Fundamentals of Employee Benefit Programs

Part Three Health Benefits
Chapter 24
Health Promotion and Disease Management Programs

Introduction

Employers and employment-based group health plans use a variety of tools to manage the utilization of health care services and to control health care costs. In recent decades, employers have looked to managed care to help control costs. Along with negotiating reduced prices for health care services, managed care promised to focus on preventive care and managing demand for services by keeping members healthy. Through active management of group plan members’ health and disease, managed care aims to reduce costs by preventing unnecessary utilization of health care services.

The purpose of managing demand for health care services is to lower expenditures on health care by reducing utilization through disease prevention and self-care medical programs (Fronstin, 1996). Various health management tools have been developed as a result of this effort, including health promotion and disease management. These tools are examples of preventive services. Employment-based group health plans generally include three levels of prevention activities, each of which responds to the needs of specifically targeted beneficiaries:

- **Primary prevention**—activities are directed at all healthy plan beneficiaries with the goal of stopping the occurrence of disease before it starts. Primary prevention reduces the likelihood that individuals who do not have a specific disease will develop it in the future, e.g., routine immunizations of healthy children.

- **Secondary prevention**—activities target health plan beneficiaries who are at high risk of disease but who lack symptoms. Some examples include PSA tests to detect early forms of prostate cancer, mammograms to detect early forms of breast cancer, smoking cessation programs for smokers without any current disease, and weight loss programs for obese individuals without any current disease. Employee assistance programs (EAPs) are common secondary prevention programs that group health plans use to address employees’ physical and mental health. (See chapter on EAPs).

- **Tertiary prevention**—directs services to symptomatic patients in order to reduce the negative consequences of their diseases. For example, it attempts to decrease the complications or severity of diabetes by care-
fully managing this condition in order to prevent vision, kidney, and nerve problems, and it offers smoking cessation programs for people with asthma.

This chapter focuses on two types of programs that relate to all three levels of prevention: health promotion programs and disease management programs.

**Health Promotion Programs**

Health promotion programs, also called wellness plans, emphasize prevention of physical and mental illness by using self-care and targeted strategies to encourage healthy lifestyles. Employment-based programs may be offered directly by the employer, through either an in-house or outside vendor or through an employment-based group health plan. Employers and health plans that offer health promotion activities and programs hope to motivate and educate employees to live healthy lives as well as provide opportunities for them to participate in healthy activities. Employers and health plans hope that by initiating these programs they will increase productivity and morale, reduce absenteeism and turnover, and manage health care costs.

The major lifestyle behaviors targeted by health promotion programs include smoking, nutrition, exercise, and stress. Health promotion programs range from modest efforts (e.g., the distribution of pamphlets on health issues or the provision of showers or changing facilities for employees who exercise) to individually targeted strategies for intervention and health improvement to major initiatives such as elaborate, well-equipped gymnasiums and a full package of physical fitness activities. Employers and health plans increasingly are using Internet and Intranet strategies to deliver health promotion programs. These may offer a cost-effective alternative to traditional approaches to communication, health assessment, and education (Hewitt Associates LLC, 2001a).

**Objectives**—Work-site health promotion and wellness plans often have several objectives, including improving and sustaining employees’ health, increasing worker productivity, recruiting and retaining good employees, improving employee morale, reducing absenteeism due to illness, and reducing health care costs (Harris and Fries, 2002). The 1999 National Worksite Health Promotion Survey, conducted by the Association for Worksite Health Promotion (AWHP), William M. Mercer, Inc., and the U.S. Department of Health and Human Services’ Office of Disease Prevention and Health Promotion (ODPHP) found the most common reason that employment-based group health plans sponsored these programs was to keep workers healthy (84 percent). Other reasons included improving employee morale
(77 percent), reducing health care costs (76 percent), and retaining good employees (75 percent) (Association for Worksite Health Promotion et al., 2000).

The Wellness Councils of America, a membership support organization for companies with wellness plans, lists six reasons for work-site wellness programs: (1) rising health care costs; (2) the prevalence of avoidable illnesses; (3) the expanding work week; (4) the technology revolution; (5) increased employee stress levels; and (6) increased work force diversity.

Prevalence of Health Promotion Programs—Ninety-three percent of very large companies offered some kind of health promotion program in 2001, up from 88 percent in 1995 (Hewitt Associates LLC, 2001b). Of work sites with 50 or more employees, 90 percent sponsored at least one health-promoting activity in 1999. When programs offered through the companies’ health plans were included, 95 percent of work sites offered some type of health promotion (Association for Worksite Health Promotion et al., 2000). Eighty-six percent of work sites with 50–99 employees offered at least one activity, while 98 percent of work sites with 750 or more employees did so (O’Donnell, 2002).

Using a definition of “health promotion program” that counted programs rather than activities, and did not include casual or sporadic attempts to inform or educate employees, 25 percent of small employers (15–99 employees) and 44 percent of larger employers offered health promotion programs (Wilson et al., 1999).

Impact and Effectiveness—The available data on the effectiveness of work site health promotion programs, while hindered by important methodological challenges, show a positive impact on employee health status, medical care costs, and key business efficiency measures such as absenteeism (Christensen, 2001). According to the 1999 National Worksite Health Promotion Survey, more than 50 percent of work sites have been able to demonstrate a return on their health promotion investment acceptable to senior management (Association for Worksite Health Promotion et al., 2000).

Employers cite various barriers and challenges to work site health promotion programs, including lack of employee interest (cited by 50 percent of work sites), lack of high-risk employee participation (39 percent), and inadequate resources (37 percent). Other challenges include tracking outcomes, management support, integration of programs, access to data, and confidentiality (Association for Worksite Health Promotion et al., 2000).

Incentives—Employers use a variety of incentives to encourage employee participation in health promotion programs. Some employers allow employees to use company time to participate in these programs (72 percent of work sites allow this) and/or allow the use of flex-time (45 percent) (U.S.
Department of Health and Human Services, 1993). Others pay a portion of the cost for employees to attend outside clinics to stop smoking or pay a higher percentage of medical expenses for employees who do not smoke or who regularly participate in an exercise program. Others set up competitions among employees, with prizes awarded to winners, or offer bonuses to employees who complete a specified number of hours of exercise. In some other cases, however, employees must pay a fee to participate in certain programs.

Some employers offer financial incentives for employees to participate in health promotion programs or to modify their health risks. Examples of these incentives include discounted health plan premiums and monetary bonuses. In 2001, 42 percent of very large firms offered programs with financial incentives or disincentives in their benefit plan designs (Hewitt Associates LLC, 2001b). Among work sites with 50 or more employees, only 10 percent offered a financial incentive to encourage employees to participate in health-promoting activities (Association for Worksite Health Promotion et al., 2000). Certain financial incentives for participating in wellness plans are regulated by the nondiscrimination requirements of the Health Insurance Portability and Accountability Act (HIPAA) (See chapter on HIPAA).

**Disease Management Programs**

In addition to keeping employees healthy and preventing the onset of illnesses, employers and employment-based group health plans seek to prevent acute complications of chronic diseases among employees or members who have already been diagnosed. Through a process commonly referred to as disease management (DM), employers and health plans aim to reduce costs by guiding the patient in effectively navigating the complex medical care system, avoiding unnecessary utilization of health care services, and providing early and ongoing treatment. DM offers the possibility of saving money while improving health by reducing employees’ need for expensive hospitalizations and other health treatments (Christensen, 2002).

DM is defined as a systematic approach to coordinated health care that seeks to identify individuals within populations who have—or are at risk of developing—certain targeted, mainly chronic, medical conditions such as diabetes, asthma, cardiovascular conditions, and depression. DM programs vary in the range of diseases targeted. A program may focus entirely on one condition or on a few specific diseases, such as asthma and/or diabetes. Or a program may manage the total health of persons with chronic conditions, since they often have comorbidities (i.e., more than one condition). Other programs focus more generally on the health of a population, in order to manage the health of current chronic disease sufferers and to prevent...
the onset of illness in members who are at high risk of developing chronic diseases.

DM supports the physician- or practitioner-patient relationship and course of treatment and emphasizes prevention of acute episodes and complications, utilizing evidence-based practice guidelines and patient empowerment strategies. DM is a proactive approach to treating chronically ill patients that places a heavy emphasis on educating patients and providers, promoting patient self-management, and building clinical support systems to aid providers.

The Disease Management Association of America (DMAA) identifies the necessary characteristics of a full-service disease management program as: (1) population identification processes; (2) evidence-based practice guidelines; (3) collaborative practice models to include physician and support-service providers; (4) patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance); (5) process and outcomes measurement, evaluation, and management; and (6) routine reporting/feedback loop (may include communication with patient, physician, and ancillary providers, and practice profiling).

The intensity of DM programs varies greatly, despite the comprehensive definition and program components endorsed by the DMAA. The Association uses the term Disease Management Support Services for programs that consist of fewer than all six of the components; however, in practice, programs of varying intensity routinely are labeled as DM programs. For example, one program may involve the simple provision of written materials on specific conditions or on-line health content, while another may provide intensive monitoring and management of the condition by health professionals. Some DM programs utilize electronic remote monitoring via computers or other devices. Increasing use of technology in health care is making it easier to manage disease from a distance. Some DM programs also conduct group activities for participants with the same condition.

DM programs may be owned and administered by various types of entities, including DM vendors that operate independently, health maintenance organization (HMO) and preferred provider organization (PPO) health plans, hospitals, pharmaceutical companies, and pharmacy benefit managers (PBMs).

Objectives—In light of the great expense involved in caring for persons with chronic illnesses, and in order to improve their health and quality of life, efforts are made to manage these illnesses rather than treating the periodic acute episodes of an unmanaged condition. Employer respondents to a survey conducted by Aon Corporation in 2000 ranked the reasons for using DM: (1) reduce health care costs; (2) improve clinical outcomes; (3) enhance
employee satisfaction; (4) reduce disability costs; (5) increase worker productivity; and (6) retain workers (Aon Corporation, 2000).

**Prevalence of Disease Management Programs**—Advances in technology contribute to the growth in DM programs. Technologies are essential to the identification of candidates for DM programs, measurement of the programs’ performance, and the operation of the programs. Internet and telephony devices allow participants in DM programs to transmit information, questions, and evaluations to care providers or medical databases. DM participants also have easier access to medical information at any time of day via the Internet or telephone. DM participants also may be able to utilize chat rooms, bulletin boards, and e-mail to communicate with care providers and others in the same programs. Some suggest that the cost savings associated with using such technologies will be so dramatic that in the future, when the technologies cost less, group health plans may provide DM participants with free computers as part of the DM program.

In 2001, 76 percent of very large employers provided DM programs to their employees. The vast majority of these programs were a function of, or were included in, the employer’s health plan. Very few were provided by an independent DM company contracting directly with the employer (Hewitt Associates LLC, 2002). Also, 20 percent of employers were adding disease management programs in 2002 in order to help control health care costs (Aon Corporation, 2002).

Data from the 1999 National Worksite Health Promotion Survey show that DM programs have become more prevalent, and that more employers plan to implement these types of programs in the near future. Among work sites with 50 or more employees, 42 percent offered programs for depression management, 35 percent for hypertension, 34 percent for cancer, 34 percent for diabetes, 33 percent for cardiovascular conditions, 27 percent for asthma, and 25 percent for obesity. For all types of programs included in the survey, employers expected to add more programs. By 2004, a majority of employment-based group health plans were expected to have DM programs for depression, hypertension, cancer, and diabetes. The responses indicate that much growth can be expected in DM programs: Less than 1 percent of employers said they would stop offering programs they currently offer. Also, among the work sites that intended to start new programs for managing chronic diseases, the majority said they would likely offer the programs through their group health plans, rather than directly at the work site (Association for Worksite Health Promotion et al., 2000).

In another survey, three-fourths (75 percent) of the responding employers provided some type of health promotion or wellness program to their employees—to encourage healthy behaviors and nearly all respondents (97 percent) thought DM could complement health promotion or wellness
services (Aon Corporation, 2000). However, this survey also found that
43 percent of employers were concerned about the confidentiality of the
health information collected and used by DM programs and were hesitant to
implement DM because of these concerns. (The applicability and impact of
HIPAA privacy regulations on a particular DM program will depend on what
type of entity administers the program and on the services the program
provides.

**Impact and Effectiveness**—Research and case studies show positive
results from individual DM programs, but there is no conclusive evidence
that DM programs, in general, improve health or reduce costs in the long
term. Improved health and cost-effectiveness may take from several months
to a few years to become apparent in a DM program, and it would be difficult
to prove that particular health outcomes were the result of a DM program.
However, many employers and health plans have experienced improved
health and decreased costs as a result of their programs, and growing
numbers of employers are convinced that DM will help save money and are
implementing the programs.

In a survey of very large employers, nearly half of employers with DM
programs (47 percent) reported that the programs were too new to assess
outcomes or return on investment (ROI). Only 10 percent reported being
able to calculate or prove the ROI for their DM programs, and only about
one-fourth reported having outcome reports for their programs (Hewitt
Associates LLC, 2002).

In an effort to simplify the evaluation and selection of DM programs,
work is under way to standardize the measurement of DM outcomes and
returns on investment (Lewis, 2002). Three organizations known for advanc-
ing quality of care have begun accrediting DM programs: URAC (also known
as the American Accreditation HealthCare Commission); The National
Committee for Quality Assurance (NCQA); and The Joint Commission for
the Accreditation of Healthcare Organizations (JCAHO). Accreditation
reviews generally evaluate the programs in such areas as organizational
structure, program scope and objectives, performance and quality mea-
urement, and program design. These standards and the subsequent
accreditation of programs that meet them promise to aid employers in evalu-
ating and selecting quality DM programs. Some DM program providers also
take on financial risk by guaranteeing the purchaser improved participant
health and a certain level of savings.

**Conclusion**

Various analyses and case studies show positive impacts of health
promotion programs and disease management programs, including improved
employee health and financial savings. Companies continue to collect data to assess the impact of their own programs. To establish whether these programs can be credited with health care cost savings, employers and researchers must track a large number of employees over a long period of time. Regardless of the results, many employers believe that the mere existence of these programs is beneficial in that they demonstrate employers’ concern for their employees and the value that they place on employees’ well-being and good health.

**Bibliography**


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Additional Information

Disease Management Association of America
1129 20th St., NW, Suite 850
Washington, DC 20036
(202) 861-1490
www.dmaa.org

National Committee for Quality Assurance (NCQA)
2000 L Street, NW, Suite 500
Washington, DC 20036
(202) 955-3500
www.ncqa.org

National Wellness Institute, Inc.
1300 College Court
PO Box 827
Stevens Point, WI 54481
(715) 342-2969 or (800) 243-8694
www.nationalwellness.org
University of Michigan  
Health Management Research Center  
1027 East Huron Street  
Ann Arbor, MI  48104  
(734) 763-2462  
www.umich.edu/~hmrc

URAC — American Accreditation HealthCare Commission  
1275 K Street, NW, Suite 1100  
Washington, DC 20005  
(202) 216-9010  
www.urac.org

U.S. Department of Health and Human Services  
Centers for Disease Control and Prevention  
National Center for Chronic Disease Prevention and Health Promotion  
4770 Buford Highway, NE, Atlanta, GA 30341  
(770) 488-5706  
www.cdc.gov/nccdphp/index.htm

U.S. Department of Health and Human Services  
Office of Disease Prevention and Health Promotion  
Office of Public Health and Science, Office of the Secretary  
200 Independence Avenue, SW, Room 738G  
Washington, DC 20201  
(202) 401-6295  
www.odphp.osophs.dhhs.gov

WELCOA — The Wellness Councils of America  
9802 Nicholas St., Suite 315  
Omaha, NE 68114  
(402) 827-3590  
www.welcoa.org