More Than Health Promotion: How Employers Manage Health and Productivity

RESEARCH BY THE INTEGRATED BENEFITS INSTITUTE

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Executive Summary

So much of what one hears today regarding healthcare management also includes employers' efforts to promote workforce wellness, prevention, and disease and disability management to get at core drivers of expanding healthcare costs.

In 2003 and 2004, in conjunction with LRP Publications, the Integrated Benefits Institute (IBI) surveyed employers about their broad health and productivity management (HPM) practices, including return-to-work efforts and disease management. Those surveys documented widespread adoption of such practices, including future plans to expand that investment in employer health. In 2009, our members suggested that it is time to take another look at how health and productivity management is playing out in the context of slipping employer-provided healthcare, declining health, tough economic times, tightened global competition and healthcare reform.

IBI, with Harris Interactive (authors of the Harris Poll), received responses in summer 2009 from 450 employers, detailing the prevalence of prevention, wellness, disease management and return-to-work initiatives they have implemented; their plans over the next two years; the goals for these programs; the measurements used to assess key program outcomes; and their views of how well HPM initiatives are meeting the desired goals.

A key conclusion from this research is that employers almost universally adopt some form of health promotion, although they deem their disease management practices most important to their goals. Respondents generally expect to add new practices and expand existing ones in the next two years. Employers use HPM practices to reduce health-related lost productivity almost as often as medical/pharmacy costs. Many don't measure productivity-related outcomes, but when they do they show solid improvement toward their goals. Finally, there is evidence that HPM has significantly expanded since IBI's previous surveys.

As a companion tool, IBI and Harris Interactive developed a ViewPort℠ query application to allow HPM survey participants, as well as IBI Stakeholder and Charter members, to create customized charts and tables of survey results. Responses can be cut by selected employer demographics such as size and geography.

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The **Integrated Benefits Institute** (IBI) provides employers and their supplier partners with resources for demonstrating the business value of health.

As a pioneer, leader and nonprofit supplier of health and productivity research, measurement and benchmarking, IBI is the trusted source for benefits performance analysis, practical solutions, and forums for information and education. IBI's programs, resources and expert networks advance understanding about the link between—and the impact of—health-related productivity on corporate America's bottom line.

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Key Findings:

- **Nearly all surveyed employers have some form of health and productivity management (HPM) practices in place, with wide variation in the types offered.** Of the three broad program categories surveyed, health promotion is almost universally offered (98% of survey participants) followed by disease management (91%) and disability return-to-work (RTW) programs (85%).
- **Employers consider disease management most important to their HPM efforts,** though those practices are less commonly offered than those in health promotion.
- **Employers are committed to their HPM efforts and in many cases intend to add financial resources to their existing practices.** Two-thirds of employers expect a net increase in resource commitments to HPM over the next two years, while only 4% expect a net decrease.
- **Generally, we might expect that employers would be more likely to adopt HPM practices that experienced managers view as important to their HPM goals. That, however, is not always the case.** The pattern varies by program type.
- **Employers use HPM to reduce health-related lost productivity almost as often as to reduce medical and pharmacy costs.** Not surprisingly, reducing sick day/disability absences is a more important outcome for RTW programs than for health promotion or disease management programs. Reducing presenteeism is the least-cited goal for HPM practices. Measurement challenges are undoubtedly tied to these goals.
- **One in three employers does not measure absence and productivity outcomes from its HPM efforts.** Employers more frequently measure sick day/disability absences—usually through administrative and claims data—than they measure presenteeism or health-related lost productivity. Employers recognize the value (in both money and effort) of measuring outcomes but typically cite insufficient resources as reasons for not doing so.
- **Many employers do not know if their HPM initiatives successfully achieve their intended outcomes.** Nonetheless, employers generally believe that HPM has resulted in reduced sick day/disability absences, presenteeism and health-related lost productivity.
- **Employers that measure sick days, presenteeism and health-related lost productivity outcomes are more likely to report that a practice improved outcomes.** Not surprisingly, they also are better able to provide an opinion about their practices' performance.
- **The study presents some evidence that employer use of HPM has increased significantly in the past five years.** When we compare adoption of the same practices in 2009 with their adoption reported in 2004, we see approximately the same order of prevalence and a substantially higher proportion of employers adopting most practices.

Contents

Introduction

The U.S. workforce is growing older, is consuming more healthcare and is generating higher medical costs. Employers, however, show clear reluctance to continue to rely solely on cost shifting and manipulation of the financial mechanisms that serve healthcare to gain relief from healthcare cost increases.[1]

Employers understand that they can mitigate some medical treatment costs by promoting good health and helping employees manage their chronic conditions. Perhaps more importantly, employers increasingly recognize the productivity advantages of a healthy workforce. Initiatives to reduce illness and disability absences, presenteeism and health-related lost productivity are properly understood as investments with a positive impact on the bottom line rather than simply human resource costs. As a result, the use of health and productivity management programs (HPM), presented as wellness programs, is on the rise.[2]

Report Structure

In the spring of 2009, IBI conducted an online survey of almost 450 U.S. employers on their use of HPM practices to better understand what employers currently do to manage their workforce's health and productivity, what they plan on doing in the near term, the specific goals of their HPM efforts, the practices they view as most important and effective for achieving these goals, and how they measure the effectiveness of their efforts.

This report is a compendium of the survey responses and is intended as a resource on the current state of employer HPM efforts in the United States. The responses come from an opportunity sample, drawn from IBI members, members of employer healthcare coalitions across the country, attendees of IBI-sponsored conferences, and clients and contacts of IBI supplier members.

Although results cannot be generalized to all employers, results give significant insight into how employers are moving forward in their efforts to manage workforce health and productivity. The results reported in this report are primarily descriptive; they provide a current, top-line view of HPM's prevalence, uses and characteristics. Survey respondents and IBI Stakeholder and Charter members may use the online ViewPort℠ tool[3] developed by IBI's partner in this research, Harris Interactive, to examine results by various respondent characteristics, such as size, geographic region, organizational structure and industry. This additional level of analysis gives survey participants and senior-level IBI members the ability to examine more closely what various employer segments are doing in HPM.

Next Steps

These data provide a rich resource of HPM information, and IBI will continue to use them to produce research and commentary over the next few months following release of this report. In particular, a second phase of this research will examine the interrelationship between HPM practices and key measurements of business performance, such as profit ratio, return on investment and productivity (revenues per full-time-equivalent employee). The results—combined with the findings of the current document—will advance the discussion of health and productivity as an indicator of competitiveness by shedding light on the HPM characteristics of successful enterprises and assessing the contributions of health and productivity to these outcomes. This research is the subject of a plenary session at the 2010 IBI/NBCH Health & Productivity Forum.

[1] IBI (May 2005).

[2] Wellness Programs, Benefits USA 2009/2010 Survey (2009)

[3] http://ibiweb.org/do/PublicAccess?documentId=1007

Survey Description

IBI developed an online survey of employers' health and productivity management practices in partnership with Harris Interactive—best known for the Harris Poll, one of America's longest-running independent opinion polls. The survey addressed four main areas:

1. The strategies and the practices that organizations use to manage medical costs, lost time and health-related lost productivity and their planned adoption of additional practices
2. The specific business goals employers seek to accomplish through their HPM efforts
3. How employers measure progress toward these goals
4. How well employers think their HPM efforts are working

The survey also inquired about employers' plans to change their resource commitments to existing HPM practices over the next two years as well as their perceptions of looming health and productivity challenges.

Representatives from 447 unique employers completed the survey.

A majority of respondents represent employers in three industries: manufacturing (29%), education and health services (24%) and trade, transportation and utilities (11%). Professional and business services (8%), public administration (8%), financial activities (7%) and other services (7%) employers are also well represented.

Thirty-six percent of respondents represent for-profit publicly traded organizations, while another 33% represent for-profit privately owned organizations. The remainder are nonprofit organizations (17%), government entities (12%) or unspecified (2%).

One-quarter of responding employers have fewer than 500 full-time-equivalent workers, and one-third have at least 500 but fewer than 5,000 FTE workers. The remainder of employers has at least 5,000 workers.

Participating organizations employ workers across the United States. We asked respondents for the region of the country in which most of their employees reside. Thirty percent of employers indicated that the majority of their employees reside in the Midwest, 25% of employers indicated the South, 25% indicated the West, and 15% indicated that most of their employees reside in the Northeast. Eight percent of employers stated a majority of workers are located outside the United States or could not determine the U.S. region within which most of their employees work.

More than half of employers have a majority female workforce. The typical (mean) employee age distribution is 24% aged 34 and below, 37% between ages 35 and 54 and 26% aged 55 and above. Only 4% of employers indicate that a majority of their employees are at least 55 years of age.

Six in 10 survey respondents identify themselves as benefits managers, HR directors, or health and productivity managers. Only about 5% identify themselves as CEOs, CFOs and COOs—the majority of whom represent small employers (fewer than 500 employees). The remaining respondents are medical directors and administrative personnel, declined to state their position in the organization or held another, unlisted position.

HPM Practices in the Survey

We designed our survey to take a broad perspective on how employers manage the health and productivity of their workforce.

To accomplish this, we consulted the medical and social science research literature and industry best-practices information to compile a list of 26 commonly cited HPM practices.[4] The purpose of this was twofold. First, we wanted to understand how and why employers implemented a range of "state-of-the-art" practices. Second, the list itself served as a useful device to prime respondents for detail about their own health and productivity efforts in later parts of the survey.

We organized the HPM practices into three broad categories: (1) health promotion or injury/disease prevention, (2) chronic disease/health condition management and (3) return to work (RTW) from a disability. These categories conform roughly with employers' interests in keeping employees healthy, helping chronically ill employees effectively manage their own conditions and facilitating employees' rehabilitation and timely return to work following an accident or serious illness. The full list of HPM practices included in the survey is shown at the right, arranged by the three practice categories.[5]

[4] The full list of sources reviewed by IBI is available upon request.

[5] See Appendix for the full list of practices with definitions.

1 Practices for health promotion or injury/disease prevention ("health promotion"):

- Nutrition education
- Weight management
- Fitness programs
- Demand management programs
- On-site or discounted fitness centers
- Nutritious meal/snack options
- Employee assistance programs
- Stress reduction education
- Ergonomic evaluations
- Health risk assessments
- Clinical screening
- Participation incentives
- On-site providers
- Smoking cessation programs

2 Practices to help employees manage their known chronic health conditions ("disease management"):

- Self-care tools
- Referrals for counselors/specialists
- Health risk coaching
- Chronic disease management
- Value-based benefits

3 Practices to help employees return to work from a disability ("RTW"):

- Early disability reporting
- Transitional return to work
- Return-to-work education
- Return-to-work incentives
- Administrative chargebacks to encourage return to work
- Disability duration guidelines
- Nurse case management

Prevalence Overall

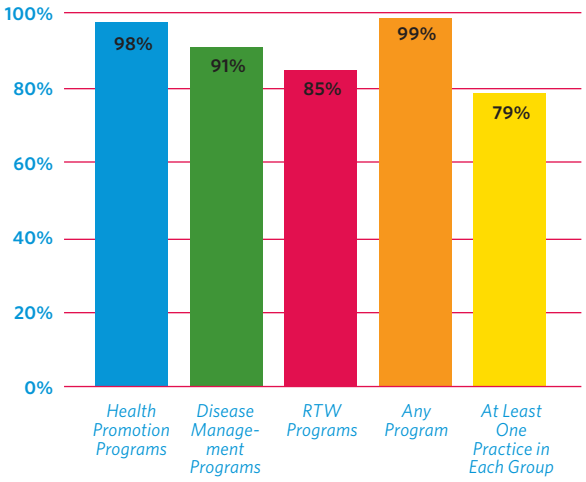
How Prevalent Are HPM Efforts?

Early in the survey, respondents were presented with all three lists of HPM practices and asked whether they currently offered each—or, if not, whether they planned to offer it in the next two years. As the chart to the right shows, 99% of employers currently offer at least one of the 26 listed HPM practices, and 79% offer at least one in each of the three categories. Health promotion is almost universally offered (98%), but disease management (91%) and RTW (85%) are also widely utilized.

These results show higher utilization of HPM than IBI observed in our 2004 survey of 15 employer practices.[6] This may indicate an increase in employer adoption of HPM efforts, but undoubtedly it also reflects the fact that the current survey asked about a greater number of practices—and thus gave respondents more opportunities to answer affirmatively.

EMPLOYERS WITH AT LEAST ONE HPM PRACTICE

[447 respondents]

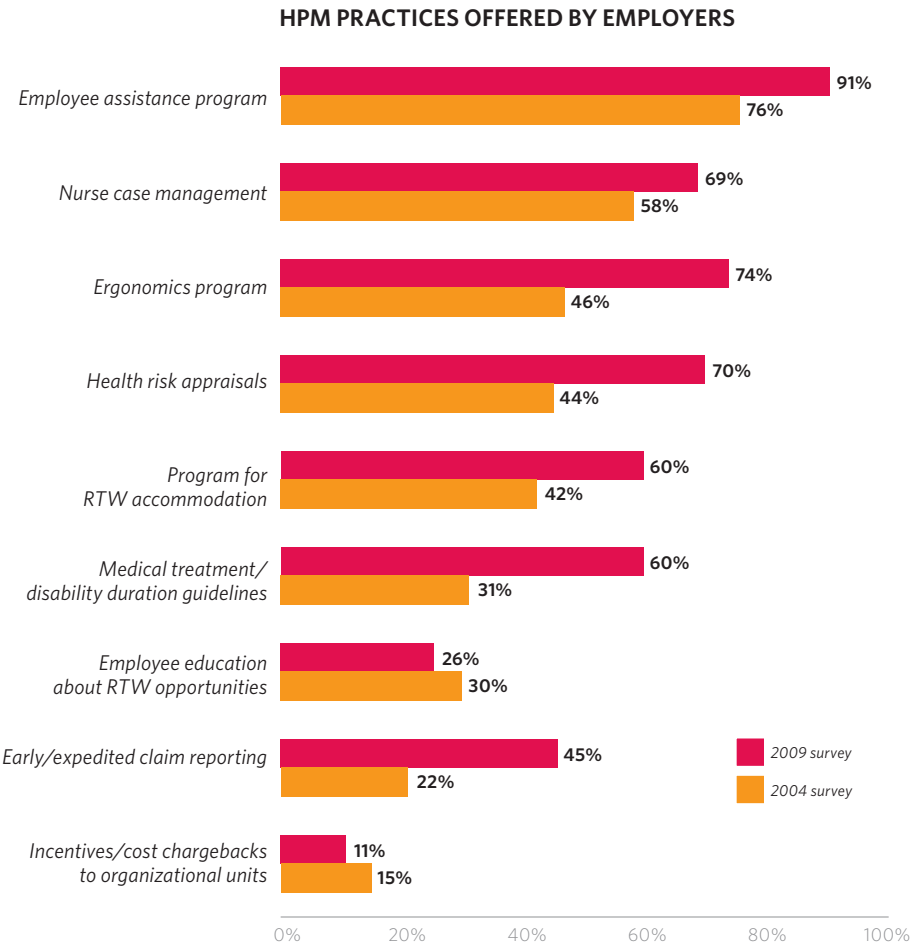


[6] IBI (July 2004).

Changes in HPM Prevalence

Several of the practices surveyed in 2009 also appeared in similar or identical form on an IBI 2004 survey of 16 HPM practices.[7] This permits some limited comparison of HPM efforts at both times. The chart to the right compares the prevalence of similar items in the 2004 and 2009 surveys.[8]

As the chart shows, for the most part employers report a higher rate of HPM prevalence for similar practices in the 2009 survey than in the 2004 version. The exceptions to this pattern are RTW education and administrative chargebacks as an RTW incentive. With minor exceptions, the rank order of practices by how widely they are offered is similar in both surveys.



[7] IBI (June 2006).

[8] The labels reflect the wording used in 2004. IBI surveyed only 16 HPM practices in 2004, compared with the expanded list of 26 in 2009. For example, the disease management practices were compressed into one practice labeled "disease management," and the 2004 "wellness program" category compressed several 2009 practices.

Commentary: It should be noted that different prevalence rates across the 2004 and 2009 surveys may reflect differences in the two survey samples. The surveys consist of different groups of employers (rather than a repeated survey of the same employers) and were drawn from different sampling frames. In both surveys, IBI members composed a substantial proportion of survey respondents, but the 2004 sample was also largely drawn from readers of *Risk and Insurance* and *Human Resource Executive* magazines. The *Risk and Insurance* audience may account for the higher rate of RTW education and administrative chargebacks—which are closely linked with workers' compensation in 2004.

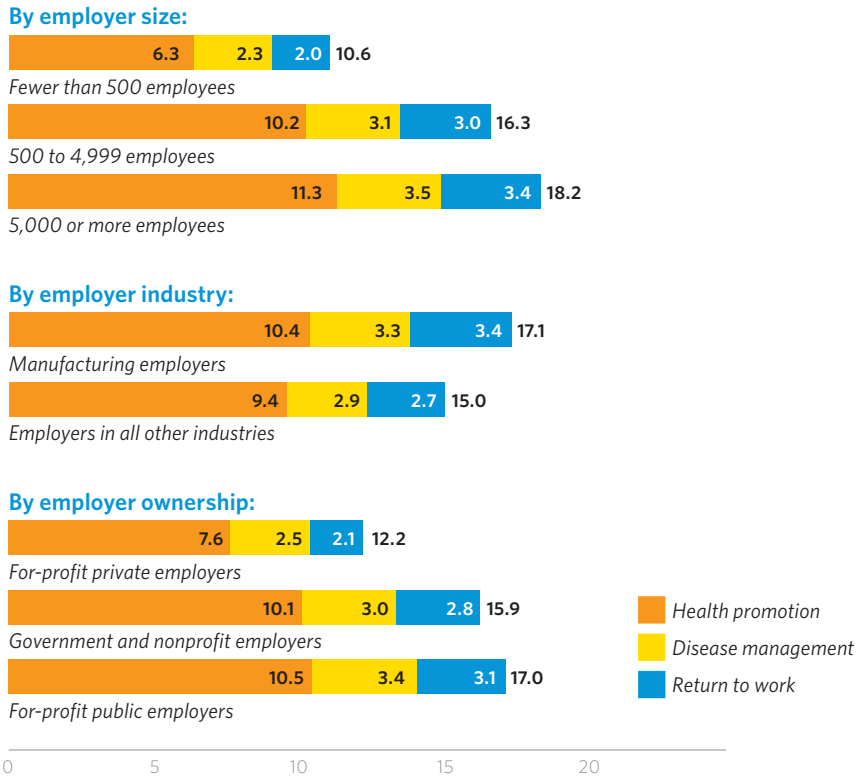
Despite the difference in samples, the similarities in rank order of the practices and the substantial difference in prevalence of the same or similar practices suggest real, significant growth in the adoption of many of the HPM practices over the past five years.

Number of Practices by Employer Characteristics

The average number of practices offered is 15.6 (out of a possible 26 surveyed), and the median (fiftieth percentile) employer offered 17 practices (i.e., half the respondents offered fewer, and half offered more). There are some discernible differences by employer characteristics, however, as illustrated in the chart to the right.[9] Not surprisingly, given greater availability of resources larger employers tend to offer more HPM practices than smaller ones. Employers across industries are more homogeneous with regard to their HPM efforts; employers in the manufacturing industry, for example, offer an average of 17 of the 26 HPM practices compared with an average of 15 among employers in all other industries (there are no statistically significant differences among employers in these other industries). For-profit private employers typically offer the fewest practices (about 12), while for-profit publicly traded employers offer the most (about 17). We observed no substantive differences across employers from different regions of the United States.

HPM PRACTICES BY SIGNIFICANT EMPLOYER CHARACTERISTICS

Average number of programs per employer



[9] The differences across employers of different sizes, ownership status and industry shown are statistically significant.

Most-common HPM Practices

Despite the high overall rates of adoption of HPM, we observe wide variation in the use of specific practices.

For example, as shown in the chart on page 9, an employee assistance program (EAP) is most commonly cited—91% of employers currently offer it, and another 1% plan to offer it within the next two years. Of the 15 health promotion initiatives, 12 are offered by a majority of employers. Participation incentives (such as adjusted premiums, copayment/deductibles and/or job characteristics) is the least-utilized health promotion practice. While not quite half of the surveyed employers (45%) offer participation incentives, an additional 19% of all respondents said they plan to offer incentives in the next two years—the highest percentage of respondents planning to introduce a practice over all.

Referrals for counselors/specialists is the most commonly cited disease management practice (76%), while value-based benefits (e.g., altering cost tiers to promote certain treatments or pharmaceuticals) is the least cited (38%). As with the health promotion group, this least-prevalent disease management initiative has the highest share of employers who say they plan to offer it in the next two years (16% of all respondents and the second-highest proportion overall of respondents with plans to offer a new practice).

Four of the seven RTW practices are offered at least as frequently as participation incentives (the least-common health promotion initiative)—45% use early disability reporting, and 69% offer nurse case management for employees on disability. Three practices—"just-in-time" employee RTW education opportunities, employee RTW incentives and financial incentives for management and supervisors to accommodate RTW (e.g., cost chargebacks to organizational units)—are comparatively underutilized (only between 11% and 26% of employers offered these). RTW is among the least planned of all HPM practices; nine of the 15 health promotion initiatives and four of the five in disease management are planned for adoption by more employers than the most-planned strategy in RTW (RTW education, 7%).

These results suggest that employers currently underuse demonstrably effective RTW initiatives.[10,11]

Commentary: It may be that workers who could benefit from RTW programs constitute a small share of all employees, especially relative to those who suffer from manageable chronic conditions. IBI research[12] shows that nine in 10 employees in the Health and Work Performance Questionnaire (HPQ) database have at least one chronic condition, while the incidence rates for STD claims[13] and reportable workplace injuries[14] are only 7.1 and 3.9 per 100 FTEs, respectively.

It also may be that RTW interventions require more in employer commitment and resources to garner the substantial health and productivity gains possible from successful RTW programs. RTW success is not likely to be available off the shelf. Instead, success comes with cross-program coordination, careful benefits design, alignment of incentives, and acknowledgment and support from senior management, supervisors and even co-workers.[15]

[10] IBI (July 1997).

[11] IBI (July 2001).

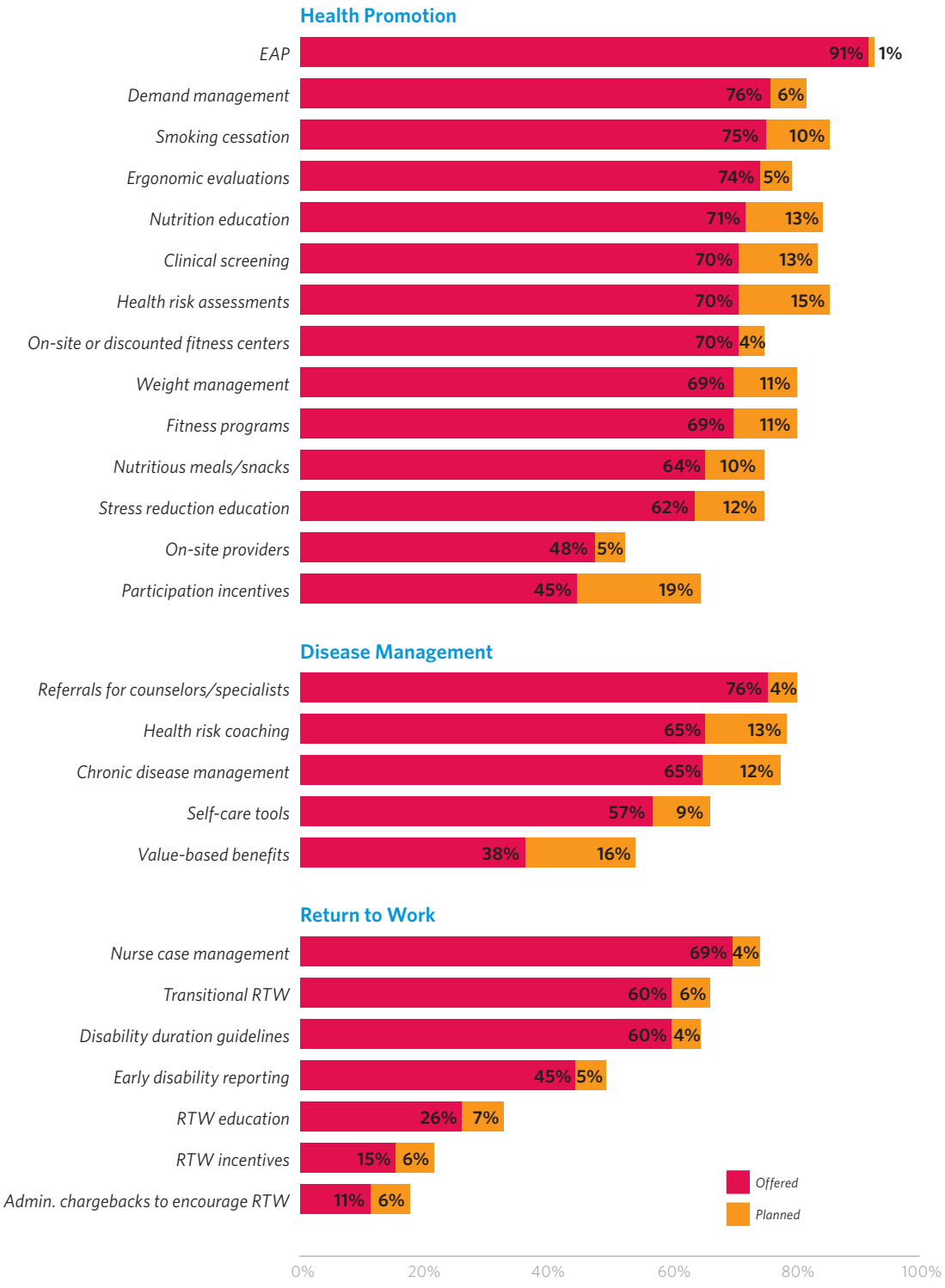
[12] IBI (August 2009).

[13] IBI 2008 Benchmarking data.

[14] Bureau of Labor Statistics (2009).

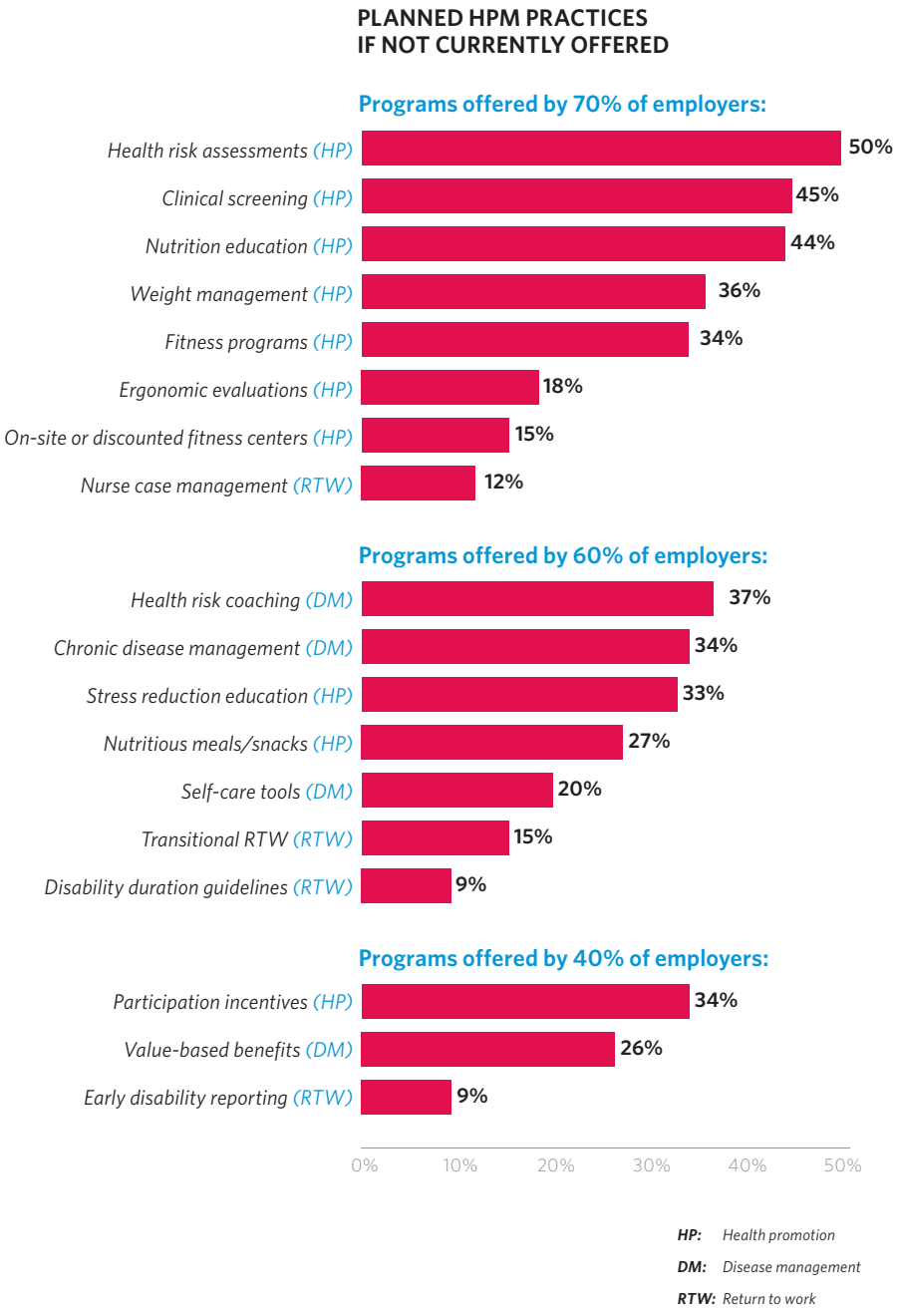
[15] IBI (July 2001).

CURRENTLY OFFERED AND PLANNED PRACTICES



Refocusing on employers' future plans for strategies with similar utilization rates (in the chart to the right) underscores this latter point. For example, participation incentives, value-based benefits and early disability reporting are all offered by about 40% of employers. But only 9% of employers without early disability reporting plan to offer it compared with 26% for value-based benefits and 34% for participation incentives.

The pattern is similar for HPM efforts offered by 60% and 70% of employers: Employers plan to adopt RTW less frequently than they do similarly prevalent health promotion and disease management in some cases by magnitudes of three and four.



HPM Practices Rated "Most Important"

While use of specific HPM practices is central to understanding employers' HPM efforts, it reveals only part of the story.

We additionally asked respondents to indicate which of their HPM initiatives are "most important," "second most important" and "third most important" for managing their workforce's health and productivity.[16]

As illustrated by the chart on page 12, health risk assessments (HRAs) are rated "most important" by 23% of respondents offering them—five percentage points higher than the next most important initiative (value-based benefits at 18%). However, the total percentage of respondents assigning any importance to their health risk assessment (43%) is very similar to that for chronic disease management (41%).

The practices least often ranked as important are RTW education (4%), nutritious meals and snacks (5%) and demand management (e.g., nurse care hotlines, employee decision-support tools and benefits education) (7%). Overall, initiatives in the disease management category are rated as important by an average of 26% of employers compared with 19% for the health promotion category and 12% for the RTW category.

Again, RTW emerges as the least central to employers' HPM efforts. It bears repeating that the results on page 12 are not affected by prevalence rates and therefore should not be read as indicative of respondents' experiences with different strategies (or lack thereof). As discussed below, however, using a practice as a tool for managing health and productivity is a separate issue from understanding its impact on desired outcomes.

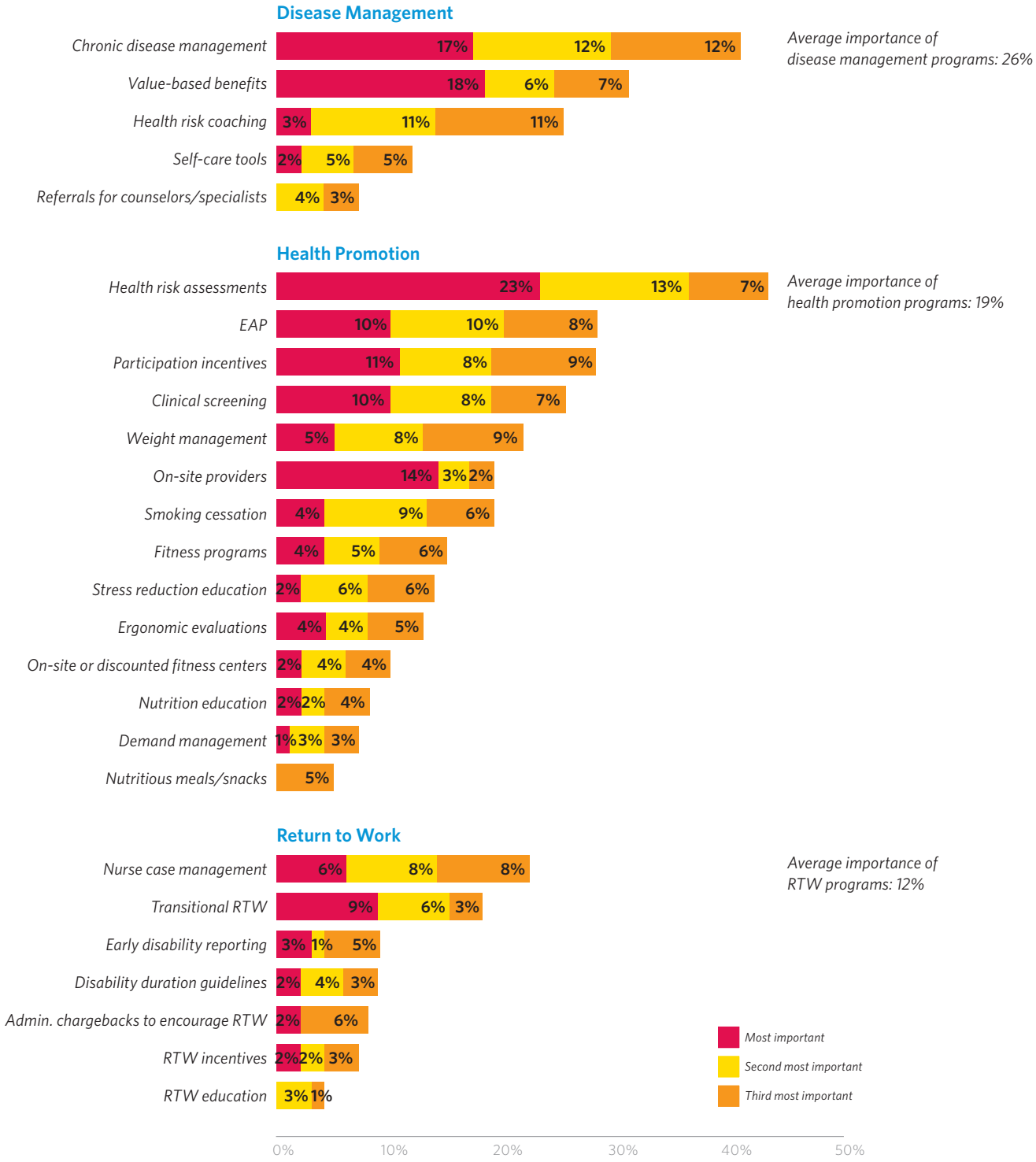
Commentary: The top three practices from ratings of importance all deal directly with the employer's ability to manage chronic medical conditions. This is not surprising given the prevalence of chronic conditions in the workforce. For example, prior IBI research[17] shows that nine in 10 HPQ respondents have at least one of 27 chronic health problems, with an average of three co-morbid clusters of conditions (e.g., at least one socioemotional condition combined with a metabolic condition and a respiratory condition). The prevalence and the diversity of co-morbidities in the workforce complicate treatment and management across those conditions and lead to additional lost work time.

[16] Respondents who selected only one practice skipped this question; respondents with either two or three practices ranked the importance of those practices accordingly. Only 10% of employers offered fewer than four practices.

[17] IBI (August 2009).

IMPORTANCE OF PRACTICES TO HPM GOALS

Percentage of employers with the program (number of respondents varies by program)



Tendency of Employers to Offer Important HPM Initiatives

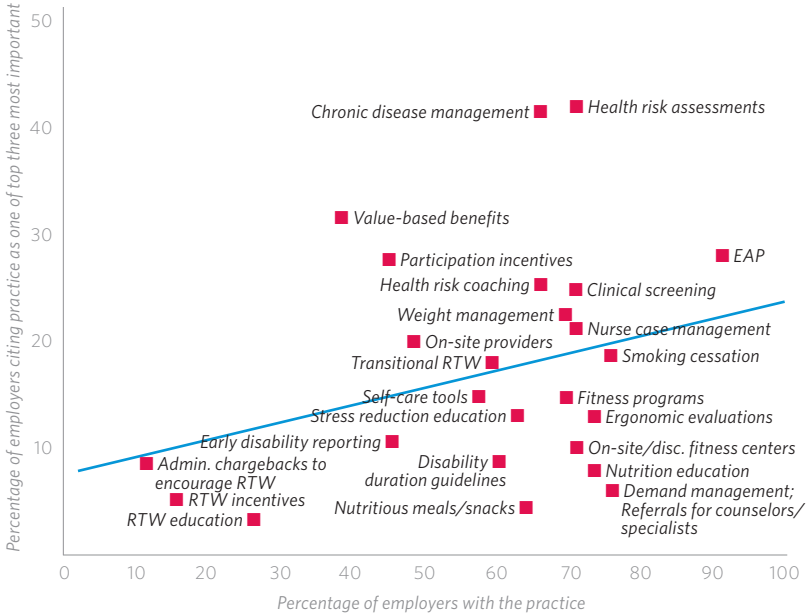
To the extent that experience matters at all, the overall employer assessment of a practice's importance can serve as a guide for employers seeking ways to improve the management of health and productivity. Ideally, those practices deemed important by experienced employers would also be the most widely utilized.

Comparing the prevalence of a practice with the percentage of experienced employers who rank it among their three most important HPM initiatives (see graph below) tells a more nuanced story about HPM. If there were a perfect relationship between prevalence and importance, the points representing all 26 practices would fall in a single line that rose sharply and steadily from left to right. That is, each point increase in the percentage of employers that offered a program (shown along the horizontal axis) would be matched by an identical increase in the percentage of experienced employers that ranked it as important (shown along the vertical axis).

Instead, the points fall in a more scattered pattern, with some of the most important initiatives (e.g., value-based benefits) among the least prevalent, and some of the least important among the most widely utilized (e.g., demand management, referrals for counselors/specialists). The line that best fits the pattern—while generally indicating a positive relationship—slopes upward rather modestly.

Because it includes all HPM practices, the graph masks some patterns that exist among the different categories. We therefore examine the relationship between prevalence and importance among the health promotion, disease management and RTW groups separately. To reflect a weighting of preference, we convert the importance rating to a score, multiplying by three the percentage that selected the practice most important, by two for the percentage that selected the practice second most important and by one for third most important.

EMPLOYERS' IMPORTANT HPM PRACTICES BY PREVALENCE OF ADOPTION

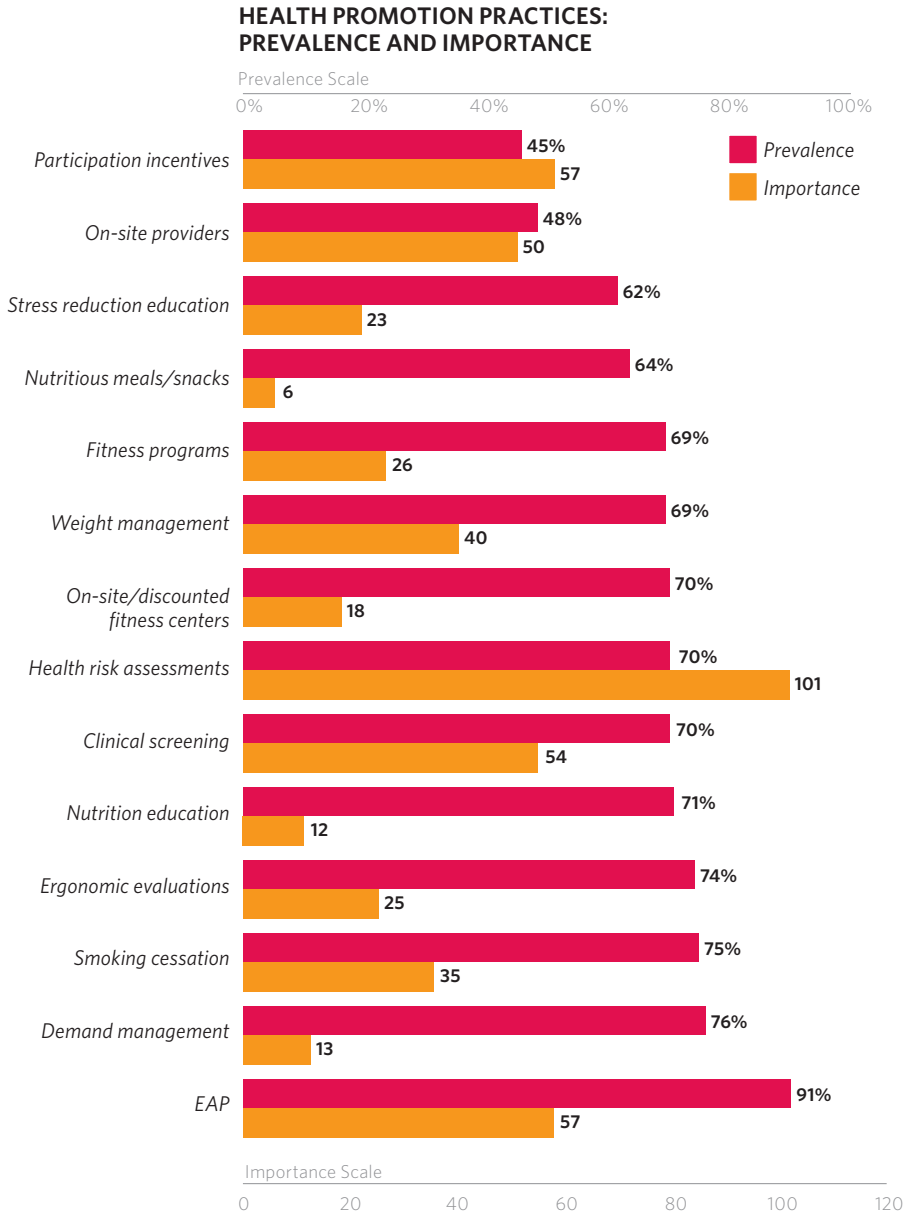


Commentary: There is likely to be a distinction between "important," as measured here, and the common usage of "effective." For example, IBI's recent incentives research[18] identified two RTW incentives as among the most effective incentives employers offer. In this survey, however, we found that relative to respondents' overall efforts at managing their workforce's health and productivity such incentives were not viewed as important. The difference may lie not in the efficacy of RTW incentives but rather in the purpose for which the incentive is evaluated. RTW incentives may be important means of encouraging early, effective return to work but are not viewed to be one of the top three in importance for overall health and productivity management.

[18] IBI (October 2008).

Prevalence and Importance of Health Promotion Practices

The chart to the right compares the percentage of respondents that have adopted health promotion with the importance score assigned by employers that have the practice. If there were a correspondence between prevalence and importance, the length of the importance bars would increase as a practice becomes more prevalent. This is not the case, however. For example, the most and the least prevalent health promotion practices have the same importance scores, with erratic bar lengths in between. The most important practice of all those in the survey—health risk assessments—is in the middle of the prevalence range for health promotion practices.



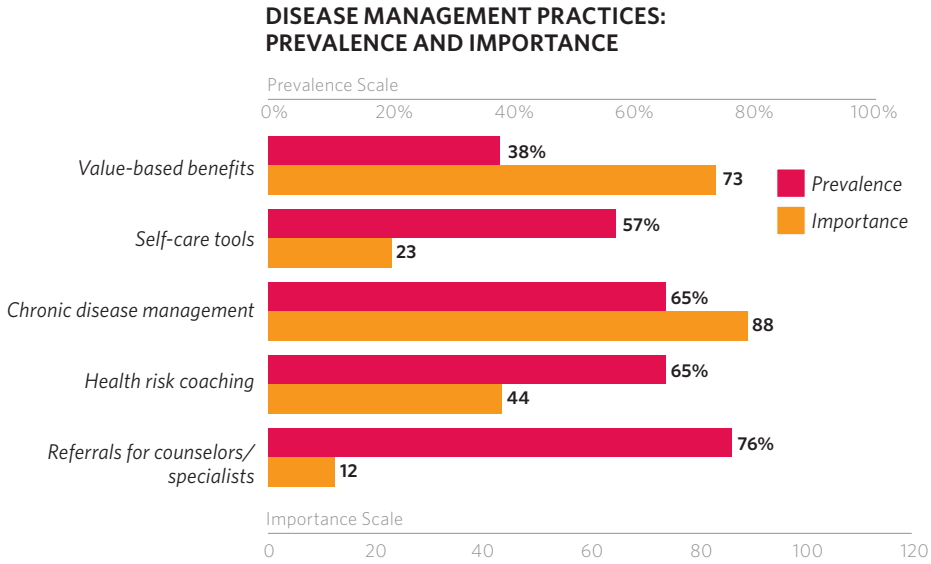
Commentary: Health promotion strategies are relatively new for employers. An overall lack of experience may account for some of the inconsistency in prevalence versus importance. In addition, it may be that programs that are less expensive, easier to implement, more popular with employees, or provided entirely by a group health plan or other outside suppliers are easier to adopt than others that require substantial employer commitment and resources, such as on-site providers.

It isn't clear why participation incentives are ranked relatively low in prevalence but quite high in importance. It may be that incentives are even a newer approach, and it may be that the corporate culture must support incentives for them to be broadly adopted. It also may be that legal issues and federal regulatory threats around the ability of employers to offer incentives may be confusing employers' willingness to implement such an important practice.

Prevalence and Importance of Disease Management Practices

The pattern of prevalence and importance is even less clear in relating the importance of practices in the disease management category to their prevalence of adoption. The chart to the right illustrates that the least important practice (referrals for counselors/specialists) is the most commonly adopted, while a highly important strategy (value-based benefits) is least prevalent.

The most important disease management approach—chronic disease management—has an adoption rate around the middle of the prevalence range.



Commentary: Value-based benefits still are quite new to disease management, and that newness may translate into the same delayed rate of adoption observed for health promotion programs as a group.

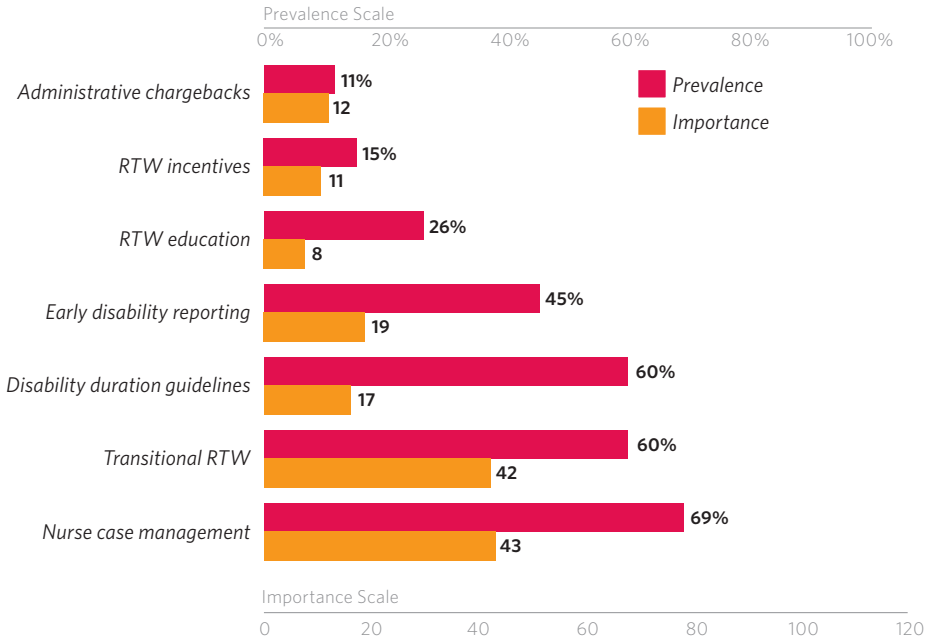
What's more, there are a number of administrative and technical hurdles in adopting value-based benefits, most significantly the adoption of a measurement component for determining which benefits, conditions and treatments a benefits design should encourage. As we report later in this study, employers often do a poor job of measuring outcomes.

Prevalence and Importance of Return-to-work Initiatives

The pattern observed in the chart on this page is more like what one would expect if prevalence were related to importance; the practices designated as important by experienced employers are more prevalent than those deemed less important.

Nurse case management and transitional RTW both are highest in prevalence as well as in importance. Incentives both to encourage employee return to work and to encourage operations management to embrace RTW (administrative chargebacks) are, at the same time, the least prevalent and relatively unimportant. The exception is RTW education—the least important of all. Because RTW education is relatively inexpensive to implement (for example, disseminating written notices), it may require less corporate buy-in than other, slightly more important practices.

RETURN-TO-WORK PRACTICES: PREVALENCE AND IMPORTANCE



Commentary: Workers' compensation RTW programs have been in existence for decades. IBI research (1998) documents RTW programs for workers' compensation and short-term disability in existence as early as 1977.[19]

With that experience may come a shaking out of adopted practices by importance—and retention of those practices that experience teaches are important.

The two RTW incentive programs surveyed—RTW incentives and administrative chargebacks to encourage RTW—are surprisingly low in importance for these respondents. IBI's 1998 research notes that incentives ranked relatively high in importance as an RTW program component: lower than transitional return to work but about the same as nurse case management.

In this research, disability duration guidelines and programs to allow and encourage early disability reporting are relatively new HPM practices and were not part of the earlier survey. They may have tended to replace incentives in the view of respondents, as employers were permitted to select only their top-three practices in importance.

[19] IBI (July 1998).

What Outcomes Do Employers Want?

We asked respondents to describe the intended health and productivity outcomes of each initiative they designated "most important," "second most important" or "third most important."

Respondents were instructed to indicate whether any of the following were primary or secondary outcomes:[20]

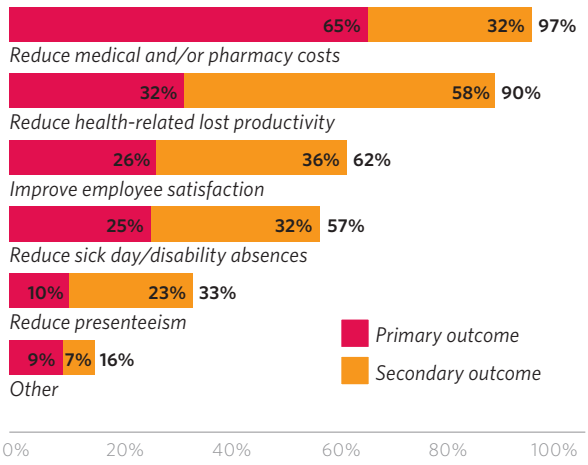
- Reduce sick day/disability absences (subsequently referred to as "health-related absence")
- Reduce presenteeism (underperformance on the job due to illness)
- Reduce health-related lost productivity
- Reduce medical and/or pharmacy costs
- Improve employee satisfaction
- Other

The chart on this page shows that a majority of respondents (65%) cite reducing medical and/or pharmacy costs as a primary outcome of their important HPM strategy. Medical and pharmacy costs are cited as an intended primary outcome twice as often as the next-most-common outcome—reducing health-related lost productivity (32%)—and six times more frequently than last-ranked presenteeism (10%). The remaining health and productivity outcome—reducing health-related absence—is cited as a primary outcome about as frequently as is improving employee satisfaction. By comparison, respondents selected an unlisted outcome as primary 9% of the time (for example, respondents would sometimes reflect the substantive goal of a program from the employee's perspective, such as ensuring timely and appropriate medical treatments or helping them quit smoking, rather than the bigger-picture organizational benefits of a program).

Considering both primary *and* secondary outcomes, however, reveals much greater comparability between reducing health-related lost productivity and reducing medical and/or pharmacy costs—these are cited by 90% and 97% of respondents, respectively. We reiterate that respondents were given the option of declaring that a program had no secondary outcome at all so that respondents did not feel forced to declare a health and productivity outcome response where they did not feel it was appropriate.

Considering secondary as well as primary outcomes also reveals that a majority of employers cite reducing health-related absence (57%) and improving employee satisfaction (62%) as goals. Presenteeism, however, remains an intended outcome for only a minority of employers—only one in three employers cite it as a desired outcome. Similar to what we observed with the relative underutilization of RTW, these results reveal a discrepancy between the considerable business costs of presenteeism and employers' efforts to manage it. Research reveals that presenteeism is often costlier to employers than either health-related absence or group health medical costs.[21]

INTENDED OUTCOMES OF EMPLOYERS' IMPORTANT HPM PRACTICES



[20] Respondents could also indicate that another, unlisted outcome was a primary or secondary goal or that a practice had no known primary or secondary outcomes. Six percent of employers indicated that a practice had no primary outcomes or that they did not know the intended primary outcome. Twelve percent of employers cited no secondary outcome or an unknown secondary outcome.

[21] See Wang et al. (2003), Goetzel et al. (2004), Loeppke et al. (2007), Loeppke et al. (2009) and Schultz et al. (2009).

Approaches Intended to Achieve Specific Outcomes

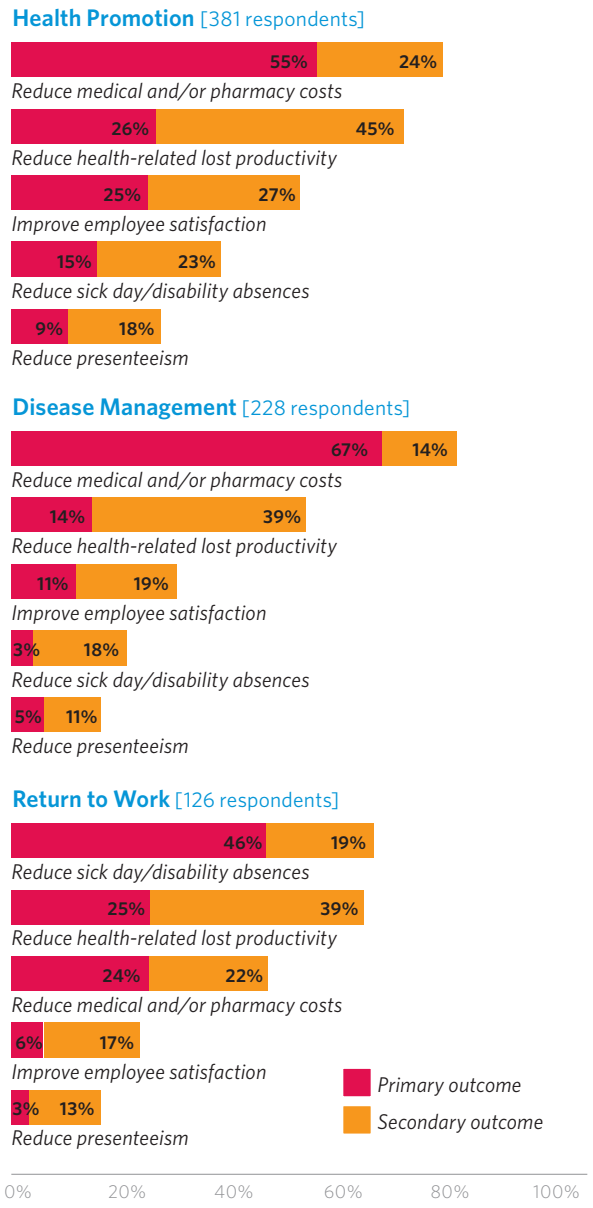
Given our sample size and the number of HPM practices surveyed, we could not analyze the intended outcomes of individual initiatives, although employers tend to use different program categories to achieve different outcomes. As shown in the chart to the right, a majority of employers cite medical costs and health-related lost productivity as an intended outcome for at least one of their health promotion and disease management practices. Employee satisfaction, health-related absence, and presenteeism are more commonly cited for health promotion than for disease management, but the order of priority remains the same for both groups.

The pattern for RTW is somewhat different: More than six in 10 employers cite reducing health-related absence and health-related lost productivity as intended outcomes. Reducing medical costs is an intended outcome for less than half the employers with RTW. Employee satisfaction and presenteeism are cited least frequently.

It may be an oversimplification to say that health promotion and disease management have essentially the same goals. It is clear, however, that employers view RTW as qualitatively different from other types of practices and that the intentions of their RTW efforts rest primarily on productivity issues rather than on medical costs or employee satisfaction.

INTENDED OUTCOMES BY PRACTICE TYPE

Percentage of employers that use at least one of their programs to achieve an intended outcome



Commentary: It is important to reiterate that to reduce the burden of completing the survey, we asked about only the two top outcomes of employers' three most important initiatives. In essence, we have information on only employers' standout results. Thus, for example, employee satisfaction may be an important outcome for an RTW practice, but employers either may not have chosen that practice as one of their three most important practices or two other outcomes for the practice may have been more important to an employer with a practice.

These results should be considered a general HPM category perspective on outcomes for this group of employers rather than the view from specific employers.

How Employers Measure Their HPM-specific Outcomes

To understand how employers monitor the performance of their HPM strategies, we asked how they measured their intended outcomes.

We asked employers whether they measured their intended outcomes through:

- Claims data
- Employee self-reports
- HR/administrative data

Participants also were given the option of responding that their organization did not measure a particular outcome for a given practice or that they did not know how outcomes were measured. They also were asked to select as many types of measurement as were applicable. Because we know that medical costs and pharmacy costs are typically monitored using claims data, we limit our analysis in this section to only those outcomes with clear productivity implications.

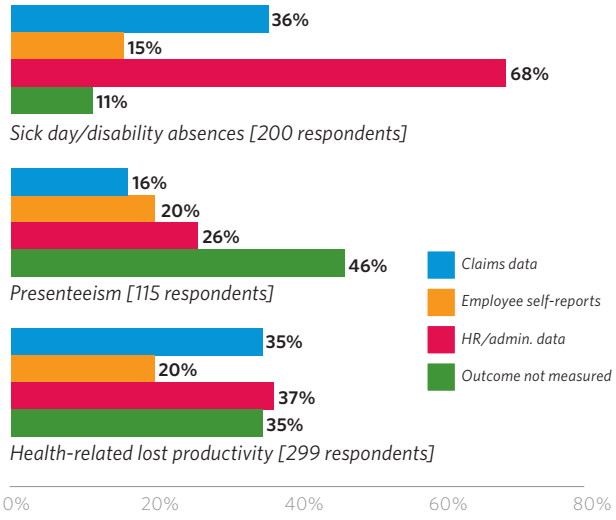
As shown in the chart to the right, employers tend to use different measurements for different outcomes. Absence is the most commonly measured outcome. Two in three employers that cite reducing health-related absence as an intended outcome measure performance with internal HR/administrative data, while one in three uses claims data (most likely for disability absences).

HR/administrative data are the most commonly cited source of measurement for both presenteeism and lost productivity, followed by employee self-reports (perhaps through HRAs or other surveys).

Only about one in 10 employers did not measure absences. By contrast, almost half of employers reported that they do not measure presenteeism, and one in three does not measure health-related productivity. Overall, one in three employers does not measure any of the outcomes for its HPM initiatives.

METHOD OF MEASUREMENT BY OUTCOME TYPE

Percentage of employees citing intended outcome



Commentary: Measurement patterns shown in the above chart reflect what employers themselves say are their three most important HPM practices. If they fail to measure outcomes for their most important efforts, they may be less likely to do so for practices of lesser importance.

Interestingly, one in three employers reports using "claims data" to measure lost productivity, and one in six uses claims data to measure presenteeism. Given that presenteeism and health-related lost productivity are less easily observed concepts than absences (it is relatively easy to determine whether an employee took a sick day off or missed work for a disability), these results are difficult to interpret. It is possible that employers use information from group health and disability claims— such as health conditions and wage replacement payments—to model or simply estimate lost productivity or presenteeism.

Perhaps for some respondents this was an expression of confusing HR data with data collected for benefits administration purposes by HR through a health assessment.

Why *Not* Measure Outcomes?

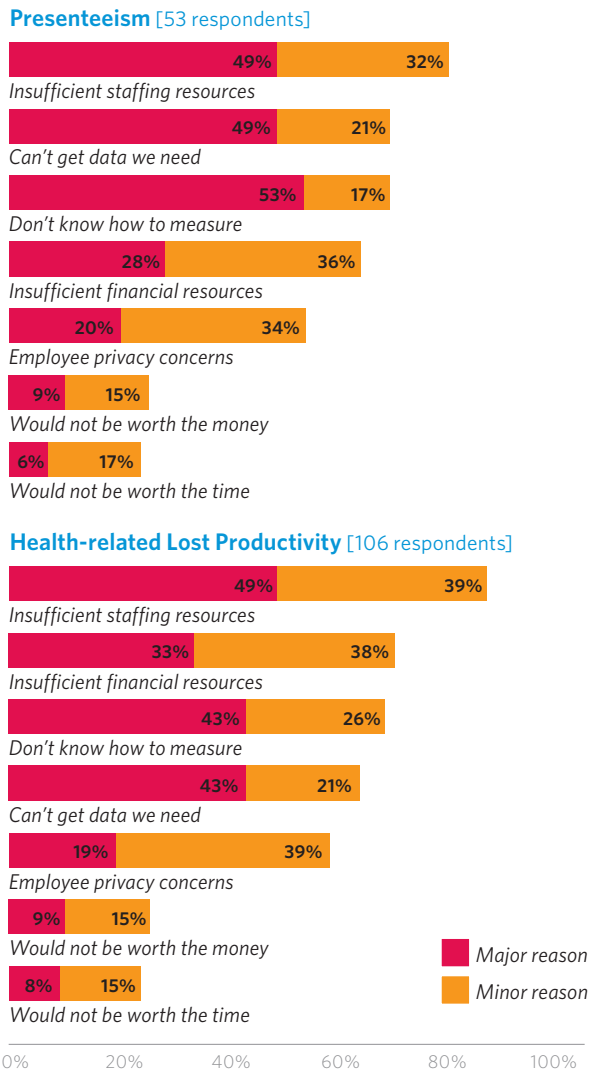
We further explored the reasons *why* employers do not measure presenteeism or health-related productivity (there are too few employers that do not measure health-related absence to conduct an analysis). We found that although employers recognize the value of measurement, they face a number of organizational constraints.

The chart to the right indicates that fewer than one in four employers believe that it is not worth the time or money to measure presenteeism or lost productivity. By contrast, all other reasons for not measuring these outcomes are cited by a majority of employers and are generally similar for both types of outcomes: Insufficient staffing resources is the most-cited reason, followed closely by insufficient financial resources and issues surrounding data availability and measurement expertise. Employers also cite a high level of concern for employee privacy, but in both cases this is more likely to be reported as a minor reason rather than a major reason.

Interestingly, we found no significant differences in nonmeasurement by employer characteristics that are potentially related to bureaucratic, human capital or financial resources: employer size, ownership status and industry.

REASONS FOR NOT MEASURING PRESENTEEISM AND HEALTH-RELATED PRODUCTIVITY

Percentage of employers that do not measure outcome



Commentary: Lack of knowledge about how to measure presenteeism is the only major reason cited by a majority of employers. This suggests either that these employers are unaware of employee self-report tools or that they don't find them credible.

There are several credible self-report tools available. IBI offers the HPQ-Select in partnership with Ron Kessler, Ph.D., Harvard Medical School. This tool is an updated version of the HPQ developed by Dr. Kessler and the World Health Organization. HPQ-Select reports include a research-based monetization of lost time to costs of lost productivity.

How Employers Perceive the Impact of Important Programs on Intended Outcomes

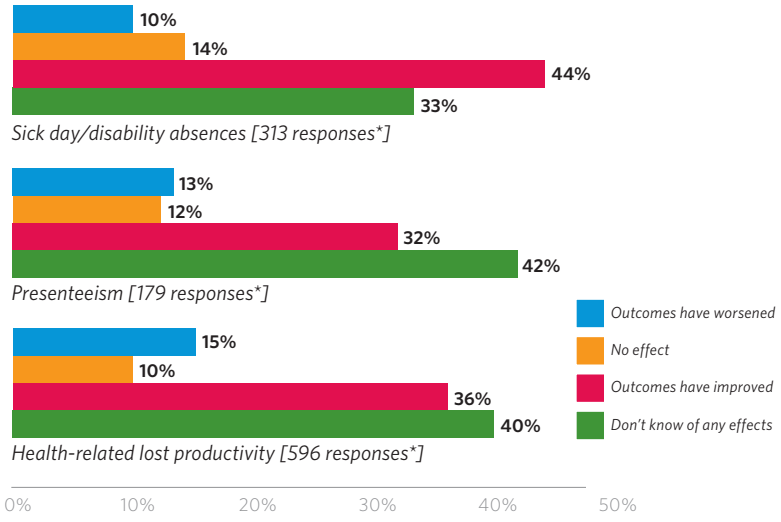
A sizable minority of respondents do not know if a given HPM strategy had any effect on its intended lost-productivity outcomes.

As the chart to the right illustrates, this is the case of between 33% and 42% of respondents.[22] Nonetheless, for health-related absence, presenteeism and health-related lost productivity alike, respondents with an opinion typically report that an initiative improved outcomes rather than worsened them or left them unchanged. This is especially true of health-related absence: Respondents reported that 44% of important practices achieved their intended goal of health-related absence. Presenteeism and health-related lost productivity showed improved outcomes for 32% and 36% of instances, respectively. Overall, for every approach employers believe to have worsened outcomes, three employers believe that outcomes have improved.

[22] Because we asked respondents about the intended outcomes for each of their three most important practices, the number of questions about effectiveness exceeds the number of survey respondents.

IMPACT OF IMPORTANT PRACTICES BY INTENDED OUTCOME

Percentage of programs intended to achieve specific outcomes



**The number of responses represents the number of instances in which respondents were asked about a practice's effectiveness at achieving an intended outcome.*

Commentary: Perhaps more telling is the result limited to respondents who say they have an opinion about the result of the practice (that is, removing those respondents that don't know). When reduction in health-related absence is sought, 65% of those respondents believe that outcomes improved. For presenteeism and health-related productivity improvement, 56% and 59%, respectively, believe that they had achieved an improved outcome.

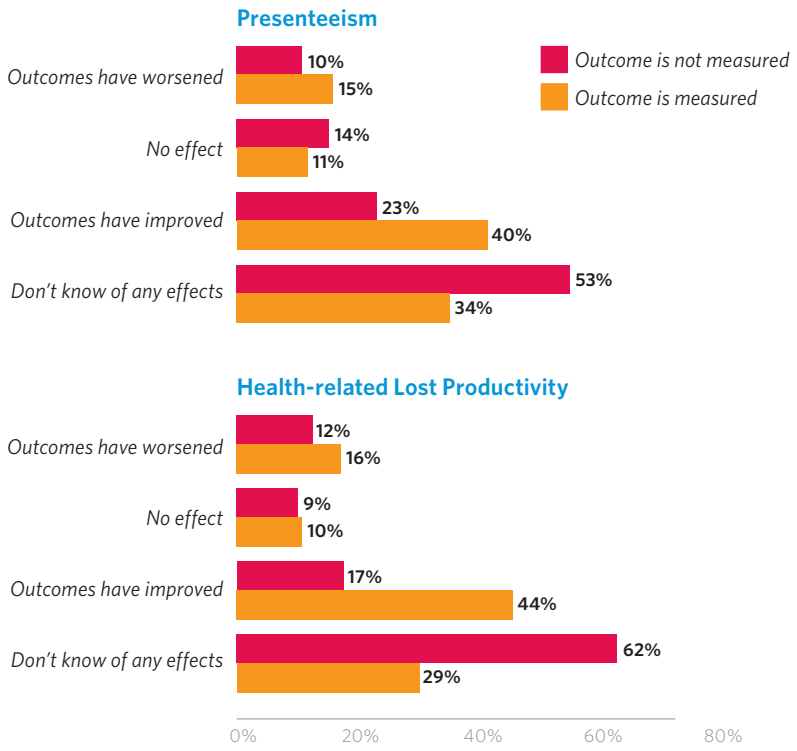
The finding that employers do not measure outcomes in many instances complicates efforts to understand the effectiveness of HPM efforts. To illustrate how measurement influences the way employers view a practice's performance, the chart to the right compares responses for initiatives with measured and unmeasured presenteeism and health-related lost productivity.[23]

Not surprisingly, employers are better able to form opinions about effectiveness when they measure outcomes than when they do not. When presenteeism is not measured, respondents are 55% more likely to say they do not know if an initiative had any effect than when presenteeism is measured. The results for health-related lost productivity are more dramatic: Strategies with unmeasured lost productivity are 114% more likely to result in unknown outcomes than those with measured results.

While measurement tends to amplify opinions about both positive and negative program outcomes, the "measurement gap" in positive outcomes is greater than the gap in negative outcomes, in both absolute and relative terms. Respondents note improvements in presenteeism 74% more often when a program measures outcomes than when it does not; by contrast, they note worsened presenteeism 50% more often. The measurement gap is even stronger for health-related lost productivity. Measured programs have 158% more observations of improved outcomes than unmeasured programs, contrasted with 33% more observations of worsened outcomes.

IMPACT OF IMPORTANT PRACTICES BY OUTCOME MEASUREMENT STATUS

Percentage of programs intended to achieve specific outcomes



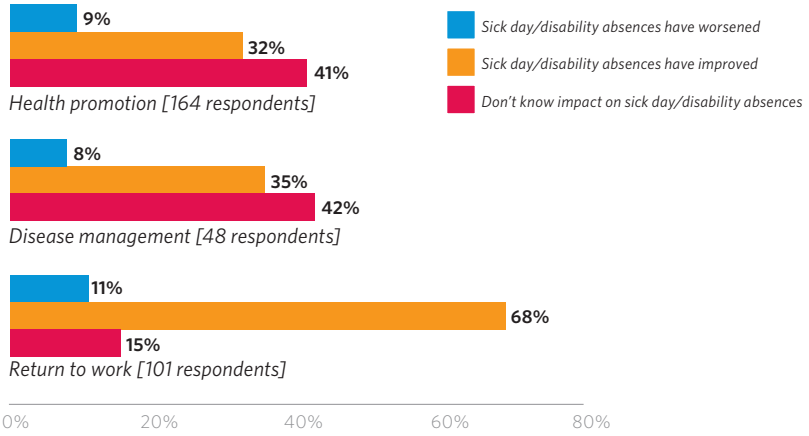
[23] The number of employers that do not measure health-related absence is too few for a meaningful analysis.

The two charts on this page illustrate respondents' abilities to form opinions about productivity-related outcomes for the three program categories. Respondents are better able to provide opinions of program outcomes for RTW than for outcomes in the other two types of program categories. The share of employers reporting that they do not know the effects of health promotion or disease management programs on health-related absence is three times greater than the share that does not know the impact of RTW programs on health-related absence. For the impact on health-related lost productivity, about twice as many employers don't know the impact of health promotion or disease management programs than don't know the impact of RTW programs (results for presenteeism outcomes followed the same pattern but were not significantly different).

Moreover, employers report more positive outcomes for RTW programs than for other types of programs. Employers report that RTW programs have reduced health-related absence nearly twice as often as they report reduced health-related absence for health promotion and disease management programs. For health-related lost productivity, employers report improvements for RTW programs 50% more frequently than they do for other types of programs.

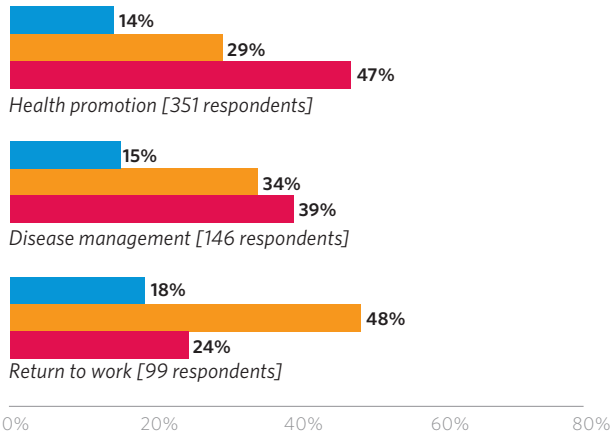
IMPACT ON SICK DAY/DISABILITY ABSENCES BY PRACTICE TYPE

Percentage of programs intended to achieve specific outcomes



IMPACT ON HEALTH-RELATED PRODUCTIVITY BY PRACTICE TYPE

Percentage of programs intended to achieve specific outcomes



Note: Differences across program groups are statistically significant.

Commentary: It is not surprising that the impact of return-to-work programs on lost time and the resulting lost productivity is better known. The baseline of days lost, the intervention and the resulting savings are all within the disability/absence program silo. It is when the goals, interventions and results are in different benefits-program silos that employers appear to have difficulty coordinating and putting the information together in a meaningful way. Separate vendors that don't coordinate their efforts can particularly exacerbate this problem.

Future Plans for Current Initiatives

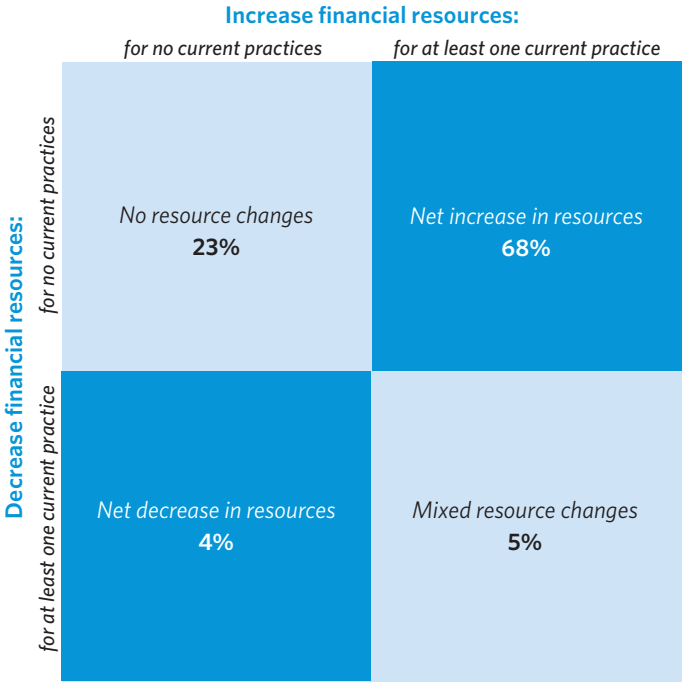
Taken as a whole, our results suggest that employers generally see positive benefits to their current HPM strategies and plan to expand them in the next two years.

As shown in the table below, approximately one in four employers (23%) with at least one HPM program will neither add nor subtract financial resources from any of its programs over the next two years, while two in three (68%) plan to add resources to at least one program with no corresponding decrease in any other program (that is, they foresee a net increase in financial resources for existing HPM programs). By contrast, only 4% expect a net decrease in HPM resources, and 5% expect to decrease resources for at least one program while simultaneously increasing resources for at least one program.

While employers' commitments to overall HPM efforts are strong, their expectations about increasing resources for specific HPM initiatives vary widely. The chart on page 25 shows employers' expected changes to their current HPM practices over the next two years. The percentage of employers that expect to increase financial resources ranges from 48% (for incentives to encourage participation in specified health promotion or disease prevention) to 6% (for RTW administrative chargebacks to organizational units). The average across all practices is 27%.

Moreover, employers that will not increase financial resources typically will not decrease them, either. For no practice did more than 4% of respondents report that they would decrease or eliminate resources entirely. (The generally small differences between the percentages reported for each practice and 100% constitutes respondents that say they don't know their company's plans for the specific program that they have in place.)

EMPLOYERS' PLANS FOR EXISTING HPM PRACTICES

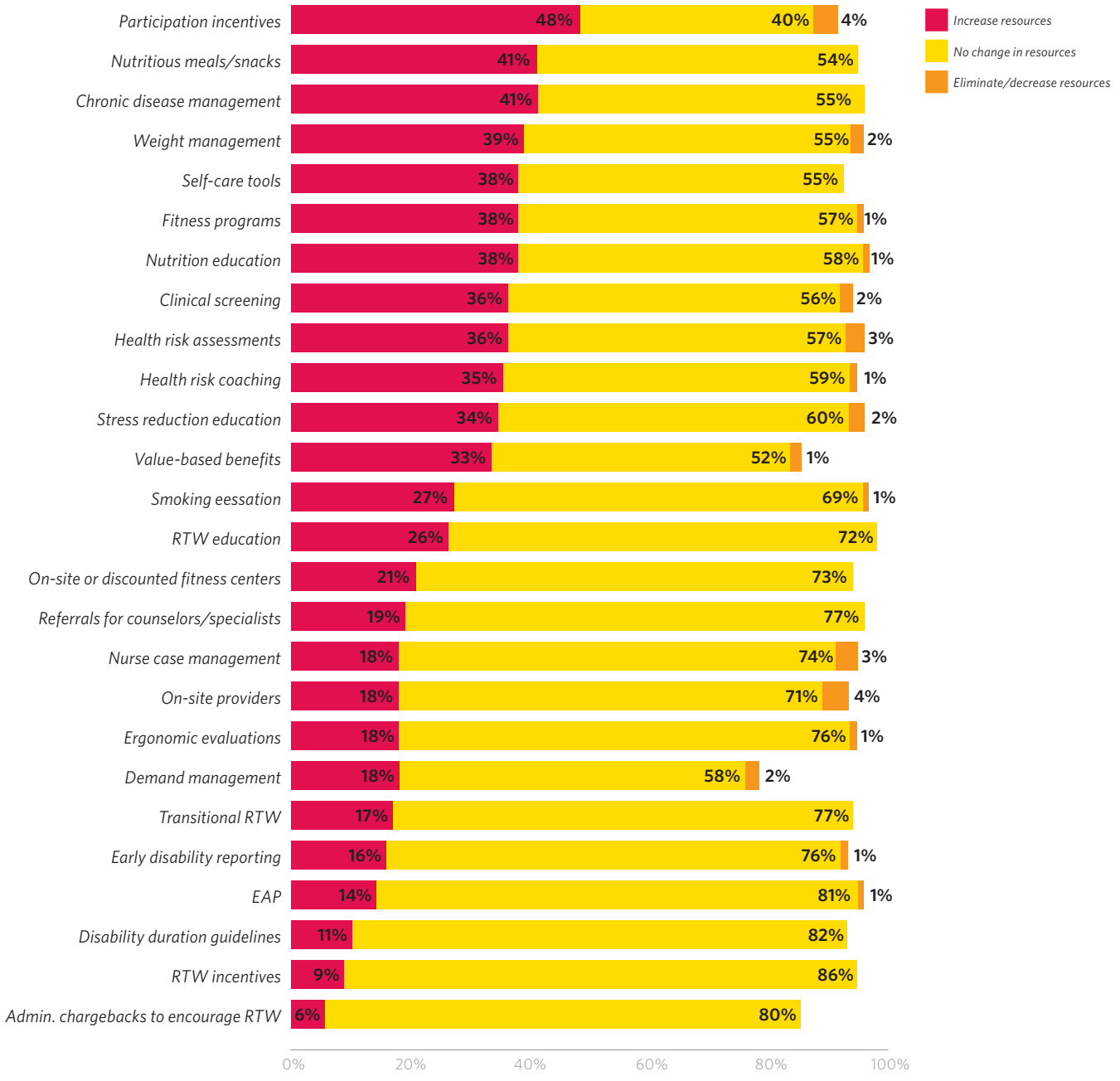


[426 respondents]

Commentary: These results constitute the best practice-by-practice evidence in this survey of employer commitment to wellness efforts though health and productivity interventions. The responses show a broad-based commitment to increases in program resources, even at the depths of the recession in the summer of 2009.

PLANS FOR SPECIFIC PRACTICES OVER THE NEXT TWO YEARS

Percentage of employers offering the program [number of respondents varies]

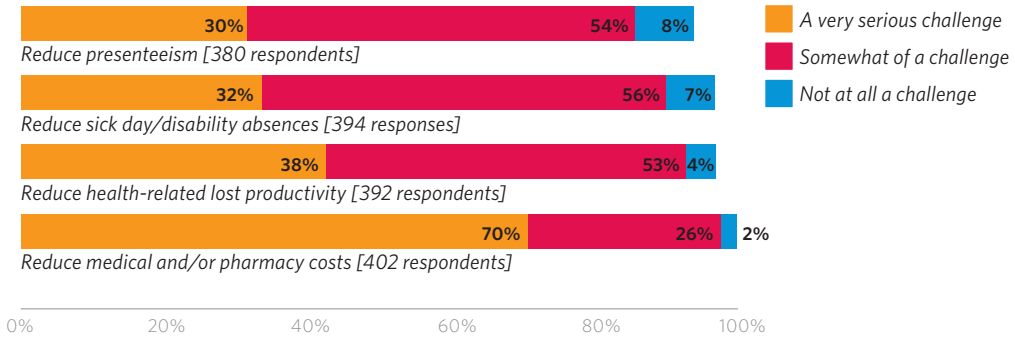


How Employers Perceive Challenges

The finding that employers generally anticipate stability—and in most cases growth—in their HPM efforts is noteworthy, not just in the context of the current business climate but also in light of what they perceive as looming health and productivity challenges.

The chart to the right shows that roughly one in three employers expects that reducing presenteeism, health-related absence and health-related lost productivity will be a serious challenge over the next two years. This is much less than the seven in 10 employers who expect reducing medical and/or pharmacy costs to be a serious challenge. Considering challenges that are both serious and somewhat serious, however, suggests that employers are nearly as mindful of the need to meet health and productivity management challenges as they are medical costs–control management, just to a lesser degree of intensity. Few employers perceive no challenges at all.

HEALTH AND PRODUCTIVITY CHALLENGES OVER THE NEXT TWO YEARS



Commentary: Given that recent research co-authored by IBI finds that lost-productivity costs from health-related lost time amounts to 2.3 times the medical and drug costs borne by study participants,[24] this finding demonstrates the challenges faced in educating employers about the true costs of health-related issues.

Given the focus on medical cost issues in today's political and economic climate, however, this employer misapprehension of the relative impact of the challenges presented by medical/pharmacy costs compared with absence/disability, presenteeism and lost productivity appears likely to continue.

[24] Loeppke, Taitel, Haufle et al. (2009).

Conclusion

Rather than simply focusing on medical and pharmacy savings that can come from a variety of health interventions, the health and productivity efforts measured in this survey of some 450 employers constitute a bottom-line view of wellness, prevention, and disease and disability management efforts.

This survey highlights the extent to which employers seek a savings in lost time and lost productivity from such efforts, which research suggests dwarfs the medical and pharmaceutical costs associated with many chronic medical conditions affecting the workforce.[25]

Probably the most telling result that reflects on a changing employer attitude is the strong emphasis by employer respondents on the importance of reducing health-related lost productivity as the primary or secondary goal of employers' HPM practices. Thirty-two percent of employers say reducing health-related lost productivity is a primary outcome for at least one of their three most important practices. Overall, 90% of respondents say reducing health-related lost productivity is a primary or secondary outcome of their important HPM programs. Given the focus most employers have had in recent years on surging medical costs, this result is significant.

Further, in addition to the broad adoption of current HPM practices across employer size groups, employers also note significant plans to add HPM practices in the next two years, and 68% plan to increase resources devoted to at least one of their current practices while planning no decreased resources for any of their other practices. It is significant that even in the difficult economic times of summer 2009, employers still were willing to invest in the health and productivity of their workforce.

Finally, though it is difficult to demonstrate a trend in adoption of HPM practices based on IBI surveys in 2004 and 2009, comparing the adoption of similar practices demonstrates significant, substantial growth in adoption of many of those practices.

Employers show strong, expanded buy-in for HPM practices. Given the likelihood that healthcare costs will continue to increase, employer efforts to improve the health and productivity of their workforce must be encouraged to provide a win/win for employers, their employees and dependents, and the nation.

[25] Loeppke, Taitel, Haufle et al. (2009).

Appendix

Description of Surveyed Health Promotion or Injury/Disease Prevention Practices

Practice	Description Provided in Survey
Nutrition education	Diet/nutritional education (e.g., weight management, cholesterol guidelines, etc.)
Weight management	Weight management
Fitness	Fitness or events (e.g., sponsorship of employee athletic participation, weight-loss contests, etc.)
Demand management	Demand management (e.g., nurse care hotlines, employee decision-support tools, benefits education, etc.)
On-site or discounted fitness centers	On-site fitness facilities or discounted/free memberships at local health clubs
Nutritious meal/snack options	Healthy meal or snack options in on-site cafeterias or vending machines
EAP	Employee Assistance (for work-family balance guidance, substance abuse issues, etc.)
Stress reduction education methods	Instruction in stress reduction methods
Ergonomic evaluations	Ergonomic evaluations of the workplace
Health risk assessments	Health risk assessments (e.g. a survey to evaluate employees' health status)
Clinical screening	Screening for conditions such as high blood pressure, cancer, high cholesterol, etc.
Participation incentives	Adjusted premiums, co-payment/deductibles and/or job characteristics to encourage participation in specified health promotion or disease prevention
On-site providers	On-site clinic, pharmacy, nurse or other health practitioner
Smoking cessation	Smoking or substance abuse cessation
Self-care tools	Tools, information or equipment to help employees diagnose their own conditions or monitor their own care
Referrals for counselors/specialists	Referrals for counselors/specialists
Health risk coaching	Health/lifestyle coaching for employees with health risks
Chronic disease management interventions	Coordinated healthcare interventions for employees with specific chronic conditions (e.g., asthma, back pain, cancer, cardiovascular disease, diabetes, high blood pressure, depression, obesity, etc.)
Value-based benefits	Value-based benefit design (e.g., altering cost tiers for certain conditions or pharmaceuticals)

Practices to Help Your Employees Return to Work from a Disability

Practice	Description Provided in Survey
Early disability reporting	Early/expedited disability claim reporting
Transitional RTW	Transitional RTW
RTW education	"Just-in-time" employee education about RTW opportunities
RTW incentives	Employee incentives for RTW participation
Administrative chargebacks to encourage RTW	Financial incentives for management and supervisors to accommodate RTW (e.g., cost chargebacks to organizational units)
Disability duration guidelines	Disability duration guidelines
Nurse case management	Nurse case management

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For almost 15 years, IBI has been in the forefront, leading businesses from concept to reality in integrating health, absence and disability management benefits as an investment in a productive workforce. IBI's independent, cutting-edge approach and innovations consistently provide added value to a prestigious roster of employers, from leading corporations to small companies as well as their benefits management business partners.

IBI is committed to and invested in ground-breaking analysis of health, productivity, disability and absence issues as they cut across traditional health-related benefits, as well as expanding and enhancing its proven suite of measurement tools. Tackling the latest business challenges with state-of-the-art research, insights and thought leadership, IBI provides companies with robust and actionable integrated health and productivity benefits strategies. In close collaboration with frontline experts working on today's critical business issues, IBI helps employers blaze a new trail both to superior benefits management in alignment with company objectives and to proving the business value of their health investment.

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