

The Rationale for Federal Policy to Stimulate Workplace Health Promotion Programs

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Health and Financial Impact of Lifestyle

Repeated analyses conclude that at least 40% of premature deaths in the United States are caused by lifestyle factors including tobacco use, sedentary lifestyle, poor nutrition, and overweight.¹ Furthermore, these lifestyle factors are responsible for at least 25% of medical costs² and possibly as much as 50%. This is occurring at a time when medical care costs are crippling United States employers, with an estimated \$7,910 per employee in 2006.³ These costs make it difficult for many employers to remain profitable. Being competitive in a global marketplace is more difficult for United States companies because per capita medical costs in the United States are double those of all but five other nations and because employee medical costs are highly subsidized by the governments in most other nations.⁴

Evolution of Workplace Health Promotion Programs

Employers started developing workplace health promotion programs in detectable numbers in the 1970s. Most of these programs were clustered in "high-tech" growth areas like the Silicon Valley in California and the greater New York City area and many of them were built around fitness centers. The primary motivation among employers was to attract and retain the most talented workers. Employers realized that spending several hundred dollars per employee per year to building a beautiful fitness center was a more effective recruiting tool than adding four or five dollars to an employee's weekly paycheck. Although it took several decades to produce a robust literature to confirm it, employers soon began to realize that employees with good health habits had lower medical costs and were more productive.⁵ A systematic review of the literature on the financial impact of workplace health promotion confirmed this.⁶ In fact, Aldana found that 88% of 32 studies showed that programs reduced medical costs, and 100% of 18 studies showed programs

reduced absenteeism. He also found a mean return on investment (ROI) of \$3.93 for medical cost savings and \$5.07 for absenteeism savings.

In the 1980s, public health professionals realized that workplaces might be excellent environments in which to address chronic health conditions, especially heart disease, which had links to smoking, nutrition, sedentary lifestyle, overweight, and stress. Workplaces showed great promise for these programs because employees typically spend more than a third of their waking hours in the workplace, most employees remain in the same company for the year or two it takes to make a successful behavior change, and many are part of cohesive social groups at

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work that can provide ongoing support. Furthermore, workplace environments can be altered to provide access to healthy food and safe places to be physically active, as well as protection from second-hand smoke. Equally important, employers have financial incentives to support these programs. By the mid-1990s, almost 400 studies had been published on the health impact of workplace health promotion programs. A systematic review of this literature showed that well-designed programs produced short-term health improvements, but that very few programs examined long-term changes.⁷

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The prevalence of workplace health promotion programs has increased significantly during the past few decades.⁸

In summary, workplaces provide an excellent environment to address employee health; hundreds of well-designed programs have shown that programs do improve health, especially in the short term; and dozens of studies have shown that programs reduce medical costs and absenteeism at least enough to pay for covering the cost of the program, possibly producing savings in excess of program costs.

Limitations of Workplace Health Promotion Programs

Despite this positive picture, workplace health promotion is not without problems. The biggest problem is that at least half of working people in the United States do not have access to health promotion programs because they work in small companies or for those employers who have employees deployed in small numbers in multiple sites. Of the 4.9 million firms in the United States, only 936 (0.01%) have 10,000 or more employees, 8,674 (0.18%) have 1,000 or more employees, and 17,246 (0.35%) have 500 or more. Conversely, 99.65% of firms have less than 500 employees, and 97.9% have less than 100 employees. These firms employ 51% and 36% of the working population, respectively.⁹ It is difficult for small employers to offer health promotion programs because they typically do not have a central human resources function to develop programs, and they often cannot afford to hire a full-time health promotion staff. Furthermore, their health insurance premiums are typically "community rated," which means their premiums are set by the medical utilization experience of their community. Large employers are "experience rated," which means premiums are based on the company's own medical utilization. The bottom line is that small employers who are successful in reducing medical care costs by improving the health of their employees will still pay the same medical premiums to their insurance company. This eliminates an important financial incentive to develop a health promotion program in these small companies.

Furthermore, most health promotion programs are not comprehensive. Most focus on enhancing awareness of health risks by offering health fairs, conducting health screenings, offering health risk appraisals, and providing information on the importance of a healthy lifestyle. Most employers do not offer programs that convey and enhance the personal skills employees need to make and maintain lasting behavior changes. Few employers make the effort required to create supportive environments, including providing nutritious foods in cafeterias and vending machines, offering access to safe and interesting places to exercise or be physically active, and fostering cultural workplace norms that value healthy lifestyle. The exception is smoking policies. By 2001, 76% of United States workplaces were smoke free.¹⁰ By any standard, this is a remarkable achievement.

Emerging Federal Policy to Support Workplace Health Promotion Programs

In recognition of the success of past workplace health promotion programs, the medical care cost crises facing United States employers, the accelerating obesity epidemic, and the shortcomings of current workplace health promotion programs, Senator Tom Harkin of Iowa has authored legislation called the Healthy Workforce Act. It was introduced on May 18, 2005 as Title II, Subtitle A of the HeLP America (Healthy Lifestyle and Prevention) Act, (S.1074) and will be introduced as a free standing bill in early 2007. The main provisions of the bill are below. Note: This legislation was in revision at press time. Check www.Thomas.gov for final provisions.

■ Employer Tax Credits

- Provides employers a 50% tax credit for workplace health promotion programs, up to \$200/employee/year, and 50% subsidy for tax exempt employers.
- To qualify for the tax credit, programs must be offered to all employees who work at least 25 hours per week and be certified by the United States Department of Health and Human Services.
- Programs for employers with 200 or more employees must have four basic components: programs to enhance awareness, programs to engage employees, programs to facilitate behavior change, and efforts to create supportive workplace environments. Employers with fewer than 200 employees must have three of these four major components.
- *This tax credit is projected to provide a \$734 million annual tax credit to employers, stimulate investments of \$3 billion per year in workplace health promotion programs, and increase corporate and individual tax receipts in excess of its cost, making it revenue-neutral to the federal government.*

■ Directs CDC to Do the Following

- Contract with experts to provide employers with technical assistance on program evaluation.
- Conduct a national study on employer health policies and programs.
- Include questions on workplace health promotion in the Behavioral Risk Factor Surveillance System.
- Award demonstration grants to test the effect of new workplace interventions and models.

■ Campaign to Educate Employers

- Directs CDC to develop a campaign to educate employers on the financial benefits of workplace health promotion programs, in conjunction with workplace health promotion organizations.
- *This campaign is projected to cost \$40,000,000 per year and is critical to stimulating employer investments in health promotion and thus, the increased tax revenues projected to result from the tax credit.*

An unpublished economic analysis of this legislation¹¹ concluded it is likely to be revenue-neutral or revenue-positive to the federal government. This means it will stimulate more tax receipts to the federal government than it costs in tax credits and subsidies. The bill is projected to stimulate investments of \$3 billion in workplace health promotion programs through a combination of promotional campaigns, technical assistance, and employer tax credits or subsidies. The promotional campaigns and technical assistance are projected to have an annual cost of \$59 million. The tax credit is projected to have a value of \$734 million to employers, but it will be earned only when employers invest in programs, and received the year after the investment is made. Assuming an ROI of 1:1 in medical care cost containment, the economic stimulus from this program is projected to stimulate \$985 million in increased federal income taxes, \$409 million in FICA taxes, and \$183 million in state income tax receipts, and these will be paid in the year prior to the tax credit. The bill will

produce net gains to the federal government. With the exception of the \$59 million stimulus, receipts to the federal government will be in the same line item as the tax credit and received prior to the tax credit. The savings to the federal government are caused by the increased economic stimulus of investments by employers and not dependent upon significant medical care cost reductions produced by the new health promotion programs. To break even, the health promotion programs must produce an ROI of 0.2 (20 cents on the dollar).

Conclusion

Workplace health promotion programs show great promise in reducing chronic disease prevalence and containing medical costs. Emerging federal legislation has the potential to improve the effectiveness of existing programs and make new programs available to employees in small companies. **NCMedJ**

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