common among employers and in what ways they might be using incentives in the design of these programs.



Respondents were asked to check which programs their companies offered and were then given the option to list additional programs in an open-ended “other” area. The five check-list programs were diabetes, coronary artery disease (CAD), asthma, congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). Common disease management programs that respondents listed in the “other” section included chronic back pain, depression, cancer and various specific heart/blood pressure ailments (Chart 9).

²¹ Disease management programs were separated out for a detailed set of questions in a parallel approach to the questions for health & wellness programs.

The most common disease management program offered among large employers who responded was “diabetes.” Given the national awareness and workplace prevalence, this finding is not surprising.

Use and types of incentives for disease management programs

Among the 48 percent of employers that use disease management programs, only 15 percent use incentives of any type in association with their programs (**Chart 10, previous page**).

With the exception of gift cards, the results show a sharp decline in the use of incentives for disease management programs. Between 2007 and 2008, health account contributions and premium reductions decline sharply, as does the use of cash or bonuses and merchandise. The results of this survey demonstrate a sharp downward trend in use of incentives for disease management programs (from an already low level of use).

Table 3 reflects, the kinds of behaviors that elicit rewards from employers using disease management programs (not asked in 2007).

Table 3.
What Consumer Behaviors Earn Incentives Through Disease Management Programs

Behaviors Earning Incentives - 2008 Only	% Using Incentives For Listed Behavior
Participation In Program	11%
Completing a Program	11%
Signing Up For / Enrolling in Program	4%
Achieving Outcomes / Goals During Program	2%
Achieving Outcomes / Goals After Program	1%
Maintaining Outcomes / Goals After Program	0%
Leading Groups to Participate in Program	0%
Recruiting Others Into Program	0%

Source: 2008 Spring Survey of NAM and ERIC membership. (N offering DM programs =86)

III. EMPLOYER EXPECTATIONS: RETURN ON INVESTMENT AND PROGRAM MEASURES FOR HEALTH & WELLNESS PROGRAMS

There is ongoing debate about the evolving science behind measurement of return on investment (ROI) for health & wellness programs. Given the lack of a single, widely-accepted methodology, for the purposes of this survey ROI is measured by reductions in overall company health care costs that can be linked to employee participation in health & wellness and disease management programs.

Of interest for this survey is employer expectation for ROI for health & wellness programs. For those offering programs, respondents were first asked whether their company had attempted to measure ROI and then, for those who had made the attempt, whether they were successful (**See Chart 11**).

While far less than half of respondents have attempted to measure ROI, the striking finding here is that more companies have become successful in the effort. In 2007, many of those attempting to measure ROI were waiting for results. It appears that in 2008 results are now available to more employers. We anticipate that this trend will continue as ROI methodology is improved and employers continue to demand measurable results.

For those who estimated ROI, more than 80 percent indicated that ROI is either break-even or positive, an increase over 2007, and a very strong result (**Chart 12**). Only a

Key Findings:

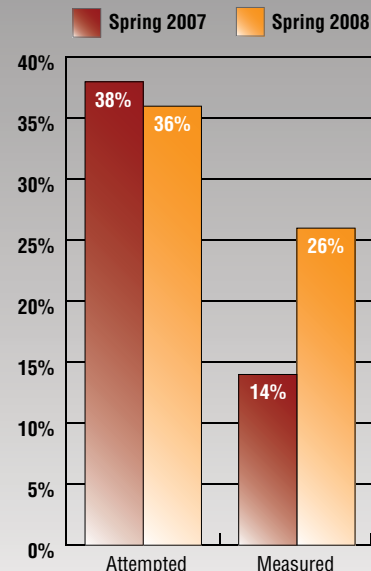
Employers are beginning to successfully measure ROI for health & wellness programs; 83 percent of those estimating results achieved greater than 1:1 return.

The proportion of those companies successfully measuring ROI increased dramatically between 2007 and 2008 from 14 percent to 26 percent of employers with programs. Among these respondents, more than 83 percent estimated an ROI greater than break-even in 2008, up from 66 percent in 2007.

Chart 11.

2008: Measuring ROI: A Growing Percentage of Employers Offering Health & Wellness Programs Have Successfully Measured ROI

Percentage of employers with health and wellness programs who report they have attempted to measure ROI and have successfully measured ROI

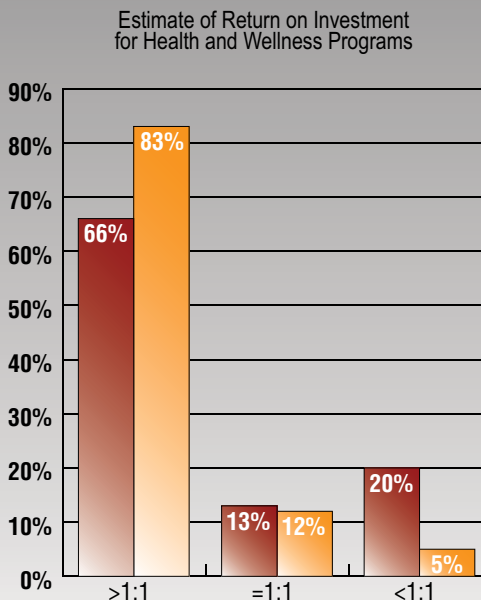


Source: 2007 and 2008 Spring Surveys of NAM and ERIC membership (N 2008=124; N 2007=78).
 Note: Percentage is of employers with health and wellness programs responding to the question. Thus, in the 2008 survey, 36 percent of employers who have health and wellness programs and responded to the question have attempted to measure ROI and 26 percent have been successful.

Chart 12.

2008: Measuring ROI: Those Organizations Willing to Estimate Health & Wellness ROI Report Strong Returns

Estimate of Return on Investment for Health and Wellness Programs



Source: 2007 and 2008 Spring Surveys of NAM and ERIC membership (N 2008=21; N 2007=24).
 Note: Percentage is of employers with health and wellness programs able to measure ROI for those programs.

very small portion estimated their ROI to be less than 1:1 in 2008, a substantial drop from the prior year.

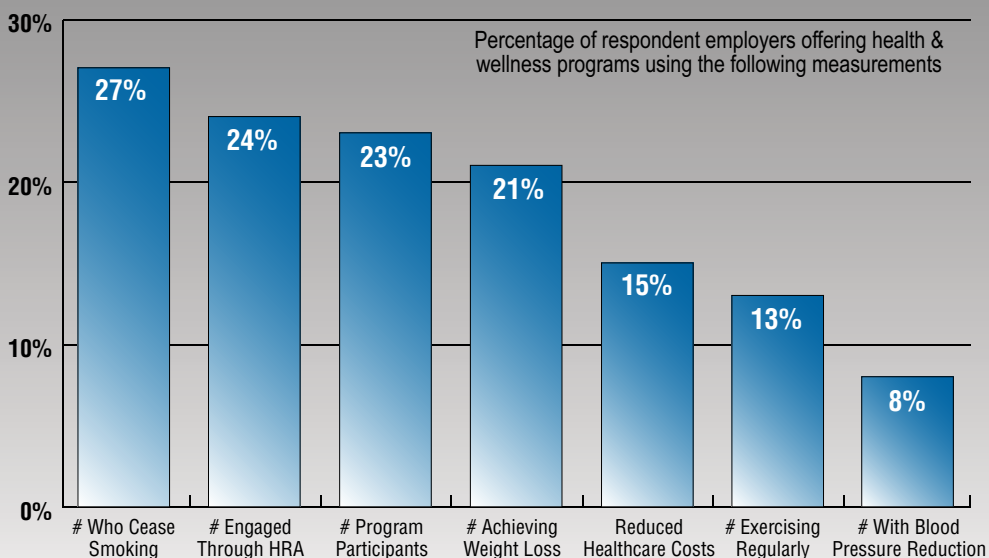
Employers with and without health & wellness programs think health & wellness programs with incentives will have a better ROI than programs that do not. An overwhelming majority—89 percent of those currently with programs and 80 percent of those without current programs—said incentives sometimes or almost always improved ROI.

Program measures

While ROI is measured by only a minority of companies, about two-thirds of employers with programs use measures other than ROI to determine program effectiveness. Respondents were asked to list up to three outcomes measures that their companies used in an open-ended format. The wide range of responses were categorized into 20 groupings, and the most commonly cited groupings yield interesting results (**Chart 13**).

The results primarily reflect a mix of **health risk reduction measures** (smoking cessation, for example) and **program engagement measures** and **participation measures** (if combined, these represent nearly half of responses). One grouping, reduced health care costs, is tied directly to program ROI.

Chart 13.
2008: Measuring Program Impact: Organizations Have a Wide Variety of Program Measures for Their Health & Wellness Programs



Source: 2008 Survey of NAM and ERIC membership
 Note: Each respondent could provide up to three measures and 86 respondents provide at least one measurement. The percentage is taken of those respondents whose companies have health and wellness programs and who responded to the question on whether outcome measurements had been attempted for their programs (N=126). Thus, the category "# who cease smoking" represents responses from 34 respondents (27% of the 126 respondents to the question).

IV. WHAT CHALLENGES DO EMPLOYERS FACE WITH HEALTH & WELLNESS PROGRAMS?

While three out of four employers have implemented health & wellness programs, as these programs are maturing employers face key challenges. In both 2007 and 2008, we evaluated the types of challenges employers face in management of current health & wellness programs and the challenges they face in initiating health & wellness programs (if their company expected to offer programs soon).²²

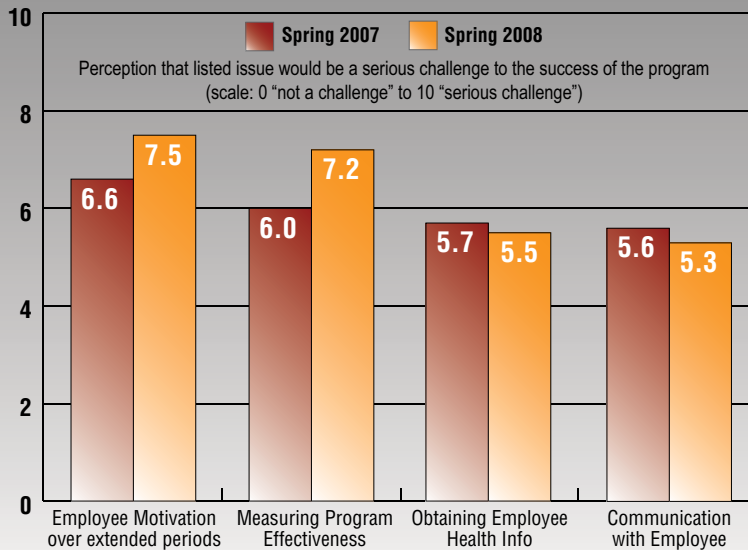
Key challenges for employers over both years, and closely ranked, were (1) employee motivation over extended periods of time and (2) measuring program effectiveness. Among the group representing employers without programs, the most serious challenge in 2008 (rating = 8.0) was “measuring program effectiveness.” These employers also ranked “obtaining employee health information” as a more serious challenge than their counterparts with programs.

Key Finding:

“Maintaining employee motivation over time” and “measuring program effectiveness” remain key challenges.

These were cited as the top challenges by employers with health and wellness programs in both 2007 and 2008.

Chart 14.
Biggest Challenges Employers Offering Health & Wellness Programs Face



Source: 2007 and 2008 Spring Surveys of NAM and ERIC membership (respondant N 2007=83; respondant N 2008=123)

²² In 2008, four challenges were presented to be rated on a 10-point scale. The results for those respondents representing employers with programs are provided in Chart 14.

CONCLUSION

Although health care cost increases are moderating, U.S. employers still face annual increases that impact both profits and their ability to compete in a global marketplace. On the productivity front, election-year public awareness campaigns underscore a national chronic disease crisis characterized as a threat to the nation's economy and health. U.S. employers recognize the connection between an aging workforce, rates of chronic disease and the corresponding costs of absenteeism, presenteeism and health care claims costs. The effective use of health & wellness and disease management programs as a tool to manage the risk for chronic disease and lower overall health care costs has become an appealing approach. **Moreover, the use of incentives in health & wellness programs is on the rise.**

Considerable expertise and experience in the use of incentives—or the science of incentives management—is emerging as a valuable commodity in the marketplace. As incentives take their place as a vital component of successful health & wellness programs, incentives intelligence—when to use incentives, how much and what kind of incentive—becomes part of the formula for positive ROI. The intelligent use of incentives will demand continuing exploration and refinement. **Incentive amounts vary widely, but average between \$100 and \$300 per person per year. Today, most employers reward participation and program completion, with 16 percent offering incentives for achieving program goals.**

One question raised by the survey findings is why employer interest in disease management programs has reached a plateau while health & wellness programs continue to gain popularity. An answer may be the rise of integrated health and productivity management programs that apply across the continuum of health risks. By integrating chronic care management into the population health management spectrum, employers may not perceive disease management as a separate program to consider for the purposes of the survey. This would reflect the significant shift in the market towards a person-centric approach to health management in contrast to the condition/disease or health behavior focus that was the previous norm.

As the market continues to evolve, we can certainly expect employers to keep a sharp eye on the bottom line—successful programs should effectively lower overall health care costs. **Of those who have measured health & wellness program outcomes, better than 1:1 ROI is not only expected, but has been achieved by a remarkable 83 percent. Other common program measures focus on engagement in health risk assessment /program participation, as well as the reduction of specific health risks.**

Employers remain concerned about the ability to motivate employees over time and the lack of standardized methodologies that can be easily applied to measure program outcomes and ROI. Opportunities for further research include a more robust analysis of program measures, outcomes and employee behavior change strategies.

We anticipate that the **science of incentives** - when, how much and what kind - will likely grow more important in the coming years. The intelligent use of incentives as a tool to overcome program challenges of employee engagement and motivation will continue to be of interest to employers as they balance the cost of programs with their investment return over time.

APPENDIX A: RESEARCH METHODS

The membership of NAM and ERIC were surveyed during late April and early May 2008 using a Web-based survey tool. The survey was an annual follow-up to a survey first conducted during the spring of 2007.

Questionnaire - The survey questions asked the members to report on the health & wellness and disease management programs offered by the represented employers and the extent to which incentives were used with the programs. The members were also asked to provide their perception concerning the cost-effectiveness of the use of incentives. The 2008 survey was redesigned to provide more explicit information about health & wellness and disease management programs. However, many questions remained the same so that comparisons could be made with the 2007 survey. The survey was estimated to take about 15 minutes to complete.

The survey solicitation - An e-mail solicitation was sent April 28 from the two associations to their membership asking the members to participate in the Web survey. A follow-up solicitation was sent out about a week later and a final solicitation was emailed four days after the second solicitation. A small number of phone calls to non-respondents were made May 12 and 13, and the survey Web portal closed May 14.

The e-mail solicitation offered a \$10 gift card and a chance to win a gift card valued at \$250 as incentive to complete the survey. In addition, respondents were offered access to a report summarizing the results of the survey.

Survey response - There were 281 respondents to the survey, representing 225 different companies.

Survey respondents

In 2008, respondents who were not sufficiently informed to respond capably to the survey were eliminated through questionnaire logic branches that led them to an early termination of the survey.

All respondents were asked the first substantive question: whether their company or organization offered disease management or health & wellness programs. They were then all asked their role in selecting programs for the company. After the “selection role” question, six respondents who did not know whether the company they represented had programs were branched to a termination page.

Of the 281 original respondents, 54 said “no” to the question of whether the company they represented offered programs (of this group, 15 indicated in the next question that they had no role in selecting programs). The entire group of 54 was then branched to the “no programs” question series, which began with whether the respondent’s company planned to offer programs in the future. The 24 respondents who said “no” or “don’t know” to the “planned to offer” question were terminated from further questions, leaving a group of 30 who answered questions concerning their perceptions about challenges to health & wellness and disease management programs and their expectations concerning return on investment for the use of incentives. These 30 individuals represented 27 different organizations or companies (employers).

Among those respondents indicating their company or organization offered health & wellness or disease management programs, all were asked their role in program selection and then all were branched to the series of questions for respondents in companies with programs. Those respondents with active programs were asked whether they managed the programs or were in any way involved in the programs. Those respondents who indicated they were not involved in any way (49 of 223 who had been branched to the section for respondents representing companies with programs) were then terminated, leaving 174 respondents to continue with the survey. However, at this point, another

four voluntarily terminated, leaving 170 respondents to answer the series of questions for respondents representing employers with active health & wellness or disease management programs. These 170 respondents represented 143 different employers.

Thus, of the 84 respondents who were terminated early, all but five were terminated because they had no role in selecting or no involvement at all in health & wellness or disease management programs. They were members of one of the two associations, but not appropriate responders to the survey.

Company as unit of analysis

The employer represented by the respondent, rather than the individual respondent, was the unit of analysis. Individual respondent's results were assigned a weight of $1/n$, where n was the number of respondents from the same company. Thus, an individual who is the sole respondent from a given company would be given a weight of 1, and a respondent from a company in which there were four other respondents would be given a weight of $1/5$ or 0.2.

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