Improve Employee Wellness
Speaker Information

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State of Health in the U.S.

- US health care spending was $2.9 trillion in 2013. An estimated 75% of the $2.9 trillion (i.e., $2.2 trillion) is spent each year on medical care for chronic illnesses that are preventable (i.e., the illnesses are a function of avoidable behavior including obesity, poor diet, smoking, lack of physical activity)
  
  Source: Institute of Medicine

- 63% have not seen a doctor in more than 5 years

- 58% percent of employees have an undiagnosed or untreated chronic condition

- There are 8 risks and behaviors (poor diet, physical inactivity, smoking, lack of health screening, etc.) that drive 15 chronic conditions (i.e. diabetes, coronary disease, back pain, etc.) which account for 80% of the total costs for all chronic illnesses worldwide
  
  Source: 2012 Aon Hewitt Health Care Survey
## Benefits of a Wellness Program

### Employer Benefits

- Increase operating efficiency by increased employee productivity
  - Improved performance
  - Decreased sick days
  - Decreased leaves of absence
  - Reduce medical, disability & worker’s compensation claims costs
  - Lower overall health insurance benefit expenses (vs. trend)
  - Ability to retain and recruit quality employees

### Employee Benefits

- Awareness of “lifestyle diseases” & the direct correlation to health care costs
  - Health maintenance & disease prevention
  - Improve health & disease management
  - Improved medication adherence
  - Lower insurance premiums
  - Decrease out-of-pocket expenses
  - Improve quality of life
Traditional Wellness Has Failed

• Despite the popularity and prevalence of employee wellness programs, we are not getting healthier.
Prevalence of Obesity and Diagnosed Diabetes Among US Adults

Obesity (BMI ≥30 kg/m²)

1994

2000

2013

Diabetes

1994

2000

2013

You Don’t Know
What You Don’t Know

<table>
<thead>
<tr>
<th>Diabetes</th>
<th>Claims information</th>
<th>HRA Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• 50 have claims with a diagnosis suggesting diabetes</td>
<td>• 111 with glucose in diabetic range</td>
</tr>
<tr>
<td></td>
<td>or pre-diabetes</td>
<td>• 580 with glucose in pre-diabetic range</td>
</tr>
<tr>
<td></td>
<td>• 50 have claims with a diagnosis suggesting diabetes</td>
<td>• 549 individuals with elevated systolic</td>
</tr>
<tr>
<td></td>
<td>or pre-diabetes</td>
<td>and diastolic blood pressure readings</td>
</tr>
<tr>
<td>Hypertension</td>
<td>• 78 have claims with a diagnosis suggesting hypertension</td>
<td>• 815 with elevated cholesterol</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>• 98 individuals have claims with a diagnosis</td>
<td>• 883 with BMI readings &gt; 30, of which 396 (44.8%)</td>
</tr>
<tr>
<td>Risk</td>
<td>suggesting being at risk of a heart attack</td>
<td>are also pre-diabetic</td>
</tr>
</tbody>
</table>

N = 1750, mfg firm
What is needed?

• Need to improve the overall health of employees which will in turn reduce the long-term cost of healthcare for employer

• Need accountability, measurable goals and tracked outcomes to ensure success

• Continuing to shift costs onto employees is an unsustainable solution that does not focus on the core of the problem. The problem is HEALTH, and more specifically health risks in the employee population.
Wellness Industry Terms

Two Program Categories:

1. Participatory (attending a nutrition class)
2. Health Contingent
   - Activity–Based (fitness challenge, weight loss competition)
   - Outcomes–Based (achieving specific criteria for health factor)
## Participation vs. Outcome-Based

<table>
<thead>
<tr>
<th>Participation-Based</th>
<th>Outcome-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduced 20+ years ago</td>
<td>Introduced in 2001</td>
</tr>
<tr>
<td>Incentives/penalties for participation/nonparticipation</td>
<td>Incentives/penalties for health results (i.e. blood pressure, cholesterol, BMI)</td>
</tr>
<tr>
<td>No true accountability</td>
<td>Accountability for health, alternatives required</td>
</tr>
<tr>
<td>No limits for financial incentives (<em>yet – pending EEOC proposal</em>)</td>
<td>May not exceed 30% of total cost of coverage</td>
</tr>
<tr>
<td>Average 10-50% participation</td>
<td>Average 70-90% participation</td>
</tr>
</tbody>
</table>
Outcome-Based Programs Gaining Popularity

bSwift – 5th Annual Benchmarking Study

- Nearly 25% of employers with wellness programs now provide outcomes-based incentives for employees who meet or exceed biometric thresholds

- *Almost half* are considering this approach for 2015

N=388 benefits decision-makers at organizations (of 50+ employees)
7 Key Considerations

- Current culture of organization
- Objective data collection
- Scoring methodology for “outcome”
- Carrier independence
- Flexible and effective incentive design
- Ongoing support for behavior change
- Data analytics, risk migration and claims analysis reporting
Current Culture

- Employee morale?
  - Positive, happy
  - Negative, toxic

- Trusting of leadership?

- Communication?

- Current wellness program?
Use of Objective Data

- Objective measurement is key to success
  - Set baseline
  - Track trends
  - Real information, not a guess

- Venipuncture biometric screening
  - Accurate data points to measure over time
  - Participants don’t “know their numbers”
  - More flexibility in test panels
  - Uncover hidden risks
Scoring Methodology

• Select health criteria that can be modified by a combination of lifestyle-related behaviors and/or chronic condition management (medication)

• Examples:
  o Body Mass Index, Waist Circumference
  o Blood Pressure
  o Lipid Panel (total cholesterol, LDL, HDL, triglycerides)
  o Glucose
  o Nicotine
Types of Scoring Models – Bucket/Non-Tiered

- “Bucket” & Non-Tiered Scoring Models
  - Pass/fail & non-tiered models can be complicated
  - Higher level of variability among risk categories (i.e. only 3 risk categories) can lead to imbalances
  - Assigns points based on achieving a predetermined set of ideal health standards (National Institute of Health)
  - Allow self reported information into health score; leads to reporting inaccuracies (i.e. tobacco use)
Types of Scoring Models – Objective Tiered

• Objective Tiered Score-Based
  – Uses only objective biometric data to formulate health score; no self reported information
  – Translates lab values into a score that is correlative to health risk factors
  – Sliding point scale using only objective biometric measures results in capturing health risks holistically and rewards participants for health progress
Some scoring models overestimate health

<table>
<thead>
<tr>
<th>Person A</th>
<th>Person B</th>
</tr>
</thead>
<tbody>
<tr>
<td>• BMI 40.8</td>
<td>• BMI 28.1</td>
</tr>
<tr>
<td>• Glucose 338</td>
<td>• Glucose 90</td>
</tr>
<tr>
<td>• Blood Pressure 122/70</td>
<td>• Blood Pressure 100/68</td>
</tr>
<tr>
<td>• LDL 116</td>
<td>• LDL 183</td>
</tr>
<tr>
<td>• Non Smoker</td>
<td>• Non Smoker</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bucket Model Score</th>
<th>3/5</th>
<th>3/5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Algorithm Score</td>
<td>54/100</td>
<td>86/100</td>
</tr>
</tbody>
</table>
Provide Clear-Cut Scoring for Participants

Scoring Model should be:

- Transparent to participant
- Balanced across all major cost drivers
- Designed to reward positive change across health spectrum
- Easily understood
Is the Algorithm Correlated to Cost?

Health Score Correlation to Claims

- Ideal (85+)
  - $3,474.83
- Low Risk (71-84)
  - $3,980.86
- Moderate Risk (61-70)
  - $4,460.83
- High Risk (≤60)
  - $5,417.24

Equation: $y = 2978.7e^{0.146x}$

$R^2 = 0.987$
Carrier Independence

Consider the following with carrier programs:

• Do you want to share proactive risk data with risk bearer?
• Will you be able to keep program consistent over time, if desired?
• As an employer, will you be able to own/keep your data if you decide to switch programs/vendors?
• Will you have flexibility in your program/incentive design?
Meaningful Incentives/Disincentives

Direct Correlation Between Value and Participation

• Results for completion of Health Screening show a direct correlation between incentive value and participation.
Effective Incentive Design

• Various studies show that 85% of people are wired to not change unless there are consequences

• Myth: People won’t change

• Reality:
  – Seat belt use 30 years ago compared to today
  – Drunk driving 30 years ago compared to today
  – Worksite/Job safety 30 years ago compared to today
Incentive Structure – Example

Year 1 – Participation-based
- Increase contribution rates by $25 per month for all covered employees
- Offer employees $25 per month discount for participating in program
- Participants find out their “score”

Year 2 – Outcome-based
- Non-participants pay standard rate
- Offer $10 per month discount for repeat participants (participation incentive)
- Offer additional $15 per month discount for repeat participants who:
  - Achieve/maintain a high level of health
  - Improve by certain number of points
  - Or successful completion of Reasonable Alternative Standard
Ongoing Support for Behavior Change

**Personal Intervention**

- **Online Health Portal** (Web & App)
  - Health/Wellness content
  - Activity/ Nutrition Tracking tools

- **Targeted Communications**
  - Focus on personal risk factors
  - Reward positive change

- **Coaching/Medical Management**
  - Health Coaching
  - Disease Management
  - Case Management

**Group Programming**

- **Communication campaign**
  - Marketing to drive participation
  - Ensure understanding of available programs
  - Effectively communicate incentives

- **Education Campaign**
  - Monthly Newsletter
  - Tips of the day, Weekly Blogs
  - Lunch & Learns

- **Activity Programming**
  - Weight loss challenges
  - Fitness programs
  - Point based initiatives

**Activity/ Nutrition Tracking tools**
Data Driven Support

DATA
- Biometrics
- HRA Response
- Demographics
- Claims

STRATIFICATION
- Ideal
- Low
- Moderate
- High
- Very High Risk

ENGAGEMENT
- Communications
- Technology
- Health Coaching
- Medical Management
Offer Multiple Methods
Aggregate Reporting

- Participation
  - Track participation by employee/dependent, location, and/or job codes
  - Goal: 70% participation (minimum)

- Program Engagement
  - Track activity in health coaching, online utilization of sites, goal tracking, classes and challenges to determine outcomes and impact

- Health Risk Analysis and Migration
  - Break out specific risk factors and risk category to track annually

- Claims Analysis and Impact
Claims Experience Correlated to Score

Medical & Rx Paid Claims

- Ideal (85+)
  - $4,229.58

- Low Risk (71-84)
  - $6,391.89

- Moderate Risk (61-70)
  - $7,826.56

- High/Very High Risk (<60)
  - $10,214.99

Risk Levels:
- Ideal (85+)
- Low Risk (71-84)
- Moderate Risk (61-70)
- High/Very High Risk (<60)
Medical Claims Correlation to Glucose

<table>
<thead>
<tr>
<th>Glucose Level</th>
<th>Medical Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideal (&lt;100)</td>
<td>$1,623.90</td>
</tr>
<tr>
<td>Moderate Risk (100-125)</td>
<td>$2,310.59</td>
</tr>
<tr>
<td>Very High Risk (&gt;=126)</td>
<td>$4,256.70</td>
</tr>
</tbody>
</table>
Bridging the Gap to Workers Compensation

• It made sense in the past when overall health care costs were a small component of organizational spending to keep the occupational and non-occupational nature of the claims separate.

• Lower direct health care and less lost time equal improved profit, as does greater employee productivity and morale.

• Combining safety and wellness efforts strengthens efficiencies and drives greater profit improvement.

• Multiple studies illustrate health risk factors and their influence on workers’ comp claims.
Workers Comp & Comorbidities

- Comorbidities = pre-existing conditions that in addition to a workers’ comp injury or occupational disease could hinder an employee’s recovery.

- Workers comp claims with a comorbidity have about twice the medical costs of otherwise comparable claims.

- WC claims with a comorbidity diagnosis are more likely than the average claim to be lost-time.
Workers’ Compensation Cost Drivers

Claims with a Comorbidity Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Lost Time</th>
<th>Medical-Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Claims</td>
<td>19%</td>
<td>81%</td>
</tr>
<tr>
<td>Obesity</td>
<td>19%</td>
<td>81%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>55%</td>
<td>45%</td>
</tr>
<tr>
<td>Chronic Pulmonary</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>56%</td>
<td>44%</td>
</tr>
</tbody>
</table>

Source: Comorbidities in Workers Compensation, NCCI Research Brief, October 2012
2,000 EE manufacturing and distribution company – Significant correlation in high health risk levels and workers compensation expense.
Workers Comp Claims Correlation to BMI

- Low (18.5-29.9)
  - $1,362.82
- Moderate/High Risk (30-39.9)
  - $4,747.37
- Very High Risk (40+)
  - $7,965.90
Implementation Process

Partner with a vendor that will provide and manage the program:

- Overall implementation timeframe
- Training your internal team
- Employee communication
- Biometric screenings & assessments
- Ongoing programming & communication
- Confidential incentive eligibility reporting
- Reasonable alternative management
- Aggregate reporting
- Advise on program design to be compliant with HIPAA, ACA and possibly EEOC
Review: 7 Key Considerations

- Current culture of organization
- Objective data collection
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Questions?

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Reminders for Wednesday October 21st

Remember to visit the Exhibit Hall!
Located in Hall C
10:30 AM – 5:00 PM

The Metal Engineering Expo Evening Event at the NASCAR Hall of Fame
Located at the NASCAR Hall of Fame
6:30 PM – 9:30 PM
(Tickets Required)