

2022

Workplace Wellness Programs: Do Programs Impact Employer Healthcare Costs?

Ryan Martin
Grand Valley State University

Follow this and additional works at: <https://scholarworks.gvsu.edu/spnhareview>

Recommended Citation

Martin, Ryan (2022) "Workplace Wellness Programs: Do Programs Impact Employer Healthcare Costs?," *SPNHA Review*. Vol. 18: Iss. 1, Article 8.
Available at: <https://scholarworks.gvsu.edu/spnhareview/vol18/iss1/8>

Workplace Wellness Programs: Do Programs Impact Employer Healthcare Costs?

Ryan Martin

Grand Valley State University

Abstract

With the overwhelming cost of healthcare in the United States and the preponderance of employer sponsored health care, it is no surprise that workplace wellness plans (WWPs), promising to improve employees' health and reduce healthcare costs, are on the rise. The effectiveness of WWPs in delivering cost savings has been debated over the past several decades as researchers attempted to replicate the savings promised by early case studies and minimize the biases of those studies. The purpose of this literature review article is to summarize the historical debate concerning whether WWPs save employers' healthcare expenditures and weigh the evidence to determine if they deliver what they have promised. Ultimately, the bulk of the recent research has demonstrated that although WWPs can deliver some health outcome improvements, these improvements have not correlated to a reduction in healthcare costs. Despite this evidence, researchers and wellness companies argue that several factors regarding program design and implementation could demonstrate cost savings in future research. Additionally, several evidence-based best practices and trends have emerged, such as the comprehensiveness of the program, communication to employees, employee engagement, and focusing on key risk factors in the program design.

Keywords: Workplace wellness, healthcare costs, workplace health, healthcare utilization

The cost of healthcare has been rising consistently over the last several decades. As of 2019, it exceeds 17.7% of Gross Domestic Product (GDP). Unfortunately, there are no signs of it slowing down. Healthcare costs are expected to continue to rise by 5.2% and 5.4% in 2020 and 2021 (Centers for Medicare and Medicaid Services, 2019). Policy makers, healthcare leaders and corporations have been searching for a way to help control these costs, while also improving the health and wellness of the American people.

The Rise of Workplace Wellness Programs

One potential solution that has been growing in popularity is the employer-sponsored health or wellness program. Since Americans spend more of their day working than any other activity, other than sleeping (Bureau of Labor Statistics, 2019), the workplace is an important area to focus efforts. Additionally, most working Americans get their healthcare through employer sponsored health benefits. In 2020, 89% of workers were employed by a firm that offered health benefits to at least some of its workers (Kaiser Family Foundation, 2020). With these factors in mind, it is understandable that workplace wellness programs (WWPs), also referred to as workforce health programs or corporate health programs, have been identified by policy makers and employers as a possible solution to curbing rising healthcare costs. An important growth driver of WWPs was the 2010 Affordable Care Act (ACA), which encouraged firms to adopt wellness programs by providing subsidies to offer incentives to employees up to 30% of the total cost of their health insurance coverage, and up to 50% if they targeted smoking cessation (Center for Medicare and Medicaid Services, 2012). They claimed that workplace

health programs have the potential to promote healthy behaviors; improve employees' health knowledge and skills; help employees get necessary health screenings, immunizations, and follow-up care; and reduce workplace exposure to substances and hazards that can cause diseases and injury. Yet, the proposed rules by CMS did not specify the types of wellness programs employers can offer. As a result, there has been wide variability in the benefits and programs offered by employers, and conflicting evidence generated on the actual return on investment to employers. Despite the ongoing debate about program effectiveness, the workplace wellness industry has exploded in size. According to a report published by Allied Market Research, the North American workplace wellness market was pegged at \$15.75 billion in 2020 and is estimated to hit \$24.29 billion by 2030 (Globe Newswire, 2021). The purpose of this article is to provide a summary of recent literature and evaluate the current evidence to determine if Workplace Wellness Programs (WWPs) negatively or positively impact the employer's health care costs.

Definition and Adoption

The interest in WWPs has been growing, especially with large employers, over the past several decades. It is challenging to get a clear picture of the growth because, unfortunately, there has been no formal definition of a WWP over the years, so cataloging the rise in popularity has been erratic. The definition given by Healthy People 2010 to comprehensive worksite health promotion programs was that they should (a) provide health education (b) provide supportive social and physical environments (c) integrate into the organizations structure (d) link to the EAP at the organization and (e) offer worksite screenings. Using this definition, in the Workplace Health in America Survey (Linnan et al. 2008), only 6.9% of US companies met these criteria in 2004. Then a similar survey was completed between November 2016 and September 2017 (Linnan et al. 2019) and the number of employers offering a comprehensive worksite health program grew to 17.1%. Alternatively, without specifying a definition for a WWP, a 2013 survey (Claxton) reported 77% of employers claimed to have offered a WWP along with their health benefits. Most recently, Kaiser Family Foundation's Employer Health Benefits Annual Survey (2020) stated that 53% of small firms and 81% of large firms offer a program in at least one of these areas: smoking cessation, weight management, and behavioral or lifestyle coaching. Among large firms offering at least one of these, 44% offer workers an incentive to participate in or complete the program. They went on to state, "Firms may have a variety of objectives for offering health screening and health promotion programs, including improving the health and wellbeing of enrollees, reducing absences from work, and reducing costs. Firms generally responded that their programs were effective to some degree in meeting certain specified objectives, although there were many who responded that they did not know." In this survey, only 38% of large firms report that their program was very effective or moderately effective in reducing costs, as can be seen in Figure 1. Regardless of the actual number of employers, the size of the employer, the specific definition of the wellness program, or the perceived effectiveness of the programs, many see WWPs as a potential solution to the rising costs of health care.

Early Examples of Cost Savings

So, what are employers chasing? How much could a WWP save on health care costs? There is significant debate around these questions, and contradictory evidence that has been proposed. Much of the initial evidence from the 1980s and 1990s were case studies that focused on a single employer, such as the Citibank Health Management Program (Ozminkowski et al.,

1999), which reported \$4.50 savings in medical expenditures for every dollar spent, the California Public Employees Retirement System (Fries et al., 1994), the Bank of America program (Leigh et al., 1992), and the Johnson & Johnson program (Bly et al., 1986). Of course, this type of savings is quite compelling to employers seeking to lower their overall healthcare costs, but is it based on sound evidence? One of the primary limitations to these case studies is publication bias. Only examples of significant or statistically significant savings would prompt an employer to publish their results. Also, can the results of these single employer studies be replicated in smaller employers, in other industries?

To broaden the scope of investigation, a meta-analysis of WWP trials was conducted by a group of Harvard researchers, and published in 2010 (Baicker et al.), titled *Workplace Wellness Programs Can Generate Savings*. The meta-analysis attempted to address some of the selection bias issues in the literature by focusing on studies that contained a comparison group of non-participants. After applying the study criteria, they narrowed the results to thirty-two original publications. Their analysis found that every dollar spent on the program resulted in \$3.27 savings in medical costs, and the authors propose that “wider adoption of WWPs could prove beneficial for budgets.” Although the conclusion of the researchers encourages WWPs, even to the point of subsidization, the authors did highlight a few limitations in the studies they used, which may limit some employers from realizing these robust savings. They include selection bias, publication bias, and several confounding variables such as the type of workplace (manufacturing vs. clerical), corporate culture, program incentive structure, and the employee social networks.

Conflicting Evidence

To help answer some of these questions, the Research and Development (RAND) Corporation was employed by the Obama Administration to study WWPs. The *Workplace Wellness Program Study: Final Report* (Mattke et al.) was published in 2013 and unfortunately only provoked more discussion on this topic. RAND collected information from approximately 600 businesses with at least 50 employees and analyzed the medical claims collected by the Care Continuum Alliance, a trade association for the health and wellness industry. The report found that people who participated in WWPs lose an average of only one pound per year over three years. Although, they reported savings, they were meager at best. The average was only \$2.38 less per month for participants of the WWPs in the first year and \$3.46 less in the fifth year. These amounts were not statistically significant, meaning they could have been due to chance and not the WWP. On the bright side, the RAND report says healthcare costs and use of expensive medical services rose more slowly for program participants than nonparticipants, which could provide hope that a larger reduction could materialize if employees continue to participate (Begley, 2013). Of course, these results are a far cry from the savings promised by the earlier case studies or the meta-analysis by Baicker et al.

About the same time, Cawley & Price (2013) sought to investigate the impact of financial incentives through a case study of a WWP focused on weight loss. They studied a relatively large sample size of 2635 workers across 24 worksites for over a year. Participation was optional for the workers, and their financial incentive was based on their employers WWP, which was one of four schedules: continuous payment, deposit contract with lump sum repayment, deposit contract with continuous repayment, or the control group which offered no incentive. They found an exceedingly high attrition rate of 68% of participants before the end of the year, which was higher than virtually all previous studies focused on financial incentives and weight loss. Yet, the

attrition rate was not random, only those that saw success in the program remained for the year. Overall, the weight loss was modest, and the authors questioned whether the incentive structure was too confusing. Their findings cast some doubt on one of the fundamental motivating factors of most WWP, whether a simple financial incentive was all employees needed to change their behavior. In conclusion, the authors called for additional research on whether financial incentives lose their effectiveness over time, and whether the introduction of external incentives leads to a depreciation of intrinsic motivation, which could be why weight regain has been observed in similar studies.

Meanwhile, another group of investigators were studying the impact of financial incentives on health and healthcare costs in a large wellness program. Einav et al. (2018) studied a single jumbo employer's (+100,000 employees) wellness program over the span of 4 years (2009 – 2012). The authors state, "we do not find evidence for overall cost reduction; however, it is possible that this objective should get less consideration in the short run...health care costs initially may rise with additional screening and in fact, we observe an increase in the use of preventive medication with the program." They go on to conclude that it seems plausible that healthcare cost reductions may be seen over a longer time horizon, which only further complicates the discussion. The program had high participation rate, approximately 80% of employees, and demonstrated robust improvements in health, such as BMI and blood pressure, especially for employees that participated for several years. Yet despite high levels of participation, and positive health outcomes, there was no correlation with cost savings in the 4-year period.

These findings were reinforced in a smaller study by Levy & Thorndike (2019), which studied whether a well-documented, effective, 10-week WWP, implemented in a large teaching hospital would demonstrate cost savings in the short-term. Employees that participated in the Be Fit program were assessed following the 10-week program and a 1-year follow-up. Researchers compared health expenditures the year prior to completing the program, and the year following. Overall, 289 employees in the Be Fit program were compared to 194 controls, between 2010 and 2014. The authors state, "Despite improvements in clinical risk factors, we find no evidence that Be Fit was associated with reduced health expenditures over 1-year of follow-up. Reducing health expenditures may require a longer time horizon and program targeting a broader set of risk factors."

Then in 2019, two randomized controlled trials were published that attempted to eliminate the selection bias limitations of the previous observational studies. The first trial by Song & Baicker (2019), published in JAMA, randomized 160 worksites to receive the WWP or receive no wellness programming over 18 months (January 2015 – June 2016). Employees at BJ's Wholesale Club sites across the country were randomized based on their location, meaning that 20 randomly selected treatment worksites were compared to the 140 control worksites. The second trial randomized employees of a large university employer (University of Illinois at Urbana-Champaign) to receive a comprehensive workplace wellness program or to a control group, which was not permitted to participate. Nearly 5,000 employees were randomized at the individual level, received financial incentive to participate, and were tracked for 30 months. The data was analyzed and published in two trials by Jones et al. (2019), and Reif et al. (2020). All three studies showed improvement in some self-reported outcomes, like greater % of participants engaging in regular exercise and actively managing weight (Song & Baicker, 2019) and a greater percentage of participants seeking healthcare screening (Jones et al., 2019) or reporting they have a primary care physician (Reif et al., 2020). Ultimately, none of the studies demonstrated

any significant effect on healthcare spending. Even when Song & Baicker (2021) extended the assessment period to 3 years, they found no detectable improvements in clinical or economic outcomes.

Conversely, the most recent study claiming significant cost savings was published in Occupational Medicine by Rezai et al. (2020) and was conducted using the Bruin Health Improvement Program (BHIP), which is a 12-week workplace wellness program that assesses multiple areas of physical and mental health. Significant decreases in all anthropometric indices and increases in all fitness outcomes were noted from baseline. Although these results were impressive and rightly demonstrated the effectiveness of the wellness program, the researchers then attempted to estimate the reduction in annual medical care costs by citing previous pharmaco-economic data by Cawley et al. (2015), in which a 5% change in BMI for individuals starting with a 35, 40, or 45 BMI would net an annual health care cost savings of \$528, \$2137, and \$10,030 USD, respectively. Beside the fact that this trial drastically over-generalized pharmaco-economic data to estimate potential cost savings, it is also riddled with selection bias and publication bias limitations.

Program Design

With the seemingly contradictory evidence over the past several decades, researchers continue to probe program design, mode of delivery (online vs. in-person), availability and structure of incentives, and program implementation as possible explanations for the variance. The primary explanations for the sizable swings in cost savings are program design and underinvestment by employers, as outlined by Fonarow et al. (2015), in Workplace Wellness Recognition for Optimizing Workplace Health. Unfortunately, there is still no widely accepted standard for WWPs concerning content, and quality. For example, there have been several scorecards developed to assist employers in determining the quality of these programs, such as HERO (Health Enhancement Research Organization, developed in 2006 by Mercer), NBSGH's Institute in Workforce Well-being (developed in 2009), and the CDC tool (developed in 2012, with the help Emory University, Research Triangle International and the National Center for Chronic Disease Prevention). Each scorecard measures different components of the WWPs design and measures effectiveness differently. Despite the discordance in assessment, some common themes have been identified. When reviews of the subject of wellness include programs that are poorly designed, meaning they are not based on evidence of effectiveness, are not adequately resourced, and are not executed properly, then the results are only marginally beneficial and, in some instances, negative. The bottom line, as stated by Fonarow, et al. (2015) is that agreed upon definitions of WWPs, and properly communicated standards could provide much needed direction for the employers interested in developing or improving their benefit offerings. According to the Centers for Disease Control and Prevention (2016), comprehensive wellness programs should not only offer screening and educational activities, but should also be integrated with other fringe benefits, align with organizational policies, and have strong support from the organization's leadership. By this definition, the studies by Reif et al., Jones et al., and Song & Baicker would not be classified as comprehensive workplace wellness programs.

In the near term, due to the lack of consistent evidence that WWPs provide a reduction in health care costs, employers may be questioning their current investments in wellness programs. However, in a recent commentary by Dr. Jean Marie Abraham, PhD in JAMA Internal Medicine (2020), she states it is premature to reach a conclusion on the effectiveness of wellness programs. As WWPs have come under increased scrutiny for their lack of demonstrated effect on

employer's economic outcomes, employers and wellness companies would benefit from a renewed focus on evidence-based program design with a cautious eye on the emerging trends in the research.

Best Practices and Future Research

Although the structure, design, and incentives may change, there are some overarching recommendations and best practices that have been agreed upon and supported by the research. One such highly referenced and cited article specified several best practices for WWPs.

1. **Leadership:** leaders should set program vision and organizational policy, ensure resources, support implementation, and connect programs to business goals.
2. **Relevance:** address factors critical to participation and employee engagement.
3. **Partnership:** collaborate efforts with other stakeholders including unions, vendors, and community organizations.
4. **Comprehensiveness:** ensure program elements are consistent with Health People 2010 definition of comprehensiveness.
5. **Implementation:** plan, coordinate, and fully execute a work plan and process tracking system.
6. **Engagement:** ensure an ongoing connection between employees and the program that creates trust and respect and builds a culture of health.
7. **Communication:** make the program visible on an ongoing basis.
8. **Data-driven:** use data in measuring, integrating, evaluating, and reporting of the program and its improvement over time.
9. **Compliance:** ensure that the program meets regulatory requirements and protects personal information of employees and participants. (Pronk, 2014)

All WWPs will require some investment of time and resources to be done properly, which is one reason why the large and jumbo employers are mostly leading the way. One article highlighted scalable best practices that small and medium sized business can utilize for their WWPs. The study identified five overarching concepts concerning strategies that small and mid-size companies can use in developing WWPs.

1. **Innovation:** emphasizes non-traditional approaches, constant iteration, and refinement.
2. **Company culture:** reinforced employee influenced and generated ideas, and autonomy from leadership to make decisions.
3. **Employee-centric:** suggests a holistic approach to employee well-being and the employer should shoulder the bulk of the financial burden.
4. **Environment:** incorporates non-work areas designed for well-being, corporate giving, and provision of health options.
5. **Altruism:** emphasizes the selfless leader, and resource allocation based on program goals and improvements rather than hard dollar outcomes. (Rucker, 2017)

Echoing the focus on employees' opinions, Abraham (2020) suggests that "the next investment for employers should be to survey a representative sample of their employee population to critically assess their perspectives and valuation of existing programs relative to other potential health-promoting investments." Unfortunately, there has been a large gap concerning program development and effective implementation with employees. Employees either do not value or are not familiar with the WWPs that employers are investing in on their

behalf. This was identified through a 2015 Harris Poll Nielsen Survey (McCleary, 2017). This survey pointed out that although WWP are offered by most US workplaces, employees are not aware of these efforts by their employers and are still asking employers to be more forthcoming in providing programs promoting good health. The conclusion of this research illustrates the importance of more consistent and strategic communication between employers and employees during implementation, otherwise the investments that employers make in WWPs would be a complete waste.

Regarding content specific design considerations, best practice and recent evidence suggest that focusing on specific risk factors could help WWPs demonstrate economic savings. The American Heart Association champions their Life's Simple 7, which is comprised of seven of the 10 modifiable risk factors that are estimated to cause between 20-30% of companies' annual healthcare expenditures (Fonarow, 2015). Those seven risk factors are: cigarette smoking, obesity, hypertension, dyslipidemia, physical inactivity, poor diet, and diabetes mellitus. A more recent study from Goetzel et al. (2020) performed an observational study of 11 large employers included in a multiemployer database to measure the short-term relationship between workers' health risks and their health care costs for 10 modifiable risk factors. Of the 10 modifiable risk factors, healthcare costs were significantly higher for employees at higher risk for blood glucose, obesity, stress, depression, and physical inactivity than for those at lower risk. They concluded that employers may achieve cost savings by implementing comprehensive health programs that focus on decreasing these key health risks.

Finally, as is the case in all organizational change efforts, the involvement of the leadership team and management is vital to success. Not only in terms of effective communication of the program itself, but the modeling of healthy behaviors and support efforts as well. One recent article tested a new twist on incentivizing the WWP (Robbins, 2016). In this survey, the researchers tested whether tying 10% of managerial annual salary incentives to worksite wellness efforts would be accepted by managers and employees. The analysis revealed favorable attitudes to this type of reinforcement by managers, and also a preference of managers to work for a company with this policy. Results were strongest for female managers, those with a personal desire for health improvement, and managers with a fewer number of subordinates.

Conclusion

Workplace wellness programs have grown in popularity over the last several decades despite conflicting evidence of their impact on reducing total healthcare costs for the employers that provide them. The early evidence promoted significant cost savings but was limited in its reproducibility and was riddled with limitations such as selection bias, publication bias, and length. In their attempts to mitigate these limitations, researchers have found that the reduction in healthcare costs have dwindled as well.

Workplace Wellness Programs (WWPs) appear to be growing in small and large employers despite the lack of concrete healthcare cost savings. Clear definitions of comprehensive wellness programs, as defined by the Centers for Disease Control (CDC), and the adoption of evidence-based best practices could improve the ROI for employers. Clear communication between workers and the employer's leadership team concerning the program design, executive-level support, perceived value, and implementation could be additional requirements for these programs to be successful.

References

- Abraham, J. M. (2020). Taking stock of employer wellness program effectiveness—Where should employers invest?. *JAMA Internal Medicine*, 180(7), 960-961.
- Allied Market Research. (2021, August 12). *North America workplace wellness market size is expected to reach \$24.29 billion by 2030*. Globe Newswire.
<https://www.globenewswire.com/en/news-release/2021/08/12/2279939/0/en/North-America-Workplace-Wellness-Market-Size-is-Expected-to-Reach-24-29-Billion-by-2030-Says-AMR.html>
- Bureau of Labor Statistics, US Department of Labor. (2020). *American time use survey-2019 results*. <https://www.bls.gov/tus/a1-2019.pdf>
- Baicker, K., Cutler, D., & Song, Z. (2010). Workplace wellness programs can generate savings. *Health Affairs*, 29(2), 304-11.
<http://search.proquest.com.ezproxy.gvsu.edu/docview/204622110?accountid=39473>
- Begley, S. (2013). Exclusive: 'Workplace wellness' fails bottom line, waistlines - RAND. *Reuters Health Medical News*. <https://www.reuters.com/article/us-wellness/exclusive-workplace-wellness-fails-bottom-line-waistlines-rand-idUSBRE94N0XX20130524>
- Bly, J. L., Jones, R. C., & Richardson, J. E. (1986). Impact of worksite health promotion on health care costs and utilization. Evaluation of Johnson & Johnson's Live for Life program. *JAMA*, 256(23), 3235–3240.
- Cawley, J., & Price, J. (2013). A case study of a workplace wellness program that offers financial incentives for weight loss. *Journal of Health Economics*, 32(5), 794-803.
<https://doi.org/10.1016/j.jhealeco.2013.04.005>
- Cawley, J., Meyerhoefer, C., Biener, A., Hammer, M., & Wintfeld, N. (2015). Savings in medical expenditures associated with reductions in body mass index among US adults with obesity, by diabetes status. *Pharmacoeconomics*, 33(7), 707–722.
<https://doi.org/10.1007/s40273-014-0230-2>
- Centers for Disease Control and Prevention. (2016). *Workplace health model*.
<https://www.cdc.gov/workplacehealthpromotion/model/index.html>
- Center for Medicaid and Medicare Services. (November 20, 2012). *The Affordable Care Act and Wellness Programs*. CMS. <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/wellness11202012a>
- Centers for Medicare and Medicaid Services. (2021). *National health expenditures 2019 highlights*. <https://www.cms.gov/files/document/highlights.pdf>
- Claxton, G., Rae, M., Panchal, N., Damico, A., Whitmore, H., Bostick, N., & Kenward, K. (2013). Health benefits in 2013: Moderate premium increases in employer-sponsored plans. *Health Affairs*, 32(9), 1667-1676. <https://doi.org/10.1377/hlthaff.2013.0644>
- Einav, L., Lee, S., Levin, J. (2019). The impact of financial incentives on health and health care: Evidence from a large wellness program. *Health Economics*, 28(2). 261– 279. <https://doi-org.ezproxy.gvsu.edu/10.1002/hec.3840>
- Fonarow, G. C., Calitz, C., Arena, R., Baase, C., Isaac, F. W., Lloyd-Jones, D., Peterson, E. D., Pronk, N., Sanchez, E., Terry, P. E., Volpp, K. G., & Antman, E. M. (2015). Workplace wellness recognition for optimizing workplace health: A presidential advisory from the American Heart Association. *Circulation*, 131(20), e480–e497.
<https://doi.org/10.1161/CIR.0000000000000206>

- Goetzel, R. Z., Henke, R. M., Head, M. A., Benevent, R., & Rhee, K. (2020). Ten modifiable health risk factors and employees' medical costs-an update. *American Journal of Health Promotion, 34*(5), 490–499.
- Jones, D., Molitor, D., & Reif, J. (2019). What do workplace wellness programs do? Evidence from the Illinois workplace wellness study. *Quarterly Journal of Economics, 134*(4), 1747–1791. <https://doi.org/10.1093/qje/qjz023>
- Kaiser Family Foundation. (2020). *Employer health benefits 2020 summary of findings*. KFF. <https://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2020.pdf>
- Leigh, J. P., Richardson, N., Beck, R., Kerr, C., Harrington, H., Parcell, C. L., & Fries, J. F. (1992). Randomized controlled study of a retiree health promotion program. The Bank of American Study. *Archives of Internal Medicine, 152*(6), 1201–1206.
- Levy, D. E., & Thorndike, A. N. (2019). Workplace wellness program and short-term changes in health care expenditures. *Preventive Medicine Reports, 13*, 175–178. <https://doi.org/10.1016/j.pmedr.2018.12.019>
- Linnan, L., Bowling, M., Childress, J., Lindsay, G., Blakey, C., Pronk, S., Wieker, S., & Royall, P. (2008). Results of the 2004 national worksite health promotion survey. *American Journal of Public Health, 98*(8), 1503–1509. <https://doi.org/10.2105/AJPH.2006.100313>
- Linnan, L. A., Cluff, L., Lang, J. E., Penne, M., & Leff, M. S. (2019). Results of the workplace health in america survey. *American Journal of Health Promotion, 33*(5), 652–665.
- Madison, K. (2016). The risks of using workplace wellness programs to foster a culture of health. *Health Affairs, 35*(11), 2068–2074. <https://doi.org/10.1377/hlthaff.2016.0729>
- Mattke, S., Liu, H., Caloyeras, J. P., Huang, C. Y., Van Busum, K. R., Khodyakov, D., & Shier, V. (2013). Workplace wellness programs study: Final report. *RAND Corporation*. <https://www.jstor.org/stable/10.7249/j.ctt3fgzgh>
- McCleary, K., Goetzel, R. Z., Roemer, E. C., Berko, J., Kent, K., & Torre, H. D. L. (2017). Employer and employee opinions about workplace health promotion (wellness) programs: Results of the 2015 harris poll nielsen survey. *Journal of Occupational and Environmental Medicine, 59*(3), 256–263. <https://doi.org/10.1097/JOM.0000000000000946>
- Ozminkowski, R., Dunn, R., Goetzel, R., Cantor, R., Murnane, J., & Harrison, M. (1999). A return on investment evaluation of the Citibank, NA, health management program. *American Journal of Health Promotion, 14*(1), 31–43.
- Pronk, N. P. (2014). Placing workplace wellness in proper context: Value beyond money. *Preventing chronic disease, 11*, E119. <http://doi.org/10.5888/pcd11.140128>
- Reif, J., Chan, D., Jones, D., Payne, L., & Molitor, D. (2020). Effects of a workplace wellness program on employee health, health beliefs, and medical use: A randomized clinical trial. *JAMA internal medicine, 180*(7), 952–960.
- Rezai, R., SantaBarbara, N., Almirol, E., Shedd, K., Terry, E., Park, M., & Comulada, W. S. (2020). Efficacy and costs of a workplace wellness programme. *Occupational Medicine, 70*(9), 649–655.
- Robbins, R., & Wansink, B. (2016). The 10% solution: Tying managerial salary increases to workplace wellness actions (and not results). *Journal of Occupational Health Psychology, 21*(4), 494–503. <https://dx.doi.org.ezproxy.gvsu.edu/10.1037/a0039989>

Rucker, M. R. (2017). Workplace wellness strategies for small businesses. *International Journal of Workplace Health Management*, 10(1), 55-68. Retrieved from <http://search.proquest.com.ezproxy.gvsu.edu/docview/1858068559?accountid=39473>

Song, Z., & Baicker, K. (2019). Effect of a workplace wellness program on employee health and economic outcomes: A randomized clinical trial. *Journal of the American Medical Association*, 321(15), 1491–1501. <https://doi.org/10.1001/jama.2019.3307>

Song, Z., & Baicker, K. (2021). Health and economic outcomes up to three years after a workplace wellness program: A randomized controlled trial: Study examines the health and economic outcomes of a workplace wellness program. *Health Affairs*, 40(6), 951-960.

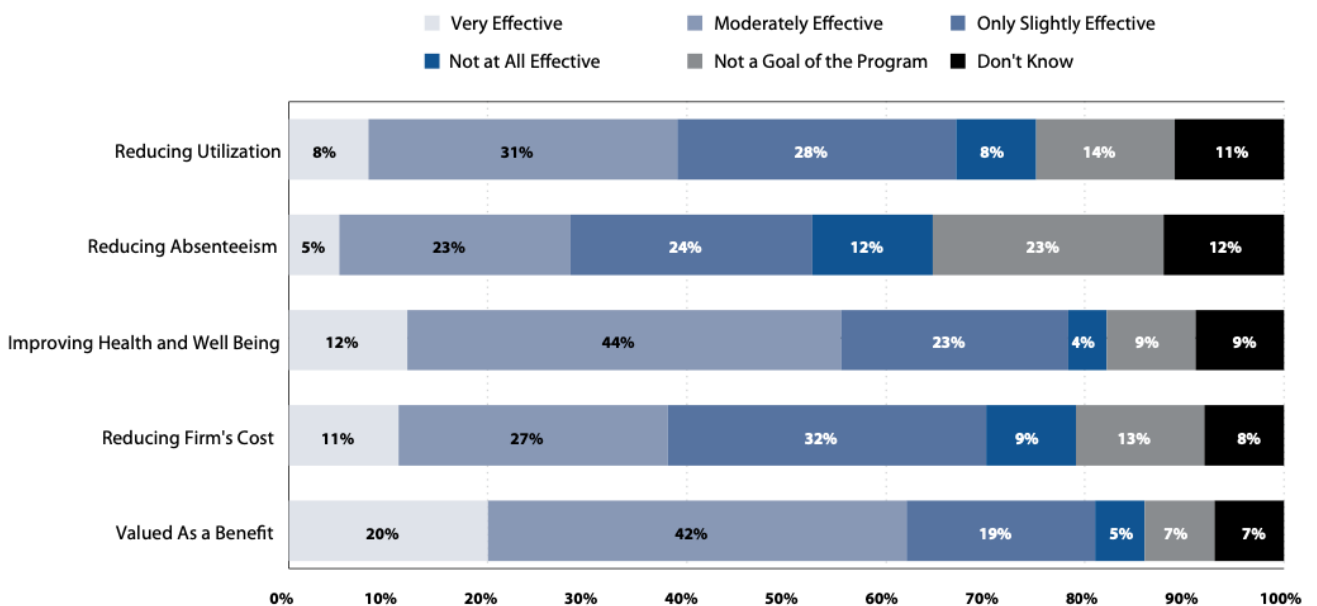
Thorndike, A. N., McCurley, J. L., Gelsomin, E. D., Anderson, E., Chang, Y., Porneala, B., ...Levy, D. E. (2021). Automated behavioral workplace intervention to prevent weight gain and improve diet: The ChooseWell 365 randomized clinical trial. *JAMA Network Open*, 4(6), e2112528-e2112528.

Figures

Figure 1

Kaiser Family Foundation’s Employer Health Benefits Annual Survey

Among Large Firms Offering Health Benefits and a Wellness or Health Screening Program, Firms Opinion of How Effective Programs Are at Meeting Various Goals, 2020



NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Wellness programs include programs to help employees lose weight, lifestyle or behavioral coaching or tobacco cessation programs. Among large firms offering health benefits, 87% have a health screening or wellness and/or health promotion program. Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

About the Author

Ryan Martin is a servant leader, learning & development champion, and experienced life sciences account manager.

He is currently an HR leader with Novo Nordisk Inc., a global life sciences company focused on improving the lives of individuals with diabetes, obesity, and other chronic conditions. As the Associate Director, Employee Experience, he consults with executives across the U.S. to assess competencies and propose learning solutions that support measurable outcomes.

As a Market Access Account Manager, Ryan partnered with health plans, health systems, and employers on initiatives and treatment options across the Michigan healthcare market.

