

THE WELLNESS IMPERATIVE

By

Dr. John Zabasky, MA, MBA, PhD  
Chief Executive Officer  
WorXsiteHR Insurance Solutions, Inc.

*and*

Dr. Diana McCosham, MD  
Medical Director  
Xtension Health, Inc.

In 1979, Surgeon General Julius Richmond authored a landmark report entitled *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. It signified an emerging consensus in the health community that the nation's health strategy required a major restructure to focus on the prevention of disease, rather than treatment only. The report established for the first-time objectives that were both ambitious and quantifiable, with the goal of dramatically improving the nation's health by 1990. The five primary goals of the report were to improve the health of the U.S. population in five major life stages (infants, children, adolescents and young adults, adults, and older adults). The method of the 1979 report encouraged people to take more *individual* responsibility for their health through proper nutrition, regular physical exercise and other healthy lifestyle behaviors.

The five major life stages theme has continued through the decades as part of the Healthy People initiative. Over 20 years later, the purpose of *Healthy People 2000* was to commit the nation to the realization of three broader goals. These goals were to increase the span of healthy life, to reduce health disparities among Americans, and to achieve access to *preventive services* for all Americans. Realization of these broad goals would help the nation reach its full potential in regard to healthy living. In a significant departure from the original *Healthy People* report, the *Healthy People 2000* now called on *employers* to lead the way to better living for “whatever the motivation, now is a particularly opportune time for employers to invest in health promotion at the worksite and beyond.”<sup>1</sup> This change had a lot to do with a noticeable shift toward an onset of chronic disease within American’s of working age. Preventive wellness services and chronic disease management became the focus of organizational wellness programs in an attempt to promote good health or to identify and correct potential health related problems to develop high functioning employees (Wolfe, Parker & Napier, 1994, as cited by

---

<sup>1</sup> Healthy Workforce 2010, U.S. Department of Health and Human Services, 2001, p. 2

Parks & Steelman, 2008)<sup>2</sup>. By doing so, organizational wellness programs sought to reduce economic burden because of illness related loss of productivity due to absence from work (absenteeism) and reduced performance while at work (presenteeism)<sup>3</sup>

Underlining the vital role of partnerships, *Healthy People 2000* was the product of a cooperative effort among government agencies, businesses, nonprofit organizations, and the scientific community. It was developed in collaboration with 22 work groups of experts, agencies of the Federal government, the National Academy of Sciences' Institute of Medicine, and a consortium of over 375 members representing national voluntary organizations and all the State health departments. Regional and national meetings provided input from a broad cross section of citizens, families, and communities. Moreover, following widespread public review of and comment on a draft document, the *Healthy People 2000* objectives were revised and polished. Modifications established baselines for all *Healthy People 2000* objectives for which data was available. Most of these baselines are the same as those established in the original *Healthy People 2000* report; others were changed to reflect revisions to the original baselines or entirely new.

In order to further emphasize the effects of a less than healthy workforce, Parks and Steelman (2008) published a Meta-Analysis, which included articles and dissertations from 1980 to 2005 focusing on the effects of participation in wellness programs on absenteeism and/or job satisfaction, both key factors in an organization's productivity in order to help determine if in fact the benefits of wellness programs justify the expense of their implementation and maintenance.

---

<sup>2</sup> Parks KM, Steelman LA. (2008). Organizational Wellness Programs: A Meta-Analysis. *Journal of Occupational Health Psychology* Copyright 2008 by the American Psychological Association Vol. 13, No. 1, 58–68

<sup>3</sup> Mattke S, Liu H, Caloyeras J, Huang CY, Van Busum KR, Khodyakov D, and Shier V. (2013). Workplace Wellness Programs Study. *Rand Health Quarterly* 3(2): 7.

Absenteeism was estimated to cost organizations more than 26 million dollars each year (Althiler & Motta, 1994, as cited by Parks & Steelman, 2008), and accounted for 10.4 million workdays lost each year (Ho, 1997, as cited by Parks & Steelman, 2008). Job satisfaction, on the other hand, but not less important, is associated with an employee's view and attitude towards his or her employer and overall organization, which in turn alters their work performance.

The meta-analysis concluded "that participation in an organizational wellness program overall was associated with lower absenteeism rates and higher job satisfaction" (Parks & Steelman, 2008). The study found that participation in wellness programs was associated with healthier employees, reducing the likelihood of sickness-related absences. They also found an increment in job satisfaction based on three supporting findings:

1. Positive impact on employees' views of Perceived Organizational Support: Employee believes employer cares and values them.
2. Wellness programs may be seen as an additional perk in today's society, which is starting to see the importance of health and fitness awareness, making it an attractive recruiting tool and possible deal maker/breaker when considering a new job opportunity.
3. Wellness programs encourage healthy lifestyles and stress management which have been shown to improve job satisfaction by reducing stress levels.

It is worth mentioning, that no moderating effects were found when examining the methodological rigor and type of wellness program (fitness only or comprehensive), indicating that smaller companies, with less budget, can also benefit from wellness programs without the need to install an onsite fitness facility per se (Parks and Steelman, 2008)

These findings were later confirmed by Mattke et al. in 2013, in the final report on a Workplace Wellness Programs study which found statistically significant and clinically meaningful improvements in exercise frequency, smoking behavior, and weight control, but not cholesterol control, when comparing wellness program participants to statistically matched non participants, indicating that wellness programs can help contain the current epidemic of lifestyle-related diseases, therefore reducing morbidity and mortality as well as health care cost in the US.

*Healthy People 2010: Objectives for Improving Health*, released in January 2000, carried the Healthy People initiative into the next decade as well as into a new millennium. As the third generation of 10-year goals for the nation, it built on initiatives pursued over the previous two decades. Setting itself apart from previous Healthy People efforts, *Healthy People 2010* introduced for the first time a set of 10 Leading Health Indicators (LHIs). Intending to serve as an instrument of the nation's well-being, the LHIs reflected major public health priorities in the United States at the beginning of the 21st century. They were chosen because of their importance as public health issues, their ability to motivate action, and the availability of data to measure their progress. The 10 LHIs are physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and *access to health care*. This last but not least objective became the focus of the Patient Protection and Affordable Care Act (PPACA). It was the passage of this Act, combined with decades of numerous cooperative agencies and institutions pushing the *Healthy People* objectives which brought us to where we are today.

PPACA clearly outlines the ten essential health benefits (EHB) that *fully-insured* plans must cover for such plans to be considered 'Qualified Health Plans':

- Ambulatory patient services (outpatient services)
- Emergency services

- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services (those that help patients acquire, maintain, or improve skills necessary for daily functioning) and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Many provisions of the ACA apply to all types of health insurance. For example, the ban on pre-existing condition denials as well as the ban on annual caps apply to both self-funded and traditional health insurance. Yet, by self-funding healthcare plans, companies can avoid significant ACA and state requirements applicable to traditional health insurance.

Below are the five main regulatory benefits that companies derive from self-funding their healthcare insurance.

1. Self-funded plans are not subject to the Essential Health Benefit (EHB) requirements of the ACA, which stipulate minimum coverage for healthcare plans sold by insurers to companies with 50 or more full-time or full-time equivalent employees. Such minimum coverage includes maternity care, mental health and preventative services, and is commonly offered through what are called Minimum Essential Care or MEC plans.

2. Self-funded plans are not subject to the community rating requirements that ACA applies now to companies with 50 or more full-time or full-time equivalent employees. These requirements restrict how much insurers may use health factors like age and smoking status within a firm's population to vary the total premiums charged to the firm.
3. Self-funded plans are not subject to medical loss ratio requirements, which apply to policies issued by traditional healthcare insurers. These requirements mandate that at least 80% of premiums received by the insurer be spent on healthcare activities, as distinct from administrative functions.
4. Self-funded plans escape the health insurance tax mandated by the ACA on most healthcare premiums paid to traditional health insurers.
5. Self-funded plans also escape the state taxes on healthcare premiums paid to traditional health insurers.

Beside these regulatory benefits outlined above, self-funding has two other benefits. In general, total costs for self-funding are lower than traditional health insurance because self-funding does not absorb the marketing costs and profit margins of traditional health insurance. These relative costs savings have been estimated at 10 to 25 percent in non-claims expenses, according to the Self Insurance Educational Foundation.

In general, self-funded plans allow greater flexibility than traditional insurance policies in the design of benefit packages. A company can customize benefits to reflect the special circumstances of its particular workforce. For example, if its workforce included a high number of smokers, the company could include

more rigorous incentives to stop smoking than a traditional health insurance policy – which would otherwise be limited by community rating requirements.

What can be done to address both the needs of a company’s particular workforce within self-funded plans, and meet the ever-sated goals of the *Healthy People* initiative? As stated above, self-funded plans can be architected to include much more than the ‘minimum essentials’. Sections 125 and 106 of the IRC allow for certain types of products to be pre-tax. Commonly known as ‘Cafeteria’ plans, such plans traditionally offered major medical in the form of a qualified health plan, along with dental, vision, and possibly an accident plan. Because Cafeteria plans are pre-tax, they can significantly reduce an employee’s taxable income, including Medicare and social security (FICA). Since FICA is a shared tax, the employer’s tax is likewise reduced per participating employee. Further, section 105(b) of the IRC allows employees to be compensated for medical expenses (not premium) as a non-taxable reimbursement. Finally, in 2016, the Department of Health and Human Services (DHSS) estimated that the average US employee spends an average of \$10,345 per year (or \$865.42 per month) on healthcare expenses<sup>4</sup>. This amount was expected to be close to \$1,000 per month by 2018.

The issues for the *Healthy People* initiative had always been 1) how to get employers motivated to sponsor a ‘Wellness’ plan for its employees and 2) drive participation. PPACA remedied the first issue with its self-funded provisions, particularly, in point one above. By creating an exemption for self-funded plans, the law thus allowed for the formation and offering of cheap, preventative healthcare plans that met the muster of PPACA. The second issue was cured less intentionally and more as a by-product of perpetually skyrocketing healthcare costs. The numbers estimated by the DHHS, were the result of Carriers and Third Party Administrators (TPAs) charging excess premiums over decades. Those

---

<sup>4</sup> PBS News Hour. *\$10,345 per person: U.S. health care spending reaches new peak*. July 13, 2016.



numbers which now represent the standard of cost for care, can be used by innovative organizations to not only provide coverage, but provide coverage at basically no cost to employee and employer.

The solution to both decades-long problems of the *Healthy People* initiative and the spiking cost of healthcare can be realized if TPAs are willing to bolster Cafeteria plans with self-funded MECs and ancillary programs such a telehealth, health risk assessment, accident coverage, and coaching in the disciplines of chronic disease management, smoking cessation, etc. However, not only must they bolster their Cafeteria plans, but they must be willing to take the risk and indemnify companies whose claims exceed premium. For sure, this is not a task for the meek. Losses in any of the above categories could put a TPA under. However, if managed correctly as in the following case example, companies and employees could save billions along with the assurance of quality health care for up to 98% of the US workforce.<sup>5</sup>

In 2017, WorXsiteHR Administration Services, a Third Party Administrator, engaged several Denny's restaurant franchises in a Wellness program. Based on the recommended estimate of the DHHS, WorXsiteHR charged \$884.76 per month for the plan (less than the DHHS monthly estimate for 2018). The pre-tax differential was sufficient to cover the fixed cost of the Wellness program (approximately \$120). The additional \$764.76 was expensed to a separate Wellness company, Xtension Health for Wellness medical services. Xtension Health, which like WorXsiteHR, indemnified the client, took a calculated risk based upon volume and reimbursed each participating employee \$734.76 of the expenses through section 105(b) of the IRC. This reimbursement resulted in every employee having either the same net check amount or a greater net check amount than before the implementation of the Wellness plan. Several factors contributed to the success of this case study:

---

<sup>5</sup> These figures include estimates of Association Health Plan participation beginning 09/01/2018.

- PPACA's language which exempts the self-funded MEC plan from the QHP standard, thus reducing cost
- DHHS's recommended estimate of healthcare expenditure
- IRC sections 125, 106, and 105(b)
- Willingness by a TPA and partnering Wellness company to indemnify employers from inadequate claims surplus
- Technology to offer and implement Health Risk Assessments
- Low utilization of the individual Wellness Coaching by doctors
- Low utilization of the telehealth services
- High utilization of the Health Risk Assessment services

Low utilization of key elements and economy of scale allowed both WorXsiteHR and Extension Health to generate a profit, while providing no-cost healthcare to the participating Denny's employees.

Participants utilized the lower cost MEC and Accident policies at a much greater frequency than the higher cost telehealth and coaching. The program also generated a net FICA savings to the Denny's franchises of \$33.26 per participant.

With regards to the actual impact on employees' health, Xtension Health focused on preventive care and the identification of health risks and interventions to reduce risks and promote healthy lifestyles focusing on the 10 LHIs. Each employee was studied individually thru a Health Risk Assessment (HRA), which was evaluated by an MD who identified individual risk factors and created a personalized wellness plan for each employee based on the recommendations from the USPSTF (U.S. Preventive Services Task Force) Preventive services Database. These recommendations address clinical preventive services for adults and are based on comprehensive, systematic reviews and careful assessment of the available medical evidence. Of course, at the end of the day the decision-making had to be tailored to the specific

patient and situation. Each wellness plan not only gave the patient the recommendations but explained why these recommendations were given and what were the possible consequences of not adhering to them. Each employee was also given different tools (videos, exercise sheets, meal plans, etc.) and methods to achieve these recommendations, along with the access to a medical provider when needed.

The recommendations were geared towards primary prevention, the type of prevention which keeps disease from occurring at all by targeting employees with risk factors, which can be achieved by providing behavioral counseling among others. In American men, for example, primary prevention has prevented many deaths from the two major killers: lung cancer and cardiovascular disease. "Lung cancer mortality in men decreased by 25 percent from 1991 to 2007, with an estimated 250,000 deaths prevented,"<sup>6</sup> as a consequence of a trend among adults to stop smoking. Smoking cessation along with the use of antihypertensive and statin medication also reduced the rate of heart disease mortality by half over the past decades.<sup>7</sup> This proves that by guiding employees towards adopting healthy lifestyles, even if we are just successful in a single intervention, we may be able to prevent multiple diseases. For example, by helping obese or overweight patients lose weight with physical activity and nutritional guidance, we can prevent diabetes and osteoarthritis as well as cardiovascular disease and some cancers.

The importance of their yearly routine checkup was also emphasized to employees, taking into account that this is the main setting for secondary prevention. Secondary prevention detects early disease when it is asymptomatic and when treatment can stop it from progressing. It involves screening tests and follow up diagnosis and treatment.

---

<sup>6</sup> Siegel R, Ward E, Brawley O, Jemal A. Cancer statistics, 2011: the impact of eliminating socioeconomic and racial disparities on premature cancer deaths. *CA Cancer J Clin.* 2011;61(4):212

<sup>7</sup> National Center for Health Statistics. *Health, United States, 2010: With Special Feature on Death and Dying.* Health, United States, 2010: With Special Feature on Death and Dying.; Hyattsville, MD 2011

Last, but not least, Denny's employees were given access to medical providers in case of non-urgent medical situations thru TeledocX, a telemedicine company. TeledocX allowed employees to contact a medical provider from the comfort of a remote location (home, office, etc.) by easy access through a phone or online platform, reducing certain issues such as transportation costs, taking time off from work and finding child care, among others.

In conclusion, the US DHHS has long sought to improve the general health of the American workforce. Initially, the goals of the Initiative were placed on the individual, but as the failure of that strategy became apparent, more responsibility was given to the employer. Employers, however, short of the nebulous idea that healthier workers perform better, had little incentive to absorb the cost. With the advent of PPACA and the MEC exemption, there was now a plan that was not only an affordable Cafeteria 125 option, but one that offered real value to employees. The MEC plan when combined with a handful of ancillary products delivered to the employee something not only for the individual but offered a form of coverage for the entire family. TPAs and Wellness companies that operate efficiently and are willing to put aside the notion that they need to seek out every penny of profit available, can choose to reimburse a portion of the healthcare expense. Such a reimbursement can easily result in the employee's net check being the same (or even slightly greater) than had the employee not participated in any plan or form of insurance at all.