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Moving Beyond "Wellness Does Not Work"

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Moving Beyond “Wellness Does Not Work”

Dennis G. Shea,[†] Ph.D., Dennis Scanlon,^{††} Ph.D.

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Introduction

On July 11, 2013, Pennsylvania State University (“Penn State”) announced planned changes to its employee-health-benefits program called the “Take Care of Your Health” initiative (“Take Care”).¹ The initiative was the first component of a larger plan to change health benefits at Penn State.² Take Care included three components and required employees to comply with all three parts in order for employees to avoid a one-hundred-dollar-per-month penalty in the form of a payroll-deducted premium surcharge.³ Under Take Care, employees were required to complete an online health-risk appraisal (“HRA”) managed by WebMD, schedule and provide documentation of an annual preventive-health exam with a licensed healthcare provider, and complete a biometric-testing battery. The biometric testing battery included invasive procedures and questions,

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1. L. Reider Jensen, ‘Take Care of Your Health’ Initiative Announced Ahead of Open Enrollment, PENN STATE NEWS (Jul. 11, 2013), <http://news.psu.edu/story/281346/2013/07/11/administration/%E2%80%98tak e-care-your-health%E2%80%99-initiative-announced-ahead-open>.

2. See *id.* (explaining that Take Care of Your Health Initiative was a program to prepare employees and their families for open enrollment in 2014).

3. Jill Shockey & L. Reider Jensen, *Benefits changes focus on employee wellness, long-term cost savings*, PENN STATE NEWS (last updated Aug. 22, 2013), <http://news.psu.edu/story/282659/2013/07/25/administration/benefits-changes-focus-employee-wellness-long-term-cost>.

requiring blood-cholesterol and blood-glucose monitoring, blood-pressure screening, and measurement of body-mass index and waist circumference.⁴ In addition, the university announced changes to its policy on spousal or same-sex domestic partner ("SSDP") eligibility for health insurance benefits.⁵ The university required partners to pay a one-hundred dollar-per-month premium surcharge to remain on Penn State's coverage if they had access to health insurance through their own employers.⁶ The University also planned a tobacco-use surcharge of seventy-five dollars per month.⁷

The announcement occurred during the summer months,⁸ a period when many faculty and staff are not on campus; however, several Penn State faculty began to voice strong negative reactions that were amplified by national press attention.⁹ Fewer than seventy days later, Penn State suspended the surcharge in response to faculty and staff concerns and created a task force to "provide advice on the implementation of the program and on health benefits matters."¹⁰

While Penn State is not the first employer to implement a worksite-wellness program ("WWP"), the events we describe in more detail below and the subsequent significant national interest in its program offer a useful and illustrative case study for the promises and pitfalls of employer wellness initiatives. In this paper, we use the Penn State experience as a narrative to highlight some of the key issues with wellness initiatives. We first focus on the link between the growth of WWPs like Penn State's and the Affordable Care Act and its wellness incentives. We then discuss some of the challenging privacy issues raised during the Penn State discussions. We subsequently highlight the lack of evidence underlying Penn State's wellness programs, connecting the Penn State experience with research on other employers' efforts to use wellness as a means for improving employee health and reducing healthcare costs amid uncertain evidence. Finally, we conclude with some key future directions related to employers and wellness.

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4. Jensen, *supra* note 1; Natasha Singer, *Health Plan Penalty Ends At Penn State*, N.Y. TIMES (Sept. 18, 2013), <http://www.nytimes.com/2013/09/19/business/after-uproar-penn-state-suspends-penalty-fee-in-wellness-plan.html> (explaining that WebMD runs the online questionnaire form for the "Take Care of Your Health" Initiative).
 5. Shockey & Jensen, *supra* note 3.
 6. Shockey & Jensen, *supra* note 3.
 7. Shockey & Jensen, *supra* note 3.
 8. See Jensen, *supra* note 1; see also Shockey & Jensen, *supra* note 3.
 9. See Anna Wilde Mathews & Timothy W. Martin, *Penn State Workers Protest Wellness Plan*, WALL ST. J., Aug. 16, 2013, at B6.
 10. Lisa Powers & Annemarie Mountz, *Penn State Suspends Fee for Employees Who Don't Take Health Care Survey*, PENN STATE NEWS (Sep.18, 2013), <http://news.psu.edu/story/288132/2013/09/18/administration/penn-state-suspends-fee-employees-who-dont-take-health-care>.

I. The Affordable Care Act and Wellness Incentives

The passage of the Affordable Care Act of 2010 ("ACA")¹¹ established the framework for Penn State's Take Care initiative, since the law included specific provisions to promote wellness and to allow employers to offer penalties and incentives for participation in employer-sponsored health-benefits programs.¹² The ACA modified federal policy regarding employer wellness initiatives that had been previously created in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").¹³ Specifically, the ACA increased the size of the incentives and penalties tied to wellness programs allowed in an employer health plan from twenty percent of the cost of the plan to thirty percent of the cost of the plan.¹⁴ The ACA also increased the size of the incentives and penalties tied to employee participation in programs related to tobacco use to fifty percent of the plan's costs.¹⁵ Disability and privacy advocates raised significant questions during the discussions surrounding both the original federal regulations in HIPAA and the changes in the ACA.¹⁶ For example, the Center for Independence of the Disabled in New York, noting that the Office of Civil Rights in the United States Department of Health and Human Services had three hundred complaints regarding wellness programs, reviewed the wellness changes in the ACA and made recommendations for addressing these concerns.¹⁷

Despite concerns about discrimination and the potential loss of privacy, employers appear to be willing to implement and expand WWP's because they believe that the risks associated with doing so are balanced by the positive effects of wellness programs on employee health and employee

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11. Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).
 12. See Soeren Mattke et al, *A Review of the U.S. Workplace Wellness Market*, RAND CORPORATION 1, 5 (2012), available at <http://www.dol.gov/ebsa/pdf/workplacewellnessmarketreview2012.pdf>.
 13. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 26 CFR §54, 33158 (2013).
 14. *Id.* at 33167.
 15. *Id.* at 33167.
 16. See Kristin Madison, *The ACA, The ADA, And Wellness Program Incentives*, HEALTH AFF. BLOG (May 13, 2015), <http://healthaffairs.org/blog/2015/05/13/the-aca-the-ada-and-wellness-program-incentives/>; Kristin Madison et al., *Smoking, Obesity, Health Insurance, and Health Incentives in the Affordable Care Act*, 310 J. AM. MED. ASS'N 143, 143 (2013); see also NAT'L INST. OF HEALTH, *BEYOND THE HIPAA PRIVACY RULE: ENHANCING PRIVACY, IMPROVING HEALTH THROUGH RESEARCH* (Sharyl J. Nass et al. eds., 2009) (extensively discussing privacy issues concerning HIPAA).
 17. Heidi Siegfried, *The ACA, Wellness Programs, and People with Disabilities*, CTR. FOR INDEPENDENCE OF THE DISABLED (2014), <http://www.cidny.org/resources/Wellness%20Paper%20MRT%20Group%20final%202014.pdf>.

and employer healthcare costs.¹⁸ Penn State and its employees have faced significant increases in healthcare costs, and Penn State leaders described Take Care as part of the solution to these cost challenges.¹⁹ Penn State is not alone in implementing WWP to combat increases in health care costs; in fact, the expansion of wellness incentives in the ACA is also known as the Safeway Amendment because of the active role that Safeway's Chief Executive Officer played in advocating for the incentives and linking them to cost savings at his company.²⁰ Two months prior to the ACA's passage, a Washington Post article detailed skepticism about the evidence from Safeway's program, describing how the decline in employee costs occurred three years before wellness incentives were implemented at Safeway and actually rose faster than average healthcare costs nationwide in the year after Safeway implemented its wellness program.²¹ Nevertheless, the wellness incentives remained part of the ACA and the incentives that the ACA provides have resulted in significant growth in the wellness industry, as vendors market their services to employers with claims of cost savings while employers face increasing pressure to find solutions to growing costs.²²

Penn State and its third-party administrator, Highmark, planned to implement a comprehensive set of benefits changes for 2014 and communicated more detail to employees on July 25, 2013.²³ These benefit changes included the following features:

- (1) offering a qualified, high-deductible health plan including a health-savings account as an alternative to its traditional preferred-provider organization ("PPO") plan;

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18. Peggy Hannon et al., *Stakeholder Perspectives on Workplace Health Promotion: A Qualitative Study of Midsized Employers in Low-Wage Industries*, 27 AM. J. OF HEALTH PROMOTION 103, 18-109 (2012).
 19. Rodney A. Erickson, *President's Message Explains Health Care Benefits Changes at Penn State*, PENN STATE NEWS (Aug. 22, 2013), <http://news.psu.edu/story/283812/2013/08/09/administration/presidents-message-explains-health-care-benefits-changes-penn>.
 20. Brendan Borrell, *The Fairness of Health Insurance Incentives*, L.A. TIMES (Jan. 3, 2011), <http://articles.latimes.com/2011/jan/03/health/la-he-health-incentives-20110103>.
 21. David Hilzenrath, *Misleading Claims about Safeway Wellness Incentives Shape Health-Care Bill*, WASH. POST, Jan. 17, 2010 at G8.
 22. Vicky Valet, *More Than Two-Thirds of U.S. Employers Currently Offer Wellness Programs, Study Says*, FORBES (Jul. 8, 2015), <http://www.forbes.com/sites/vickyvalet/2015/07/08/more-than-two-thirds-of-u-s-employers-currently-offer-wellness-programs-study-says/#2965faf46c7b>.
 23. Jill Shockey & Reider L. Johnson, *Health Benefit Choices, Value-Based Design Offer Lower-Cost Options*, PENN STATE NEWS (last updated Aug. 22, 2013), <http://news.psu.edu/story/282685/2013/07/25/administration/health-benefit-choices-value-based-design-offer-lower-cost>.

(2) implementing a value-based benefit design option in the PPO plan, giving employees with high blood pressure, high cholesterol, or diabetes the opportunity to eliminate cost-sharing copayments and deductibles if they complied with preventive care protocols;²⁴

(3) enacting a one-hundred-dollar-per-month surcharge for employees' spouses and SSDPs enrolling in Penn State's coverage when coverage was available through their own employer;²⁵

(4) creating a tobacco-cessation and differential program that required employees and their spouses or SSDPs to certify each year that they do not use tobacco or are attempting to quit tobacco use, and pay a seventy-five-dollar-per-month surcharge per tobacco user;²⁶

(5) requiring employees to complete a biometric screening, and

(6) requiring employees and their spouses or SSDPs to complete an online wellness profile provided by WebMD Health Services and certify that they have had or will have a preventive physical exam by their medical provider, with failure to complete these measures also resulting in a one-hundred-dollar-per-month surcharge.²⁷

Though the incentives provided for WWPs in the ACA meant that other employers were implementing these types of benefit changes, Penn State faculty and staff began raising critical questions about privacy concerns and the lack of credible evidence supporting the link between WWPs and employee health and healthcare cost. As we describe below, the program's features, lapses in communication between Penn State and its faculty and staff, and Penn State and Highmark's inability or refusal to provide adequate responses to questions led the administrative leadership of Penn State to suspend the biometric-screening and wellness-profile portions of the program and initiate further consultation with employees. In the next two sections, we address these issues of privacy, employee health, and health care costs.

24. *Id.*

25. Jill Shockey & L. Reider Jensen, *Health Care Plan Changes Include Modifications to Spouse, Partner Costs*, PENN STATE NEWS (last updated Aug. 22, 2013), <http://news.psu.edu/story/282688/2013/07/25/administration/health-care-plan-changes-include-modifications-spouse-partner>.

26. Jill Shockey & L. Reidar Jensen, *University Announces Tobacco Cessation, Differential Program*, PENN STATE NEWS (last updated Aug. 22, 2013), <http://news.psu.edu/story/282692/2013/07/25/administration/university-announces-tobacco-cessation-differential-program>.

27. Shockey & Jensen, *supra* note 3.

II. Privacy Concerns in Wellness

While an initial Penn State news release indicated that more than a quarter of the university's employees had initiated efforts to complete their wellness profiles and biometric screening after just two weeks,²⁸ an opinion article authored by Penn State faculty member Matthew Woessner raised strong concerns about the ethical and privacy issues associated with requiring employees to complete online wellness profiles that asked for sensitive information about mental health, specific illnesses, and alcohol, tobacco, and drug use.²⁹

Woessner's article was preceded by an open letter he wrote to the Pennsylvania chapter of the American Association of University Professors.³⁰ Woessner's efforts then gained national media coverage.³¹ Together, Woessner's writings about Penn State's plan galvanized faculty and staff opinion about the privacy issues.³² A combination of factors at Penn State helped to create fertile ground for the growing controversy. First, some Penn State faculty, including a past head of the University Faculty Senate, Larry Catá Backer, suggested that the planning for the initiative was conducted without appropriate input from Penn State faculty and staff members.³³ Backer also raised concerns that the strategic announcement of the program in early July, when many faculty members were not on contract and many staff were on vacation, was timed specifically to avoid strong reactions from employees.³⁴

An additional factor added further fuel. Though most employers had taken an incentive approach to their WWP, rewarding employees who

28. Jill Shockey & L. Reidar Jensen, *'Take Care of Your Health' Sees Record Participation Following Announcement*, PENN STATE NEWS (last updated Aug. 22, 2013), <http://news.psu.edu/story/282680/2013/07/25/administration/take-care-your-health-sees-record-participation-following>.

29. Matthew Woessner, *PSU's punitive new health policy is an invasion of privacy: As I See It*, PENNLIVE OP-ED (last updated Aug. 07, 2013), http://www.pennlive.com/opinion/index.ssf/2013/08/psus_punitive_new_health_policy_is_an_invasion_of_privacy_as_i_see_it.html.

30. Mathew Woessner, *A Call for Action and Civil Resistance for Penn State Employees*, PA. Div. AAUP (July 30, 2013), <https://pa-aaup.com/2013/07/30/the-penn-state-healthcare-mandate-and-a-call-for-civil-disobedience/>.

31. See Mathews & Martin, *supra* note 9.

32. Jeff Brady, *Penn State To Penalize Workers Who Refuse Health Screenings*, NPR (Aug. 2, 2013), <http://www.npr.org/sections/health-shots/2013/08/02/208167230/penn-state-to-penalize-workers-who-refuse-health-screenings>.

33. Colleen Flaherty, *Weigh In or Pay*, INSIDE HIGHER ED (Jul. 22, 2013), <https://www.insidehighered.com/news/2013/07/22/penn-state-faculty-object-details-new-preventive-health-care-plan>.

34. *Id.*

participated in their programs,³⁵ Penn State chose to implement penalties for failing to participate in the biometric screening and wellness profile.³⁶ In addition, rather than phase in this change to a penalty for failing to complete the biometric screening and wellness profile, Penn State introduced penalties that were double the national average among employers.³⁷ So, the combination of intrusive questions in the WebMD wellness profile—such as asking employees whether they had ever driven after drinking—and the coercive nature of a \$1200 penalty for refusing to reveal that information made employees consider whether employers like Penn State were digging too deeply into their private lives in the quest for wellness.³⁸

To respond to Penn State and Highmark's efforts to collect their data and the wellness profile's intrusive nature, Woessner urged employees to complete the questionnaire with ludicrous information³⁹ and told an interviewer that he had "filled out his WebMD profile with nonsense," like "I'm 3 feet 8 inches tall, I weigh 50 pounds, [and] my last cholesterol check was when I was six months old."⁴⁰

This combination of events—questionable consultation and communication, intrusive questions that participants could not avoid, coercive financial penalties for noncompliance, Penn State's decision to require sharing health information with Highmark, and Woessner's creative encouragement of noncompliant compliance—ensured that the events at Penn State would gain greater attention. The privacy issues gained significant local and national media attention, with many news articles and stories published in major outlets like the Wall Street Journal, the Philadelphia Inquirer, and the Harvard Business Review, among others.⁴¹

35. Paul Fronstin, *Findings From the 2011 EBRI/MGA Consumer Engagement in Health Care Survey*, EMPLOYEE BENEFIT RESEARCH INST. 1, 1 (Dec. 2011), https://www.ebri.org/pdf/briefspdf/EBRI_IB_12-2011_No365_CEHCS.pdf.

36. Singer, *supra* note 4.

37. Soeren Mattke et al., *Workplace Wellness Programs Study Final Report*, RAND CORP. 126 (2013), http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR254/RAND_RR254.pdf.

38. Natasha Singer, *Rules Sought for Worksite Wellness Questionnaires*, N.Y. TIMES (Sept. 24, 2013), <http://www.nytimes.com/2013/09/25/business/rules-sought-for-workplace-wellness-questionnaires.html>.

39. Woessner, *supra* note 30.

40. Brady, *supra* note 32.

41. See Mathews & Martin, *supra* note 9; Tom Emerick & Al Lewis, *The Danger of Wellness Programs: Don't Become the Next Penn State*, HARV. BUS. REV. (Aug. 20, 2013), <https://hbr.org/2013/08/attention-human-resources-exec>; Karen Heller, *Karen Heller: Penn State's Unpalatable Policy on Health*, PHILLY.COM (July 25, 2013), http://articles.philly.com/2013-07-25/news/40773924_1_penn-state-health-incentives-health-care.

The University Faculty Senate scheduled a discussion of the issues at their first meeting on September 10, 2013.⁴² Representatives from the university' administration and Highmark attended to answer questions about the program. They may have hoped that the meeting would address concerns and defuse the growing controversy. Instead, the administration and Highmark representatives failed to answer faculty concerns, further fueling the controversy. At this meeting, a faculty member spoke about a question in the WebMD profile asking female faculty and staff members to indicate whether they intended to attempt to have a child in the next year.⁴³ That this question invaded the privacy of faculty members required to answer it was lost on the Highmark administrator answering her question. Nor did Highmark or Penn State address the concerns about forcing women to reveal this information to anyone at the university, much less their insurer or a third-party vendor like WebMD. The representative's extended response focused on the efforts his company was making to ensure that the information was kept private once it was collected, failing to understand that the issue was with the fact of its collection and not whether it remained private.⁴⁴ The next person to speak cut to the heart of the privacy issue for many Penn State employees, describing her "difficulty with [Highmark's] definition of private. For me, discussing my reproductive plans with an unknown entity at an insurance company does not constitute private."⁴⁵

Since Penn State's University Faculty Senate meetings are recorded and available to the public, the exchanges in the YouTube video provided in the New York Times article quickly became part of the national media story.⁴⁶ A little more than a week after the meeting, Penn State suspended the surcharge and the program and announced the formation of a task force to engage faculty and staff in discussion of the future of health benefits at Penn State.⁴⁷

42. Dennis Scanlon & Dennis Shea, *Statement and White Paper From Penn State Faculty—"Assessing the Evidence for Penn State University's "Take Care of Your Health" Benefits Program,"* MONITORING UNIV. GUIDANCE (Sept. 8, 2013), <http://lcbpsusenate.blogspot.com/2013/09/statement-and-white-paper-from-penn.html> (corrected version available at <http://theincidentaleconomist.com/wordpress/wellness-programs-arent-ready-for-prime-time/>).

43. Natasha Singer, *On Campus A Faculty Uprising Over Personal Data*, N.Y. TIMES (Sept. 15, 2013), <http://www.nytimes.com/2013/09/15/business/on-campus-a-faculty-uprising-over-personal-data.html>.

44. *Id.*

45. *Id.*

46. *Id.*; see also *Penn State Professor Questions Administrators about Invasion of Employee Privacy*, YOUTUBE (Sept. 11, 2013), <https://www.youtube.com/watch?v=RURZLK5yA3Y> (YouTube video embedded in the article).

47. Powers & Mountz, *supra* note 10.

Just days following this decision, Representative Louise Slaughter from New York cited the issues raised at Penn State as she asked the Equal Employment Opportunity Commission ("EEOC") to investigate worksite-wellness programs and to issue guidelines to protect employees from discrimination.⁴⁸ The EEOC had already met to discuss such guidelines but had not issued any guidance on the relationship between the ACA's provisions for wellness programs and federal antidiscrimination laws like the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act.⁴⁹ In May 2016, the EEOC released final rules on employer wellness programs, addressing both the incentives that employers may offer to employees, as well as employees' confidentiality rights.⁵⁰ The rules allow incentives of up to thirty percent of the cost of self-only coverage to be used for WWP, including those that involved questionnaires or medical examinations, but bar incentives for having employees provide certain types of genetic information.⁵¹ They also prevent employers from requiring employees to agree to the sale and other uses of their data and only allow employers to view aggregated information about their employees' health.⁵²

Penn State's experience with workplace wellness demonstrates some of the challenges for employers seeking to implement WWP as they attempt to balance efforts to gather information to guide improvements in employee health with privacy and discrimination laws. Isolated incidents of employees raising concerns about WWP have occurred over the past few years⁵³ and the topic has been hotly debated at research and industry conferences.⁵⁴ As employers continue to expand WWP, they will certainly test the limits of what employees are willing to accept with respect to incentives, privacy, and discrimination. The EEOC rules provide guidance on what is permissible, while Penn State's experience demonstrates the constraints on their actions because of employee concerns.

48. Singer, *supra* note 43.

49. Singer, *supra* note 43.

50. Press Release, U.S. Equal Emp. Opportunity Comm'n, Press Release on EEOC Issues Final Rules on Employer Wellness Programs (May 16, 2016), *available at* <https://www.eeoc.gov/eeoc/newsroom/release/5-16-16.cfm>.

51. *Id.*

52. *Id.*

53. Jay Hancock, *Workplace Wellness Programs Put Employee Privacy at Risk*, WWLP (Sept. 28, 2015), <http://wwlp.com/2015/09/28/workplace-wellness-programs-put-employee-privacy-at-risk/>.

54. Susan Dentzer, *What's Missing in the Debate Over Employer Wellness Programs*, HEALTH CARE BLOG (Dec. 4, 2015), <http://thehealthcareblog.com/blog/2015/12/04/whats-missing-in-the-debate-over-employer-wellness-programs/>.

III. Employers, Employee Health, Health Care Costs and Wellness

Given the privacy issues that wellness programs can cause, the WWPs would need to provide substantial benefits to encourage employees to participate in the change. While the benefits of WWPs received far less media attention than the risks in the case of Penn State, the benefits were another part of the argument that Penn State and Highmark advanced. This section focuses on summarizing the University's effort to advance their case that the impact of WWPs on two primary outcomes—healthcare costs and employee health—would be positive for Penn State employees. In describing the program to Penn State employees, the university identified reduced health-benefits costs and improved employee and beneficiary health as important goals of the changes to employee health benefits.⁵⁵ As we discuss in the next section, their arguments' weaknesses further undercut their efforts to convince employees to accept the Take Care program.

IV. The Impact of Workplace-Wellness Programs on Health

In presenting the case for the Take Care program to employees, Penn State referenced a handful of studies on the impact of WWPs.⁵⁶ Only one of the studies Penn State cited, a report from the Centers for Disease Control's Task Force on Community Preventive Services ("Task Force"), provided a detailed analysis of the health outcomes associated with WWPs.⁵⁷ The report assessed the value of workplace HRAs and other commonly used workplace interventions, such as smoking-cessation policies and immunization initiatives.⁵⁸ The study reviewed the evidence on assessment of health risks with feedback ("AHRF") programs. AHRF programs include

55. Shockey & Jensen, *supra* note 3.

56. See Annemarie Mountz, *Health Care Changes to be Discussed at Faculty Senate Meeting*, PENN ST. UNIV. NEWS (Sept. 3, 2013), <http://news.psu.edu/story/286134/2013/09/03/administration/health-care-changes-be-discussed-faculty-senate-meeting> (citing Larry S. Chapman, *The Art of Health Promotion*, 24 AM. J. OF HEALTH PROMOTION 1 (2009); then citing R. E. Soler et al., *A Systematic Review of Selected Interventions for Worksite Health Promotion*, 38 AM. J. OF PREVENTATIVE MED. S237 (2010); Barbara L. Naydeck et al., *The Impact of the Highmark Employee Wellness Programs on 4-Year Healthcare Costs*, 50 J. OF OCCUPATIONAL ENVTL. MED. 146; L. C. Williams & B. T. Day, *Medical Cost Savings for Web-Based Wellness Program Participants Form Employers Engaged in Health Promotion Activities*, 25:4 AM. J. OF HEALTH PROMOTION 272 (2001)).

57. Center for Disease Control, Task Force on Community Preventive Services, *Recommendations for Worksite-Based Interventions to Improve Worker's Health*, 38 AM. J. OF PREVENTATIVE MED. S232, S232 (2010), https://www.thecommunityguide.org/worksite/Worksite2010Recommendations_TaskForce.pdf.

58. *Id.*

three elements: (1) the collection of information about at least two personal health behaviors or indicators; (2) translation of the information collected into one or more individual risk scores or categorical descriptions of risk status; and (3) providing participants with feedback regarding their risk status, either overall or with respect to specific risk behaviors.⁵⁹ The report also examined AHRF Plus programs, which are AHRF programs that include other intervention components in a worksite setting.⁶⁰ An AHRF Plus program, for example, may offer incentives for employees who smoke to enter a smoking cessation program after their HRA.⁶¹

While Penn State cited the study as evidence of the positive impacts of WWP on employee health, the Task Force's recommendations were mixed regarding the effectiveness of these various workplace interventions.⁶² In its review, the Task Force indicated that there was insufficient evidence about the effectiveness of AHRFs when implemented alone as a primary intervention.⁶³ For example, the Task Force explained that its

finding of insufficient evidence to determine effectiveness is based on concerns with recurring combinations of flaws in individual studies across the body of evidence. The most important concern was the paucity of comparative studies in which the intervention was offered to one defined population and outcomes compared to another defined population that received a lesser (or no) intervention. Many of the studies identified in this review provided the intervention of interest (AHRF alone) to the "control" arm of a trial that was primarily intended to evaluate the effectiveness of a more comprehensive intervention that included AHRF as a single component. The absence of measurements from a relevant concurrent comparison group in these studies raised the potential for bias in the estimated intervention effects, particularly for self-reported changes in behavior. Most studies analyzed only a small subset of participants for whom there were complete follow-up data, which may have favored the inclusion of results from individuals who had changed their health behaviors in the interval.⁶⁴

While the Task Force reached a more positive assessment of AHRF Plus programs, Penn State's efforts did not provide such interventions, at least in their initial phase.⁶⁵ As a result, the university's communications and evidence undercut their own claims about positive health impacts.

59. *Id.* at S233.

60. *Id.*

61. *Id.* at S234.

62. *Id.* at S233.

63. *Id.*

64. *Id.*

65. Shockey & Jensen, *supra* note 3.

Additional research presented by faculty during the course of the subsequent year further clarified that weakness.⁶⁶ For example, a review article on WWPs published just months before the announcement of the Take Care initiative suggested that the expectation that WWPs are effective is based on three key assumptions.⁶⁷ First, this expectation is predicated on the assumption that wellness programs can accurately identify employees with specific health risks and effectively target incentives to employees for participation in wellness interventions to address these risks more effectively than usual care.⁶⁸ Second, it assumes that financial incentives to participate in wellness programs will lead employees to change their behavior in a way that will improve their health.⁶⁹ Third, it assumes that improvements in health will result in cost savings for employers.⁷⁰ The first two assumptions are critical for having an impact on employee health.⁷¹ The study's authors, however, found little evidence of improved health as a result of WWPs.⁷² In examining weight-loss programs, the authors examine four comprehensive literature reviews, none of which find evidence of long-term sustained weight loss.⁷³ Their review of smoking-cessation programs similarly found that programs had initial effects, but that there was often no long-term impact.⁷⁴ They found no comprehensive, high quality reviews of programs to manage high blood pressure or cholesterol.⁷⁵

That research was one of a number of studies presented as part of a report to the University Faculty Senate at the September 2013 meeting and then in a more detailed report the University's Health Care Task Force prepared and presented in April 2014.⁷⁶ Those reports included evidence from comprehensive reviews by a group of researchers,⁷⁷ as well as a

66. See Dennis P. Scanlon & Dennis Shea, *Assessing the Evidence for Penn State University's "Take Care of Your Health" Benefits Program*, INCIDENTAL ECONOMIST (Sept. 9, 2013) (Corrections made Sept. 20, 2013), http://theincidentaleconomist.com/wordpress/wp-content/uploads/2013/09/Scanlon-Shea-Assessing-the-Evidence-for-Penn-State-University_Sept_20_2013_correction.pdf; PA. ST. UNIV. FACULTY SENATE, REPORT OF THE HEALTH CARE TASK FORCE 27 (2014).

67. Jill R. Horwitz et al., *Wellness Incentive in the Workplace: Cost Savings Through Cost Shifting to Unhealthy Workers*, 32 HEALTH AFF. 468, 469 (2013).

68. *Id.*

69. *Id.*

70. *Id.*

71. *Id.*

72. *Id.*

73. *Id.* at 471.

74. *Id.*

75. *Id.* at 471-72.

76. PA. ST. UNIV. FACULTY SENATE, *supra* note 66, at 33.

77. See Soeren Mattke et al., *supra* note 37.

systematic review of evidence by a related group of investigators.⁷⁸ The report of Penn State's Health Care Task Force concluded that

workplace wellness programs appear to have, at best, a small, but statistically significant impact on a few employee health behaviors or health risks. These appear to be most commonly found in programs addressing smoking cessation or weight loss. The clinical relevance of these changes may be very modest. The long-run maintenance of the improved behaviors/risk reductions and the impact on actual health outcomes, such as mortality and morbidity, are not well-established by research. The short-run improvements appear to occur primarily in programs that apply fairly significant and ongoing incentives and/or involve more than basic lifestyle management programs.⁷⁹

In its efforts to communicate to employees about the positive effects of WWP's on employee health, Penn State relied almost exclusively on a single study that did not fully support the features of their program.⁸⁰ While at first glance WWP's impact on health may seem like common sense, the chain of connections to create real health improvements is more complex.⁸¹ Though they have no legal obligation to demonstrate that WWP's truly improve health, employers have a moral and ethical responsibility to ensure that their employees are well-informed, especially when the employer requests, requires, or incentivizes participation in these WWP's.

The impact of WWP's on health care costs is, of course, the second reason that employers often argue for their implementation.⁸² Employers argue that healthcare cost savings can be passed on to employees through cost-sharing, lower premiums, or higher wage and salary growth for employees.⁸³ The importance of these cost issues was heightened for employers because the ACA planned to impose a "Cadillac tax" on employers who had excessive healthcare costs.⁸⁴ Among the questions that the Faculty Senate submitted to the Penn State Benefits Office in advance of its meeting in September 2013 was one that challenged the quality of the

78. See Karen Osilla et al., *Systematic Review of the Impact of Worksite Wellness Programs*, 18:2 AM. J. OF MANAGED CARE e68, e68 (2012).

79. PA. ST. UNIV. FACULTY SENATE, *Special Informational Report from the Health Care Task Force*, PA. ST. UNIV. (Apr. 18, 2014), <https://web-beta.archive.org/web/20160605204341/http://senate.psu.edu/senators/agenda-s-records/april-29-2014-agenda/appendix-s>.

80. Naydeck et al., *supra* note 56; Williams & Day, *supra* note 56.

81. See Jill R. Horwitz et al., *supra* note 67, at 469.

82. Katherine Baicker et al., *Workplace Wellness Programs Can Generate Savings*, 29 HEALTH AFF. 1, 3 (2010).

83. Linda J. Blumberg, *Who pays for employer-sponsored health insurance?*, 18 HEALTH AFF. 58 (1999).

84. Jeff Lemieux & Chad Moutray, *About that Cadillac Tax*, HEALTH AFF. BLOG (Apr. 25, 2016), <http://healthaffairs.org/blog/2016/04/25/about-that-cadillac-tax/>.

evidence supporting the design of the Take Care program and its impact on costs.⁸⁵ In its response, Penn State referenced three studies that focused primarily on the cost savings associated with wellness programs.⁸⁶

One well-known study cited in the university's response reported a positive return on investment ("ROI") of \$3.27 in reduced healthcare spending per dollar spent on wellness programs, experienced over the first few years of a program's operation.⁸⁷ In addition, the authors reported a positive return related to reductions in employee absenteeism, estimated to be valued at \$2.73 per dollar spent on wellness programs.⁸⁸ As the authors note, however, these estimates of savings are far less than previous reports, a result they attributed to the more rigorous evaluation standards that they applied in reviewing the literature.⁸⁹ The authors also listed important caveats in the limitations section of their study,⁹⁰ stating that their

analysis cannot address the important question of which attributes of wellness programs are most important, and how such programs should be optimally designed. Well-designed field experiments that compare the effectiveness of program components such as patient education and professional counseling across different industries and populations are needed to answer it.⁹¹

The university's response to the Faculty Senate question about supporting evidence also referenced two published Highmark studies as evidence supporting the proposed Take Care program.⁹² One study examined the impact of a WWP that Highmark initiated for its own employees in 2002.⁹³ It estimated the impact of the program on costs for four years after the program's implementation and calculated an overall ROI.⁹⁴ The study's reported results suggested an overall ROI of \$1.76 for every dollar spent on the wellness program.⁹⁵ Specifically, the authors estimated that participants in Highmark's wellness program had annual

85. Mountz, *supra* note 56.

86. *See Id.*; Soler et al., *supra* note 56; Naydeck et al., *supra* note 56; Williams & Day, *supra* note 56.

87. Baicker et al., *supra* note 82, at 1.

88. *Id.*

89. *Id.* at 2.

90. *Id.* at 7.

91. *Id.*

92. *See* Mountz, *supra* note 56; Soler et al., *supra* note 56; Naydeck et al., *supra* note 56; Williams & Day, *supra* note 56.

93. Naydeck et al., *supra* note 56, at 147.

94. *Id.*

95. *Id.* at 151.

healthcare expenditures that were \$176.47 lower than those that did not participate in the wellness program, with the majority of the savings resulting from lower hospitalization costs for program participants versus non-participants.⁹⁶

The second Highmark study attempted to examine the impact and value of the “web based wellness program components” that were added to existing wellness programs between 2004 and 2007.⁹⁷ The study examined employees whose employers adopted Highmark’s web-based wellness features—the treatment group—and compared their outcomes to the outcomes for employees whose employers did not adopt any of Highmark’s wellness-program components—the control group.⁹⁸ The results showed lower costs for program participants relative to non-participants, and also suggested that web-based content can have value.⁹⁹

Just as there were questions about the quality of the evidence relating WWP to cost savings, there were similar questions about the evidence relating WWP to improvements in the health status of wellness-program participants. Research presented to the University Faculty Senate in September 2013 and April 2014 demonstrated less dramatic evidence of cost savings.¹⁰⁰ The university cited only four studies to provide evidence for the impact of its changes on employee health and healthcare costs and did so without fully understanding the limitations of the evidence cited.¹⁰¹

Also problematic about the university’s response to the questions about evidentiary support for their claims was that two of the three studies they cited were conducted by parties of interest. Two of the three studies were from their own third-party administrator, a vendor with a demonstrated interest in proving the effectiveness of programs that they were marketing and selling to Penn State and other employers.¹⁰² Just as some policy-makers during the ACA debate seemed to accept the Safeway evidence without critical review, only to later find important questions raised about the data, employers and their human-resource offices can be too reliant on vendors to provide evidence on the effects of WWPs. Reliance on evidence sources that have an interest in promoting WWPs, coupled with a failure to fully engage with the evidence base, creates conditions for employers to face significant employee opposition to WWP.

96. *Id.*

97. Williams & Day, *supra* note 56, at 272.

98. *Id.* at 278.

99. *Id.* at 275.

100. Scanlon & Shea, *supra* note 66, at 1.

101. See Mountz, *supra* note 56.

102. Naydeck et al., *supra* note 56, at 147; Williams & Day, *supra* note 56.

As raised in discussions about conflicts of interest in medical research,¹⁰³ vendor-supported studies should be used with caution. There are many decisions made in evaluation research, including the selection of the sample; how program and healthcare costs are allocated among the wellness program, the employer, the employees, and the insurer; how to address co-occurring changes in health benefits; and a host of other issues that will impact results.¹⁰⁴ While some of these concerns were noted in the published studies that Penn State cited, the inherent conflict of interest in vendor-based research requires employers to be extremely cautious in basing decisions on such evidence.

Furthermore, the question of whether health improvements actually lead to cost savings is additionally complicated by the fact that many employers change their health benefits at the same time as they implement or add to their WWP.¹⁰⁵ WWPs involve increased costs associated with duplicate testing, false positives, and associated follow-up costs. In addition, in some cases, WWPs simply adjust the timing of costs, rather than preventing costs;¹⁰⁶ simultaneous changes that adjust consumer cost-sharing in a variety of ways complicate determining whether costs were actually reduced or simply shifted across time and between employer and employee.¹⁰⁷ These program savings might not be the result of health improvements; instead, savings “may come from making workers with health risks pay more for their health care than workers without health risks.”¹⁰⁸ It becomes even more complicated to show employees that they are benefitting from lower costs when factors other than the WWP are also changing.¹⁰⁹

Penn State’s efforts to demonstrate the benefits of its WWP on employee health and healthcare costs evinced some of the pitfalls of trying to expand wellness programs for employers. The university offered a thin evidence base for the impact of its changes on employee health and healthcare costs, without fully understanding the limitations of the evidence it cited. In its effort to demonstrate the benefits of its WWP, Penn State also relied on sources of evidence that had conflicts of interest. Subsequent review of the research demonstrated to the employees that the evidence for the benefits of the WWP changes was much weaker than the university had suggested. Penn State failed to adequately communicate with its faculty and staff, failed to address its employees’ privacy concerns,

103. See generally CONFLICT OF INTEREST IN MEDICAL RESEARCH, EDUCATION, AND PRACTICE, (Bernard Lo & Marilyn J. Field, eds., 2009).

104. Scanlon & Shea, *supra* note 66, at 18.

105. *Id.* at 14.

106. *Id.* at 15.

107. *Id.* at 14.

108. Jill R. Horwitz et al., *supra* note 67, at 469.

109. Scanlon & Shea, *supra* note 66, at 16.

and cited studies that failed to dispel—and in some cases, raised—concerns about the benefits of WWP, creating an environment of employee distrust.

V. Summarizing Key Lessons and Future Directions

Penn State's problematic effort to implement a WWP and its subsequent decision to drop significant elements of the program emphasizes the many challenges for employers in trying to use WWPs and provides some guidance on how employers and employees can move beyond a "wellness-does-not-work" mentality. Employers and employees should establish shared ownership of the WWP through extensive consultation and communication prior to design and implementation of the plan. In implementing WWPs, employers are asking employees to share sensitive information and to modify the way they have traditionally interacted with healthcare providers. Employers claim to be interested in employee health, but often stress the need to control healthcare costs. Cost savings are difficult to track and both employers and employees want some stake in those savings. Without significant consultation and communication in the design and implementation of the WWP, employees are unlikely to accept the changes and employers are unlikely to find they have shifted the needle on health or costs.

Given employers' growing interest in having employees share personal health information, employers owe it to their employees to exercise due diligence, to collect only what is necessary, to protect what is collected, and to give employees options regarding what information they provide. Dr. Donald Berwick, President Emeritus and Senior Fellow at the Institute for Healthcare Improvement and former Administrator of the Centers for Medicare & Medicaid Services, notes that our health system must change the way it treats information, arguing that medical records should belong to the patients and adopting the rule of a public-health researcher: "Nothing about me without me."¹¹⁰ Employers engaging in WWPs must begin with the assumption that the data belongs to the employee/patient, and allow employees to make the rules about access to their information.

Employers and employees should also work to develop their own independent assessment of the evidence in support of or against WWPs. Cherry-picking individual studies or relying on vendors with inherent conflicts of interest to provide evidence for WWP is unacceptable. Efforts should focus on a more sophisticated review of the evidence and on identifying and adopting evidence-based practices. Rigorous evaluations often dramatically reduce the estimated ROIs from WWPs. Concerns about conflicts of interest and their impact on medical research are considerable. Employers and health plans, however, are not in the business of conducting rigorous evaluations of health programs and have deep conflicts of interest in the operation of such programs. Employers and employees should work together to identify evidence from public agencies (e.g., Department of

110. DONALD BERWICK, ESCAPE FIRE: LESSONS FOR THE FUTURE OF HEALTH CARE (2014).

Labor, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention), health-services research organizations (e.g., RAND, Truven Health Analytics), or private foundations that offer a more independent and scientific review.

Assessing the evidence requires going beyond just examining WHPs and their role in the healthcare industry. Employers and employees need to develop a shared understanding of the real drivers of healthcare inflation and health-benefits costs, both nationally and in their local regions. Despite the challenges, both parties need to work together to see how technology, malpractice, demographic changes, health-benefit design, provider prices and practice patterns, and more drive costs. Lifestyle and health behaviors are only one component of the cost equation in healthcare and addressing only those criteria may not be the easiest or most effective strategy for controlling costs and improving health. Health-behavior change is hard work; employees are trying to reverse decades-old lifestyles. In general, incentives, not penalties, are more effective.¹¹¹ In addition, the evidence base on incentives for health-behavior change is relatively new. Employers should move cautiously and continually re-evaluate their efforts. Moving beyond the idea that wellness does not work is likely to require substantial effort to retreat from the existing standard vendor-driven, third-party, pre-packaged set of programs of questionable credibility. Furthermore, employers and employees need to understand how WHPs fit into the overall design of their health benefits and in the overall context of their health system. WHPs focus on changing the behaviors of consumers on the demand side of healthcare. These programs do little to address the supply-side cost issues. To have an impact on costs and health, employers and employees should also consider the local cost drivers from the supply side, especially as healthcare-provider markets change through consolidation, new payment models, organizational changes like accountable care organizations and patient-centered medical homes, and efforts to revise the ACA. In some cases, wellness does not work because substantial changes are necessary on the supply side of healthcare for costs to fall and health to improve.

To move beyond the idea that wellness does not work, employers need to develop an understanding of what components of WHPs work best for their particular workforce, worksites, and provider markets. They need to engage in an ongoing discussion with their employees and consultants about the design of their WHPs and address the challenging privacy issues with respect to employees' rights to their own health information. Finally, if the goal is truly to improve employee health, then employers must engage in far more discussion with employees about how to help them change and far fewer conversations with third-party vendors on how to make employees change.

111. Kevin G. Volpp et al., *Redesigning Employee Health Incentives - Lessons from Behavioral Economics*, 365 N. ENG. J. MED. 388, 388-89 (2011).