Workplace Wellness Programs, Healthy Behaviors, and Health Reform
Alliance for Health Reform
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ED HOWARD: My name is Ed Howard with the Alliance for Health Reform and on behalf of Senator Rockefeller and Senator Collins we're pleased to welcome you to this program to examine workplace wellness programs and the changes in them being proposed in the health reform legislation.

The idea behind these programs is fairly straight forward. Firms want a healthier, more productive work force and they want lower health insurance costs and they think these programs can accomplish both of those goals.

Kaiser Family Foundation's HRET, the annual benefits survey for this year, says that 58-percent of all employers that offer health benefits also offer at least one wellness program. There is, according to the proponents of these programs, a lot at stakes. Some of you may know that Steve Burd is the CEO of Safeway, is a major advocate of wellness programs.

Mr. Burd says that if the country could reach the level of savings that his company has realized, over the four years since they started they're wellness program, our total national health care bill would be lower by; want to take a guess at that number? 500 billion dollars a year, actually more. Enough so, pay for coverage for every uninsured person in the country for five times over.

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But some folks are raising caution flags about at least some of these wellness programs - the ones that reward or penalize certain health outcomes rather than just participation in programs. They raise questions about discrimination based on health status or genetic makeup and the potentially shifting costs from healthy employees to sicker ones.

Our co-sponsor in this briefing is AARP, which represents, I know you know, millions of Americans over 50 and which has definite views on this issue we're examining today. I should note that the makeup of our panel and the materials you receive are fully our responsibility, not anybody else's. That's not the only potential conflict of interest that I need to mention.

The Alliance has a senior AARP official, John Rother, on our Board of Directors as of last fall. Now you'll hear from Nancy LeaMond from AARP in just a few moments, but I wanted to make sure you understood that this program is an Alliance program and an AARP program and we are trying, very hard, to make sure that you get the full story about the different viewpoints and facts behind this issue.

In your packets you're going to find a lot of background information including slides from our speakers and biographical information. There will be a web cast and a podcast available probably tomorrow on Kaiser Family

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Foundations Website, KFF.org, and then in a few days you can look at a transcript of this discussion along with copies of the materials at AllHealth.org, which is our website.

You see the green question cards in your packets? Please take the opportunity to use them when you get to the Q&A. There are also microphones that you can use to ask your question orally and blue evaluation forms in the packets. So, let's get to the program.

We have a bunch of experienced, articulate panelists assembled and they'll do very brief presentations and then we'll open it up to discussion among them and questions from the floor. We're going to start with Kathy Buto, and I should say, when I okayed the agenda for today I was looking in a mirror, so the order is exactly the opposite of the one that's printed on the piece of paper that you have in front of you.

So, Kathy is going to lead off. She's the Vice President for Health Policy and Governmental Affairs for Johnson and Johnson. She has spent years in senior policy positions at what is now CMS, did a stint at CBO as well and there are few more respected policy voices in Washington than Kathy Buto and we are very pleased to be able to hear that voice today. Kathy.

KATHY BUTO: Thank you Ed. I really appreciate the introduction and I'm going to go straight to the slides. We

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were given a very strict time frame, so I'm going to try to cover essentially something about the fact that Johnson and Johnson has been in the wellness and prevention business for more than 30 years.

In fact, I've met people who, when Johnson and Johnson sold its original health and wellness business Live for Life are still in that program; I think Emory University and others, still have the program. I should point out something important for those of you who don't know J&J.

We have a credo that governs a lot of--it really governs the value system—of what Johnson and Johnson is about. And it really has four simple points, and one of them is that we serve – we are here, we are present and in the business world - to serve patients, physicians, nurses and families. Secondly, we consider our second most important duty to serve our employees and actually encourage them to have a healthy and productive work life.

Third, we serve the communities in which we live and work, and fourth our view is, if we do all of the above we will deliver a fair return to shareholders. So that's the philosophy of Johnson and Johnson and I can attest to our really believing and embedding that in everything we do, and that's why we've spent more than 30 years in the wellness and prevention business.

One of the things I would point to is total health. Total health really is about everything from on online risk assessment, which is offered to employees every other year, in which there is an ability to track, over time, how well you're doing on several risk factors and there's a $500 deduction from your premium costs if you participate in the program. We found it enormously successful.

We went from less than 60-percent participation before the $500 incentive and it's up to more than 90-percent, nearly everybody participates in this assessment. It gives us more than 10 years of longitudinal data on individuals but really on populations: people who have diabetes, people who have hypertension, etc, and what's happened to them.

Mental health and well being has been a critical part of what we do and we believe strongly in environmental and cultural support, which I'll touch on in a moment.

And last, health education and awareness, which permeates a lot of what we do. So examples that I want to point to, because I don’t have lot of time here, is that we have banned smoking on the premises of Johnson and Johnson facilities, worldwide. That means everywhere, even in countries where smoking is pervasive. The exceptions have been made only when there's an issue of safety.

When it's not safe for employee's to go off premises to smoke. We have cafeteria offerings that are geared to healthy eating, which display fat content, protein, calories, etc. There's onsite Weight Watchers at some facilities, fitness centers on site and discounts to employees if they should join fitness facilities.

So there's a real push to get people into that wellness habit, if you will. So, if you look at this chart, this will give you something of a picture of what's happened at Johnson and Johnson, really between one of the snapshots taken between 1995 through 1999.

Our record there, if you look at it for inactivity, was about 39-percent of the population. Now it hasn't gotten a whole lot better. This is the area where we are still struggling to figure out how to crack the code on activity. But it's down to 31.5-percent, and you can see in the US population that figure, according to CDC is about 51.2-percent.

But if you look at smoking, high blood pressure, and high cholesterol, you will see that we started out with 12-percent rates, 14-percent rates, 19-percent rates, and for smoking we're down to 4.2-percent.

And I should say, Steve Burd of Safeway turned to our CEO and said, "How did you do that?" Okay, so you've heard a lot about Safeway, but this is a sustained effort to get

smoking out of the workforce and to give people alternatives to smoking.

The US population, as you can see, between 2007-2008 is at 18.4-percent. High blood pressure down to 6.4-percent in the most recent assessment and US population at 27.8-percent, high cholesterol 7.2-percent, the population, this is uncontrolled high cholesterol, is 37.6-percent.

And I can testify to the fact that our per capita costs have consistently been 1-2 percent below benchmarks, really over the last 10 years, and we have the data to show that. Risks are trending better than the overall industry as well as the overall population, in a number of areas, and our costs have been reduced by $400 per employee, per year in 2007 dollars.

We figure, if you look to the next slide that, and slip down to overall results, that the 10 year cumulative savings have been about 250 million and our health benefits people have calculated that that would roll up to about a trillion dollars in savings for the whole healthcare system if the employers were to follow suit and would actually totally cover the cost of health care reform.

I want to really just call out here, but not dwell on the mental health savings are much higher for employees who take advantage of our Employee Assistance Program, $4,000 in

saving's per user and an improvement of mental health status of 78-percent in those individuals. So, again, something we're very proud of.

Wanted to just highlight briefly that last year our CEO decided that we would get into the wellness and prevention business. He felt that in order not to just be a company that developed products for people who were sick, we really needed to start earlier, work on what we'd call underlying risk factors in the population.

We acquired two businesses; Health Media is a personal coaching web-based tool. I understand that a number of the Federal employee health benefits use Health Media and embed them in their plans as a way of customizing the interventions for individuals who are at high risk.

And then the Human Performance Institute, which originally was set up to work with athletes, is now working with people at the managerial level in corporations.

Public policy interactions: here the – wanted to highlight that our chairman, Bill Weldon, is the chair of the CEO Roundtable on Cancer. This was started by George HW Bush, really in response to the fact that the Bush's lost a child to cancer early in her life and their lifelong passion was to do a better job of getting cures to the marketplace. It's a diverse group of business people. He chairs it – and we found that a

lot of the interventions to prevent cancer are also wellness and prevention interventions.

Our CEO has met with President Obama and a number of other CEO's from REI and other places, Pitney Bowes, etc, to talk about this 30 year history and what we've done and so on. And the White House followed up with us recently to meet with OPM, because OPM is thinking of pilot testing some of the wellness and prevention approaches that we've used.

I want to highlight that we were very strongly in support of the healthy workforce act and we're sorry to see it come out of the Senate bill, and we're still hoping that there may be something like a wellness and prevention grant program for small businesses that's analogous to what is in the House bill, because there are 100s of millions of dollars that are going into community health prevention.

We'd really like to see some investment in workplace wellness and prevention. And last, on this page, we recently supported a panel at, at the World Health Summit, on prevention and wellness, which included a lot of people from all over the world, looking at how they can improve the health of their populations.

So, in short, lessons from our experience. Commitment is key, and you've got to have it from the top. Carrots can work. We've only used incentives that were positive to get

people to change behavior. Employee engagement is critical, and we work with metrics and demonstrated outcomes, and we do look for return on investment.

We also put a strong emphasis on communication and data confidentiality, so that people are secure in knowing that we are working with them, and we think, which is a surprise to many people, that many of these programs and approaches that we've used are scalable to small business and individuals. So, I'll stop there and turn it back to you Ed.

ED HOWARD: Great, thanks very much Kathy. Next we turn to Nancy LeaMond. She's the Executive Vice President of Social Impact for AARP, which gives her some pretty broad responsibility for a wide ranging portfolio of programs.

She also directs something, you might have heard of, called Divided We Fail, which is a coalition of diverse groups, including AARP, that's working for positive change in health care and economic security. Nancy's been an assistant US trade representative among other executive branch assignments. She's served on several congressional staffs as well and very pleased to have you to your first panel appearance, Nancy, for the Alliance.

NANCY LEAMOND: Thank you for much and thank you all for being here today. We appreciate the Alliance sponsoring this program and bringing together a balanced panel to address

the issue, and I am especially pleased to be here with four experts. I, as you probably could tell from my bio, am not an expert in health policy.

Fortuitously if you're at AARP, you can always find experts, and we have Kelly Griffin and Paul Cotton here today as well, who can help with that. I always enjoy doing panel discussions at lunch time because people tend to be happier when they're eating and especially for a wellness panel.

But I also learned the other day from a colleague that she said, I go to panel discussions at lunchtime, because it's a good way to get away from the phones and to just kind of think about other things.

So in case you're gonna be tempted to do that during my slides, I just wanted to make three points at the beginning.

First, we absolutely believe that personal responsibility is key in the health care system, and that any reforms are going to have to encourage individuals to be more responsible for their health. And workplace wellness programs have great potential to promote healthy behaviors leading to healthier lives and lowering health costs. AARP itself, as an employer, offers a host of programs to our employees.

Second tax credits for employers who offer these programs and incentives to employees to participate in wellness

programs. Other than health insurance premium discounts, we believe merit strong support.

And then finally in overview, we believe that proposals to link participation or outcomes to health insurance premiums, perhaps appealing at first blush, will ultimately do more harm than good.

So I know move into my slides and hope you'll move with me to them, but I did want to just give you an overview of our position. AARP supports workplace wellness. Workplace wellness programs we believe have great potential to promote healthier lives and lower premiums and the total health system costs.

They promote healthy behaviors like physical activity, smoking cessation, and include important programs like proper medication management. And these are areas in particular that AARP has done an awful lot of work in, in the last few years. Grants or tax credits for employers who offer these programs, also, we believe merit strong support.

We support the House Workplace Wellness Provisions, including grants to small employers for up to half the cost of evidenced based programs and importantly the programs must meet specific, reasonable criteria.

But reasonable criteria would include policies and services at the worksite to address, for example, tobacco use

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at the worksite, nutrition in cafeteria and vending machines, minimizing stress and promoting positive mental health and encouragement of physical activity before, during and after work hours.

We also think that reasonable criteria include counseling, seminars, online programs, on tobacco use, obesity, stress management, physical activity and nutrition, and substance abuse and mental health promotion. In fact, AARP, as I mentioned earlier, has a number of such programs for our employees.

In addition, we support active employee engagement through these worksite assessments, onsite delivery, evaluation and improvement efforts, making programs physically accessible and culturally competent, for employees, and the opportunity for periodic screenings and referrals for appropriate follow up.

The House bill criteria further included, as many of you already know, making sure participation is voluntary, which we believe is key, making programs available to all workers, similarly important, protecting employee privacy.

Obviously the hallmark, I believe, of all of our groups and all employers, and not tying financial incentives to premiums or cost sharing. The Senate bill also provides,

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includes many good wellness and prevention provisions, from our point of view.

It does not include all the important wellness program criteria in the House bill, and it increases the amount employees can be charged for not meeting specific outcomes, from the current 20-percent to at least 30-percent and potentially up to 50-percent.

Linking participation and outcomes to employee costs, as I said, seem very appealing. We all want to promote individual responsibility as health care reform. But lower costs for successful participants, we feel, requires higher potentially unaffordable costs for people who cannot participate, cannot change their behaviors or achieve certain health targets.

And linking employee costs to specific outcomes is a serious concern for us and others because behavior alone often cannot control wellness priorities, such as obesity, high cholesterol, and high blood pressure.

Weight, cholesterol and blood pressure problems are caused not just by behavior, as we all know, but also strongly linked to genetics, physical and mental disabilities, lack of community resources or other life priorities, like care giving, the need to work multiple jobs to pay family expenses or the

challenges of following health care reform on Capitol Hill day and night, over periods of months [laughter].

That's my own personal excuse. This is a big concern for AARP because many of these conditions are not completely controlled by behavior, become more prevalent with age. Pre-existing condition discrimination is a key reason why more than 7 million 50-64 year olds cannot find affordable coverage today.

And it's also a concern in low income and minority communities, because of higher obesity, hypertension, and high cholesterol rates. Barriers to behavior change from economic hardships, unsafe neighborhoods, little access to healthier foods, and other reasons.

And the Senate bills explicit ban on premium subsidies covering high costs linked to wellness participation and outcomes. With the average family premiums over 13,000 a year, increasing costs by 50-percent could make coverage unaffordable for those who cannot achieve target outcomes because of genetics, disabilities, or life circumstances.

Health reform should ensure that everyone can have affordable coverage regardless of health status. The Senate makes a good faith effort to address these concerns, we believe with reasonable alternatives, for those who cannot meet targets due to medical conditions.

But as we all know, doctors often cannot tell if genetics or other factors than behavior are at fault, and so reasonable alternatives do not fully prevent this from becoming a backdoor to pre-existing conditions discrimination.

We have promised the American people that reform will end health status discrimination, and in fact, at AARP we've spent an enormous amount of time this year, continued to spend an enormous amount of time this year, on issues related to discrimination in health insurance.

And I can tell you that particularly among our 50-64 year olds this is at the top of their agenda and the top of their focus as they evaluate whether health care reform will be good for them. Healthy behavior discounts should not become, as I said, a backdoor way of discriminating against people with pre-existing conditions.

And not to impugn motives of people that put it in, but we all know that loop holes or potential loop holes can have different consequences. Charging more, based on health status, is a practice that health reform must end, once and for all. With that, once again, appreciate the time to be here and look forward to engaging with you all in questions.

ED HOWARD: Thanks very much Nancy. We enjoyed Nancy's remarks so much, we're gonna have another Nancy talk to you know. Nancy Taylor from the DC based law firm of Greenberg

Traurig, where she advises a range of health care clients on FDA matters and other issues.

And one of those clients is the Business Roundtable on whose behalf she principally appears today, which is the same Business Roundtable that is part of the Divided We Fail Coalition, which Nancy LeaMond directs.

So we have an interlocking directorate here. Some of you may remember Nancy Taylor from her days as Chief of Health Policy for what's now the Senate Health Committee. We're very happy to have you back in the Senate but on our stage, Nancy.

NANCY TAYLOR: Yes, I appreciate the opportunity to be here and it's great to be with Karen. We were together on the hill and love working with Nancy LeaMond at AARP and Kathy Buto is, in fact, a consummate professional in health care policies, so I'm grateful to be here today.

I am outside counsel to the Business Roundtable and have been for many years. Today many of the views however will come from the legal review of what the rules are that currently require and there are a lot of experts in employer sponsored prevention and wellness programs in the audience.

But first, I want to play a little bit with the notion of HIPAA. When we also think about HIPAA, Paul Cotton and I, from AARP, always think about privacy, and when you can and can't disclose. Well HIPAA was first done with as a way of

ensuring there was an ability to get health insurance coverage from one group plan to another group plan.

And what's happened is it is evolved in the regulatory process and that is where we've been able to fashion, as employer sponsored providers of services, some additional ways to incentivize employees to participate in the kinds of activities that Kathy Buto talked about at Johnson and Johnson.

So I want to tell you about two specific issues before I go into my slide presentation; first is the Business Roundtable has published a booklet on workplace prevention activities, and how it works.

And they have CEO's who are communicating about their prevention and wellness programs, because they believe in them. They want to help employees have access to these kinds of wellness and prevention programs.

In addition Steve Wojcik is here today and he's brought the latest edition of their awards on workplace programs that have achieved successes. He's got copies back there, but he's available to provide you with more. But I want to tell you about one to start out with, and it's IBM's.

Because a lot of people talk about Safeway, I want to talk about IBM. IBM pioneered the concept of healthy living rebates for its employees in 2004, the offerings are updated

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each year, and in 2010, US employees can choose among five cash incentives for a maximum of $300 per year.

Over 100,000 employees have enrolled in IBM's physical activity rebate in a single year. Of the employees enrolled in the smoke-free program, nearly 25-percent quit smoking and 80-percent of those who were smoke free one year later, IBM's programs now have reached hundreds of thousands.

The Child Health rebate launched in 2009; they are estimated IBM to spend 80 million a year to yield 191 million return and the bottom line and thanks to Steve Wojcik for providing that. So these kinds of cash incentive rebate programs can help to incentivize employees to participate.

So, what I want to do is kind of walk you through kind of the issues that are contained in the current regulatory structure that permits these kinds of programs to occur, talk about where the Senate and the House bills are, and we have so many common principles on this table that I think we can all come to a common agreement of what we can do together to make these kinds of successful programs continue.

So let me start out with HIPAA. Oh I have to do this, I forget. HIPAA does permit employer sponsored wellness programs to exist. When I first started working on the hill I was given ERISA as an assignment and ultimately HIPAA because no one else wanted to handle ERISA.

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So, I'm sure if you're here as staffers you may feel the same way. But ERISA covers all employer sponsored health benefit plans, in the private market place. And employers can either offer self-insured products or buy fully insured products or do a mixture of two.

But contained in that law is the ability to offer benefits to employees, and we have over 135 million workers who get coverage through a workplace. The laws that govern these activities, though, are found under HIPAA, and they're found in the regulations, and I encourage all of you, it's just one page in the regulations.

I encourage you to read it. Because I think better than having other people tell you what the law says, I always encourage people to read it themselves, about what the regulations are intended to do. So, employers and coverage providers may offer rewards for all who participate in wellness programs.

The rules permit you to offer wellness programs to everyone. But if you only want to offer it to employees who would benefit from some programs, you have to have the ability to vary your benefit structure. Because ERISA requires that you offer all similarly situated employees who are eligible for a plan, to offer comparable benefits.

So that's why this HIPAA law, combined with the ERISA law permits employers to unify their ability to offer these kinds of programs.

So, the only way you can offer these programs is it must be designed to promote health or prevent disease, employees must be eligible to qualify for the reward at least annually, the reward must be eligible to all similarly situated individuals and you have to provide each worker that you've identified with a reasonable alternative or you may waive the requirements for them to meet the incentive.

In the Senate bill it codifies the existing regulations. The existing regulations permit up to a 20-percent incentive based on the premium. And the incentive has to be, in my view, tagged to something that is related to the health care spending, otherwise it could fall into another area of the law.

And so that's why it was tied to the premium costs, and yes, the average premium cost is running $13,000 and many employers will tell you that the cost of health care coverage is becoming unaffordable, but these kinds of incentive programs are currently tied to the value of the premium.

We do believe that what is in the Senate bill is a good way to ensure that these kinds of programs can continue and it does have the right types of protections in place, so that we

continue to preserve the non-discrimination clause in the underlying HIPAA law.

The House bill also has wellness grants for small employers. Currently if you have an onsite wellness and prevention activity, it can be excluded from taxes, but many small employers don't have any tax base to exclude these kinds of activities and may need financial help.

So many employer groups and consumer groups have joined together to support these kinds of efforts. So what do we support? We support retaining the current non-discrimination rules and HIPAA and Karen will be going through those more distinctly.

Those rules say you cannot, and I'm going to read it directly from the regulations, the HIPAA non-discrimination provisions generally prohibit a plan or issuer from charging similarly situated individuals different premiums or contributions based on a health factor.

However, the HIPAA non-discrimination provisions do not prevent a plan or issuer from establishing premium discounts or rebates or modifying applicable co-payments in return for adhering to programs of health promotion and disease prevention.

We can make these kinds of efforts as a positive incentive and we should all work to make these kinds of

incentive plans a positive exception. The types of programs that are eligible for these activities have been outlined. They include issues like fitness center membership or weight management programs, diagnostic and testing programs that provide rewards for participation rather than outcome.

Programs that encourage preventive care by waving co-pay or deductible requirements for the cost of prenatal care or well baby visits, or programs that reimburse employees for the cost of smoking cessation programs, without regard to whether the employee quit smoking.

Or a program that provides a reward to employees for attending a monthly health education seminar. We believe that these kinds of efforts are important as we move forward in ensuring that we can provide our employees, especially those who need it, with extra support as they participate in these prevention and wellness programs.

They're not intended to discriminate. They're intended to assist and help employees gain certain kinds of goals and meet certain kinds of objectives in the workforce that will promote health. I appreciate the opportunity and look forward to questions and answers.

ED HOWARD: Very good, thank you. Thank you Nancy. Now I know I know that woman at the end. Oh yes, it's Karen Pollitz. A lot of us have known Karen Pollitz as she has done

great work in a number of places around this town over many years. She's currently a research professor at the Georgetown Health Policy Institute and one of the country's leading authorities on the regulation of private health insurance.

We routinely steer people with question about what they can do in Delaware or South Dakota to Karen and Karen's website because it's the best source around for very practical information about what you can do with a big problem. She's been on the Hill at several offices, House and Senate, and for four years was the Deputy Assistant Secretary for Health Legislation at HHS. Karen Pollitz, glad to have you with us.

KAREN POLLITZ: Thanks Ed and I'm also very honored to be on this panel. Can I grab the clicker from you? We women up here have an awful lot of history. I worked with Kathy at HHS when my daughter was born; she's in high school now.

I worked with Nancy up here on the Senate side, when I was pregnant with my son and she with her twin daughters, they're in college now. And, Nancy LeaMond hired me for my first Hill job, on the House side. She has gone on to AARP and I have gone on to be an AARP member [laughter].

So, we all have a lot of history and I appreciate the reunion in addition to the forum on this important topic. I want to pick up where Nancy began in terms of the history of

this wellness adjustment issue and how it relates to HIPAA and non-discrimination.

This dates back. This is something I've been looking at since HIPAA was enacted in 1996. The wellness adjustments to premiums that we're talking about are exceptions to a law that was enacted back in 1996.

A non-discrimination law that says that people cannot be treated differently based on their eligibility for benefits, the content of the benefits or what they have to pay for their benefits, based on their health status.

And that rule is in health reform bills now, House and Senate, and moves from the group health plans into all health insurance, including individual health insurance. There was an exception to the non-discrimination rule, back in 1996 as Nancy Taylor mentioned, that said, that this shouldn't prevent a group health plan from establishing premium discounts or rebates in return for participation in a wellness program.

So the first thing that had to happen was the Clinton administration when they implemented HIPAA and wrote the rules to explain it, had to figure out what that meant. And they came down with the decision that group health plans can establish discounts or rebates in return for a bona fide program, but a bona fide program is one that does not condition the rewards or the penalties based on a health status factor.

And as an example, the administration offered an employee plan that offers a premium discount to people who participate in a cholesterol reduction wellness program, they meet with nutritionists and receive counseling, and then at the end of the program they are given a cholesterol test.

And those who have a count under 200 get the premium discount. The Clinton administration said that would not count as a bona fide wellness programs because the reward is based on the health status factor.

But if the reward were given to people on attending the program, based on keeping food records, adjusting their dietary intake that would be okay. But as soon as you measure a health status factor and give the reward based on that, the Clinton administration said, that's the line.

That's how the rule worked for about a decade and then the Bush administration revisited this rule, and re-wrote it. And the Bush administration decided that wellness programs that conditioned rewards based on satisfying a health status factor are permitted, as long as they meet five requirements and Nancy started to mention some of those.

The program has to be reasonably designed to promote good health or prevent disease. The maximum reward or absence of penalty is 20-percent of the cost of the program.

Participants have to be given at least one chance per year to earn their reward.

Those who can't meet the standard due to a medical condition have to be given an alternative and there has to be notice about the program in the plan documents. The Bush administration took the same example from the Clinton Administration regs, reworked it a little bit to explain what they meant and in this case they talked about an employer plan that gives an annual premium discount of 20-percent of the total cost of coverage to people who participate in a wellness program.

But this time the wellness program consistent solely of giving an annual cholesterol test, and those who achieve a count of 200 or lower get the reward. There's no other supports, the kinds of stuff that Kathy and Nancy talked about. There aren't dietary changes, exercise programs at work, Weight Watcher memberships, none of that.

And, this, the Bush administration said, this kind of program would work if the reward met the other tests, no more than 20-percent, annual opportunity to meet it, if you can't for a medical reason, you need an alternative and there's notice about it in the program.

The fifth standard is that the program has to be reasonably designed to promote wellness. What does that mean?

Well that's not defined in the reg. The only place you see any mention of what reasonably designed means is in the pre-amble to the reg.

And it says the reasonably designed requirement is intended to be an easy standard to satisfy. There does not need to be a scientific record, that the method promotes wellness to satisfy the standard. It is intended to allow experimentation in diverse ways of promoting wellness, for example a plan could satisfy the standard by giving rewards to individuals who participate in a course of aroma therapy.

The Bush plan also capped the reward at 20-percent and also in the preamble the justification for that is that a larger reward could have the effect of denying coverage or being too heavy of a financial penalty on individuals who can't satisfy the wellness program.

So, now here we are today with health reform, and the Senate bill, as Nancy mentioned, would codify the 2006 Bush regs, put them into law. So, Clinton wrote it one way, Bush wrote it the other way; this would keep the Obama administration from going back and writing it the third way.

The Senate bill does increase the maximum reward or penalty up to 30-percent with authority for the secretaries down the road to increase that to 50-percent. Based on CBO's estimates of what plan premiums would be in 2016 that means the

maximum penalty for an individual could exceed $1500 a year, not the couple hundred dollars that we heard about from IBM and J&J and over $4200 per year for someone who has family coverage.

Reasonably designed is still not defined in the Senate bill and the wellness adjustments can also be used in individual health insurance under a demonstration project that would take place in 10 states.

And in those demonstration states, if low income people are eligible for premium subsidies those premiums would be – or those subsidies would be calculated on the base premium but would not cover the wellness adjustment. So, for example, someone at about 133-percent of poverty, who might otherwise pay only $300 a year, under the Senate subsidy program, or only 2-percent of income for their health insurance coverage.

If they couldn't meet the wellness standards they might have to pay close to $1900 or 13-percent of income if the wellness penalty applied to them. Now, I appreciate very much what Nancy and Kathy have had to say about the importance of – Nancy, and Nancy and Kathy, about the importance of promoting wellness and personal responsibility, but it's also important to health reform to end medical underwriting.

That is a key part of health reform. And unfortunately the language in the Senate bill is so broad that is permits insurers to continue medical underwriting.

So what we now call a wellness program, that consists solely of the incentive, sort of incent-a-care wellness program, requires somebody come in, submit to a health screening, talk about their health status, their health history, maybe give a blood test, a cheek swab, a urine sample and then if they don't meet health tests, they can pay a very large penalty, over $4200 a year if they have family coverage. That is exactly how medical underwriting works today, in health insurance, exactly.

You fill out an application, your health history, you perhaps submit to a physical examination, give samples and if you don’t meet the employers risk target, then you pay a higher premium. Insurers can do the same thing.

I'm going to skip this next slide; it just talks about some other programs that are out there today that are different from that you heard from Johnson and Johnson and IBM and others. But there are, in fact, programs out there today that do apply this financial incentive and that is the sum total of the wellness program.

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And the result is that it does shift cost to people and it can even discourage them from enrolling. The House health reform bill, as you've heard, takes a different approach.

It does provide grants to small employers to adopt wellness programs, will reimburse up to 50-percent of the cost that they incur, to do things, like you heard, offering a gym, discounts on membership, healthier foods in the cafeterias and so forth. The programs have to be evidenced based; there have to be good privacy protections, and whatever the programs are they cannot build the financial incentives into the health insurance premium or cost sharing.

In addition there's 15 billion dollars authorized over 5 years for a new prevention and wellness trust that would continue to invest in community based wellness strategies and also research in terms of what works. And in particular the House bill stipulates that when there are findings about wellness interventions, incentives that work that those actually can get – there's feedback loop and those can get built back into the minimum benefit package.

So if it turns out that offering Weight Watcher memberships is effective, that might become something that could even become covered under people's health insurance plans down the line.

To wrap up, I think there is general agreement that wellness is good, that it should occur, that opportunities for healthier behaviors should occur everywhere. Wellness in the work place is a good idea. We spend most of our waking hours at work.

But I think there's also general agreement that medical underwriting is bad and that we can't make health reform work if medical underwriting continues in health insurance. So legislation needs to be designed so that opportunities to promote wellness don't also undermine protections against health insurance discrimination.

And to do that I think it's important to resist applying a reward or penalty to health insurance premiums and cost sharing. To apply incentives for healthy behaviors but not health status factors, not based on the results of a physical, and to develop standards for reasonably designed programs that actually promote and support healthy lifestyles and that go beyond simple financial incentives with no other components. Thank you very much.

ED HOWARD: Thank you. We're not in the discussion and Q&A part of the program. We'd love to have you be part of it. There's a microphone here. Is there one in the back too? You may have to troop up here to the front then. And if you have a

question on a green card, if you'll hold it up, someone will bring it forward.

As I mentioned, we'd love to have our panelists engage in a little discussion as well, and let's start with Nancy Taylor.

NANCY TAYLOR: I want to take exception to the fact that this is medical underwriting. How this, in fact, works, is that if you have a premium variation, that variation can only occur if someone is enable to participate in a wellness program and can meet, and participate, and it's mostly participate in those activities.

If they are successful in either participating or succeeding at whatever measure it is, then they can get the difference in the premium back. Some employers do it that way; other employers merely make it a pure incentive at the end of the program.

And the regulations do require that everyone understand the rules before the differential is provided, before the additional benefits are provided, which cost more than just the final cost of the incentive payment. That's why, when IBM does these kinds of additional benefits those costs are more than the final cost of the incentive program, but they are intended to be permissive on people to participate and achieve it.

And if you cannot achieve it or cannot participate, every employer must have predetermined a mechanism to wave the requirements of these kinds of rules. So they are not merely medical underwriting, they are a mechanism to allow people to participate in these kinds of programs, to get varying benefits under current law, that relate specifically to these kinds of behavioral modifications that talked about.

ED HOWARD: Yes, Kathy Buto.

KATHY BUTO: I just wanted to clarify, our $500 reduction in the premium is only related to taking or filling out, I should say, there's no taking, filling out the Health Risk Assessment.

And as part of that, agreeing to, if risk factors would suggest it, to allow intervention or somebody from the benefits disease management or chronic disease interventions coach, whatever it is, to essentially follow up with you. So you sort of agree to do the assessment, you submit the assessment and you agree to follow up and that's it.

There is no calibration or assessment of your actual risk factors, whether you change them or not. So, we found this to be enormously successful, just on its own. Because people essentially become more aware of what's going on, and have indicated a great willingness to follow through with their

own personal interventions with the help of a coach or some other enabler.

ED HOWARD: Actually. Go ahead Karen.

KAREN POLLITZ: Well, actually, could I have my slides back up and I would just go back to the one that I skipped. The language in the regulation is very broad, and it specifically states, and that was the reason I put one slide up there, the wellness program can consist solely of a financial incentive and a measure of biometrics.

That can be it. And as a result of that regulation, moments after that regulation took effect, there was, let's see, this program, came onto the market. You can go on the website and read about it, it's called BeniComp Advantage. It is a wellness program.

It is marketed to small businesses and the way it works is this: this small business perhaps previously had offered a health benefits plan with a $500 deductible. When you sign up for BeniComp, you switch to a $2,500 deductible and then employees who want to participate can submit to four medical tests.

They can have their blood pressure taken, they can have a blood test that checks their cholesterol, be tested for evidence of tobacco, and their weight, their Body Mass Index.

Those are the four tests. Each time they pass a test and get a passing score, they get a $500 credit against the deductible.

And so if they can pass all four tests they're back to the plan that they started with. The reward is the absence of the penalty. And if they can't pass any of the tests, they've been moved up to a $2,500 deductible.

That is participation in the health program. This is explicitly described in the 2006 regulations, and when you go to the website, how does this save money? You bet it saves money. It saves all kinds of money for the employer and for the insurance company that sponsors it.

Because now the sick people have a $2,500 deductible, so they pay more of their claims. You want to take your blood cholesterol medicine, well; you've got to pay for those statins out of pocket until you've spent $2500. And if you look at the FAQ's on this website, it discourages some people from signing up.

They say, what the hell, I'm gonna go sign up for my wife's plan where I don't have to put up with this nonsense and that saves the employer money too, and the insurer money, because now it shifts them sick people out of the program all together. So, while these programs may not all, and I firmly believe, and take it to heart that, many of these programs, including the ones you've heard described today are very kind

of carefully and thoughtfully designed, those programs along with this program are all permitted under the regulations, that were issued in 2006 and that would codified in the Senate bill.

ED HOWARD: Yes, we have somebody at the microphone. You want to identify yourself please.

MARY BETH BUCHOLS: Hi, I'm Mary Beth Buchols with the Neimand Collaborative and I thank you for hosting a very informative panel discussion today. I don't think anybody disagrees that there's certainly more need for clarification of what should be allowed, in an employer wellness program.

But we do have ADA, we have GINA and HIPAA, all of which do really create a very confusing environment for an employer to try to do the right thing.

ED HOWARD: Before you go on, do you want to give us the English translation of those terms?

MARY BETH BUCHOLS: I'm coming up to your very distinguished panel, between HIPAA, the American Disabilities Act and now the Genetic Information Non-Discrimination Act, so.

ED HOWARD: Very good.

MARY BETH BUCHHOLZ: Now having said all that – having said all that and of course Nancy being an expert in this can point to more of it, but one thing that I find very perplexing is the opposition to the not only tying it to premium discounts but also co-pay.

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And my experience with employer-based wellness programs that have really seen success in targeting populations of their employers and dependants have really come in our leading chronic conditions. And that's where the foundation of these programs have started, with hypertension and with diabetes in particular.

But those programs also give co-pay reductions and what I have heard, from a lot of those who are opposed to any sort of additional changes, as in the Senate bill, is that they are against co-pay reductions and yet to me that makes a lot of sense.

Because, you're right, a lot of these things cannot just be overcome by behavior and if we are also giving people a break financially, by having their medications in those targeted programs reduced, we have an opportunity to really give them the support that they need, both from a behavioral standpoint and from the care and treatment that they need.

ED HOWARD: You want to – You want it Nancy, go ahead.

NANCY LEAMOND: Yes, you know, there are five laws on non-discrimination tests against employers, and employers are working very hard to find the best way to do wellness and prevention programs. One of the things I've learned over the past couple of years in working with AARP and SEIU and NFIB, is we try not to create, you know, the enemy of the good.

As we look at ways of promoting these kinds of efforts, and as we've looked at these promotion and wellness programs, we don't want to vary benefits, and we don't want to discriminate, but if you have efforts that will improve people's health in the workforce, we have to find ways to help foster them, and to help employers through the varying kinds of roles, so I appreciate the comment.

MARY BETH BUCHOLS: But can we comment on why is the opposition to the co-pays? I'd like to hear from Nancy and Karen about that because that really – a lot of people have struggled why is that a bad thing?

NANCY LEAMOND: I personally believe people are focusing on the negative rather than the positive, and so we have to find a way to make these incentives work. This is not underwriting, this is not – This is a way of permitting people to have extra benefits, or access to extra programs, in order to help them succeed in improving their health.

So I get very concerned when I get pulled into a political discussion about these provisions and I hope we can all sit down and throw away the negative arguments and find a way to foster these programs.

ED HOWARD: Well actually that – Well, go ahead.

STEVE WOJCIK: Hi, Steve Wojcik, National Business Group on Health. I just wanted to add to the discussion to kind

of put the numbers in perspective too, because often question that's asked of us, is how large are these incentives and how many employers are approaching the HIPAA allowed 20-percent.

And in reality very few are approaching 20-percent and our 2010 plan design survey shows that the mean incentive is $318 per year. The median is $245. There are some companies that provide a higher incentive but often, like Kathy Buto mentioned, Johnson and Johnson, it's just for participation, completing a health assessment, not conditioned upon meeting a standard.

And that's pretty much the norm among large employers in particular. But all employers, and to just get back to the earlier point about the positive, if you want to call it, positive discrimination of co-payments, that's an increasing trend among employers.

Because the evidence among large employers in particular, shows that if you waive any kind of co-payments or cost sharing for maintenance medications for cardiovascular disease, for asthma, for lowering your cholesterol level that actually not only improves health and productivity but saves the plan money.

So, I agree with Nancy Taylor that we have to be careful that we're not looking at maybe one isolated example. I'm not familiar with the BeneComp Advantage, but overwhelming

number of plans are designed to help and alleviate the cost burden for people, especially that have chronic conditions that can easily be maintained, by medication, so we don't want to put up any barriers, for them to do that, and I just wanted to make that point. Thank you.

NANCY LEAMOND: And there's nothing in HIPAA, even before any of this wellness discussion that would have ever prevented a benefit design that said, for example, co-pays are lower on maintenance drugs for chronic conditions.

I mean, how long have plans waived all co-pays for prenatal care. There's nothing in any of the discrimination rules, there was never any question that benefit design couldn't adjust co-pays in order to make it easier for people to manage their chronic conditions.

And, I guess, I appreciate your data, and that's consistent with what's on the Kaiser Family Foundation employers survey, and I guess it just begs the question, if that's what employers are doing, and that's what employers find works, why do we need to increase the incentive to $4000 a year?

ED HOWARD: Yes, I actually was wondering the same thing.

STEVE WOJCIK: Well, that's obviously a great question. A lot of the research shows that the more you can give an

incentive the greater the participation, but also the greater the awareness of the wellness activity. So it's a dual purpose.

I'm just pointing out the facts here. I'm not saying we need to raise the incentives but if you look at the academic research, the higher the incentive, the more somebody's going to participate or even if they don't participate, the more they're going to be aware that there is some wellness activity that's available to them and the benefits of that activity.

ED HOWARD: Let me just read a question from a card because I don't want to hold Steve to answering this question but with the kind of audience we have, maybe somebody in the audience, in addition to our expert panel, has the answer.

That is, "What kind of evidence is there in the literature about the efficacy of a 20-percent threshold or if we have any examples of things above it. In other words, how big of an impact is it? How big of a constraint is 20-percent? Is there anything that we know about?"

KAREN POLLITZ: I'm happy to defer to anyone who is more thoroughly involved with the research literature on this. What I have seen is that the literature's been, there are a lot of claims that get made but in terms of kind of peer-reviewed journal articles about what works.

The few things that I've seen suggest that modest incentives along the level that you just heard about from IBM and from Steve and J&J of $100, a couple hundred dollars seem to be effective in getting people to take a health risk assessment, which is sort of the cataloging of sort of your risk status in joining programs, joining smoking cessation programs, weight loss programs, exercise programs.

But not necessarily persisting and making lifetime changes, which is what we're talking about in wellness and secondly that when the rewards exceed that modest level that it certainly does make people aware but it also raises a great deal of concerns about who's asking.

Is this something about saving money as opposed to encouraging need to be wellness the same kind of backlash that you've almost seen on this mammogram issue lately. Like wait a minute, wait a minute, why are you trying to kind of cut my benefits? So that there tends to be when the rewards get to these very high levels, there's an HRQ report on this, that people become mistrustful, become concerned, start engaging in privacy protecting behaviors, and feel resentment about, it doesn't feel like an incentive anymore. It feels like a penalty and they don't like it.

NANCY TAYLOR: I think I'd like to try to find some evidence that we need to expand our opportunities to do this.

We can work on something to make sure that these are positive plans and positive incentives. I think we all need to evaluate, as we're sitting here, what is it that would help employees to succeed at achieving certain kinds of wellness and prevention goals. I know that in my workplace to get someone to stop smoking takes more than merely $150.

We have committed to smoking cessation-type programs, which cost more than $150 in the benefit design. We have taken efforts to try to assist them. That is a discrimination in a positive sense. That's how I want all of us to think about this and whether or not it's the value of that benefit with the incentive that should be captured as we move forward rather than focusing on how it's going to be a nefarious thing and not something that's important for our workers.

KATHY BUTO: Could I just comment on one thing we're focusing right now on financial incentives but I think we found, and I don't have the data with me, that prohibiting smoking anywhere on the premises of a Johnson & Johnson facility, it's like prohibiting smoking in bars and restaurants, has had a huge impact because people begin to think not just I have to walk outside the door to smoke but they've got to walk across the street or even down the block. It's become enough of an impediment.

It's one of the first questions we asked OPM when they said what are some things you think we could do easily. I said well, can federal employees still smoke on the premises, right outside the door? They said yes. I said well, that's something that employers, I know, have or are considering but it seems simple but smoking cessation is one of those areas where the return on investment is a lot shorter than some of the other initiatives in obesity reduction and weight reduction, and so on.

I think it's within the first two to three years you start to see a return on investment for employees in terms of absenteeism, presenteeism, productivity, and actual sick days and so on. So I just encourage people to think about that.

ED HOWARD: Yes, go ahead. Nancy LeaMond is now my co-moderator.

NANCY LEAMOND: Just in the course of the discussion in the Senate and the House, was there focus on how to, regardless of what provisions you put in, how you create a body of evidence in an evaluation system?

NANCY TAYLOR: In the Senate bill, it permits the Secretary to evaluate whether or not the percentage should be increased on the basis of successful use of these kinds of what I view as positive discriminatory benefits. Remember, as large employers, we have to offer the same benefits to all similarly

situated individuals. These programs are intended to discriminate for people who can benefit by these kinds of programs.

So it permits up to a 30-percent differential in how you can conduct it through an incentive or a rebate or some kind of an effort. Then the Secretary is studying whether or not that should go higher based on evidence.

KAREN POLLITZ: Although I think the study or the evaluation in the Senate bill is of the 10-state individual market demonstration. That's a whole other component of this. In the individual market, even if you wanted to have all of these other things, I don't know how you could do it. I don't know how Blue Cross of Ohio can offer everybody who lives in Ohio a smoking cessation class. I mean how does that work?

So in the individual market, the incentive only, program design is kind of what there is. That is very much akin to medical underwriting practices. I appreciate Nancy's emphasis on the positive and don't mean to take away from that. I'm just concerned that we have had, now for three years, authority to have the 20-percent.

It sounds like employers aren't even coming close to capping out on that and without any further evaluation and with very scant literature, we're going to move ahead to 30 and blow it into the individual market and then maybe evaluate it to see

if needs to go higher. I kind of go back to my original question where is the evidence that we need to go higher?

KAREN TAYLOR: I guess I would ask where's the evidence that it is causing problems under current law.

KAREN POLLITZ: That program, which is used by clues.

NANCY TAYLOR: There are several states that already have these kinds of programs, in effect, and I'll give those to you. I've got copies of those states that currently have them in effect in the individual market, small group market.

ED HOWARD: Yes, you've been very patient.

LAURA: Hi. My name is Laura. I'm from the National Community for Quality Assurance. I have a question related to GINA, which was brought up before, the Genetic Information on Discrimination Act. It seems that family health history and incentives are important to wellness programs when they include those things tied to the health appraisal.

I was just wondering if you could comment in how you think that GINA affects wellness services when the health appraisal cannot include these things or what you think about them. Thank you.

ED HOWARD: Kathy?

KATHY BUTO: We're very concerned about it. I think we'd be glad to provide our written comments. I don't have them with me but family history is an important consideration

in advising patients about the appropriate ways to intervene, to address risk factors and not having access to that or being unable to collect it will be a real problem.

ED HOWARD: Actually that raises a question that has sort of been skirted a couple of times an that is the question of privacy concerns. Kathy, you were talking about a coach, who hires the coach? Does your boss know if your coach knows that you're taking some kind of anti-depression medication? In the real world, how do these programs make sure that you don't compromise the kind of privacy concerns that we obviously have in this area?

KATHY BUTO: Yes and Ed, privacy is a huge and important underlying principle to this and the answer's no your boss doesn't know. Your boss doesn't even know if you didn't fill out the health risk appraisal. Your boss doesn't know anything and neither does anyone else. So we think that's critical to maintaining the trust of the employee in these kinds of programs.

Again, we've been doing this for basically 30 years although I'd say in the last 10 to 15 really focused in on both coaches and enablers to help individuals with chronic disease or risk factors, even if they don't yet have chronic disease, manage those and work with them. We even work, at times, with families. So in particular, there are a number of adolescents

in recent years who have had issues with alcohol and drug abuse and we provide services to assist families as well but it's also confidential to answer your question.

ED HOWARD: Forgive me, I'm having trouble understanding how you can help a teen in a family without somebody knowing that the teen has a problem. Are these coaches employees of third parties? Are they Johnson & Johnson employees?

KATHY BUTO: They are third parties, yes, yes. We work with third parties.

ED HOWARD: Yes, very good. Yes, go ahead.

THERESA MORGAN: Hi, my name is Theresa Morgan and I'm asking a question with the Consortium for Citizens with Disabilities. I've heard the term positive discriminatory incentives used a lot. That's interesting to me because I haven't heard a program yet described where you go in and you get a blood test and you get a high cholesterol level and you get an incentive to then participate in the program. You then get a discount because you have high cholesterol. That's what I would think of as in terms of positive discriminatory.

Instead, what's happening, well this example shows what's happening is you're going in. You're getting the blood test and you're getting the higher deductible or the higher premium. So I don't see that as a positive discriminatory

incentive. Though there may be programs out there that are very good and we've heard examples of them today and those sound great, I'm just wondering how the provisions can be changed in the bill now to avoid this from continuing. That's my question.

KAREN TAYLOR: That's for me. The issue is that that particular person would hopefully be offered an incentive or some basis for participation in a program to reduce their cholesterol or to measure their cholesterol. We have many of those kinds of programs. Kathy Buto can maybe talk about those things. So that's why it is seen as a positive basis for giving them an extra benefit to assist them in controlling cholesterol so they don't have long-term effects.

In addition, you have to have some ability to waive those requirements if a person cannot meet them. I hear lots of concerns about the 'what if's' and what we need to do is focus on how can we help that person with higher cholesterol succeed a healthier activity for them to improve their own health.

I found now three studies, which I will give to Ed Howard that document the empirical evidence. The greater incentives are necessary to get people to participate. We need to strengthen those provisions, which say if you can't do it

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because of your health or because of other kinds of issues, they should be waived.

We need to make sure that all employees know about these programs and that you have a way of them so that they don't have to participate in them. That is what the regulations currently say. So let's make certain that we provide those kinds of protections around it that are in the regulations and if we need to strengthen certain areas, let's have a talk about it not put words around what we think they mean but I do have three sides. So I have three sites. So I will get them to Ed.

ED HOWARD: We will post them with the materials.

NANCY TAYLOR: It was in the *New England Journal of Medicine* published peer-reviewed article.

ED HOWARD: Nancy, let me just follow up on one aspect of that question on a card, asks for some examples of the alternatives, in quotes, that are described in the regulations of people who can't get to the outcome that is proposed.

NANCY TAYLOR: Well when we asked some employers what they do, they will generally waive the requirements of participation in a program if one of their employees can't participate but there may be other ways of meeting those objectives. Unfortunately, I'm just a lawyer. So I'm not an HR executive so I would not know but I would hope and challenge

others like Kathy Buto to talk about ways that you can find reasonable alternatives and that would be critically important.

ED HOWARD: Sure. Kathy?

KATHY BUTO: One tool that has been very effective, I mentioned, is health media. It's a web-based sort of coaching, self-coaching tool that helps the individual navigate various options and ways to address their risk factors. So that's been effective, I gather, at the Chamber of Commerce, a week or so ago now that Mike Critelli the retired CEO of Pitney Bowes, mentioned health media as being a really effective tool.

We found it, one reason we decided to try to buy the company, found it was extremely helpful with our employees in getting them to really address their risk factors and look at different alternative ways to do that.

ED HOWARD: Thank you. Yes? Go right ahead.

GRETCHEN: Hi. My name is Gretchen. I'm with the U.S. Industry Committee. I want to make one comment to start with, which is I think having employers save money on health care costs is not necessarily a bad thing. There is a finite amount of money that they're willing to spend and the fact that programs can save money for individuals as well as employers. It's not a negative. It's a dual positive. I think my question goes to Karen and that is to follow up on an earlier question. One of the, a regulation that came out recently

under Title I of GINA is making life extremely difficult if not impossible for a lot of employers of wellness programs.

The immediate problem for us is that the regulation itself, published on October 7th, takes away the ability of employers to get financial incentives with the completion of an HRA that asks for family medical history. So clearly that, as we talked about earlier, takes away a valuable piece of information from the HRA.

The second thing the regulation does is it takes away the ability to guide people to disease management programs if they, for instance, have a family member with diabetes or congestive heart failure, whatever. I just wanted to get your take, Karen, how do you feel about the use of incentives for the HRA in that context and also how do you feel about using this kind of information to guide people to disease management programs?

ED HOWARD: Before you answer, HRA is not a health reimbursement account in this context.

GRETCHEN: Well it is but not in this question, a health risk assessment.

ED HOWARD: A risk assessment.

GRETCHEN: Yes, thank you.

KAREN POLLITZ: This is another example of how these issues can intersect. I'm not sure if that was fully thought

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about. GINA was adopted unanimously, House and Senate, everybody agreed no discrimination based on genetic information. There were lots of reasons why.

Title I says no discrimination based on genetic information in health insurance. It says no underwriting based on genetic information in health insurance. Underwriting is defined in the law as anything that adjusts the premium or your eligibility for the benefits.

The standard to many civil rights protections, nondiscrimination protections, the rule under GINA is that insurers and health plans may not use genetic information for underwriting and to make sure they don't use it, they can't even ask for it before you enroll or at any time after enrollment for underwriting purposes, again being adjustment of premiums, measuring your eligibility or continued eligibility for the benefits.

When the regs came out and I should mention Title II of GINA, which applies to employers, so outside of ERISA now, ERISA's about health plans, but in the ADA and other rules about employment discrimination, there were protections or there were exceptions rather.

Title II says employers also can't discriminate based on pay benefits because of your genetic information. They can't even ask about it either. There was an exception for

wellness programs but again, those programs had to be voluntary, which means you can't charge people money to come into them.

The EEOC has never said what voluntary was but there was no wellness exception in Title I, wasn't. This bill lived on the Hill. It was first introduced when Ellie was born. So this is 13 years this thing flopped around on the Hill before it got enacted.

So the regs got issued on GINA just a couple of months ago and said that under Title I, if you ask, in a health risk assessment, about family history, which is included in the definition of genetic information and you adjust people's premiums based on whether they take that health risk assessment, that's underwriting.

So if you're going to ask for underwriting purposes, you can't adjust the premium. You could give them $500 just in cash. That's fine. You can give them a gift card. You can give them a blender. You can give them other incentives but you can't touch the premium because that's the definition—

GRETCHEN: In the regs themselves, you can't give an incentive regardless.

KAREN POLLITZ: No, no. You can give an incentive. You just can't adjust the premium.

GRETCHEN: In the regs, there's an example that says you actually cannot give them an incentive at all. The only way you can give them an incentive is if you take out the question on family medical history.

KAREN POLLITZ: I'll need to go back and re-read that. I was quite sure it was specific to the premiums.

GRETCHEN: Trust me, it's become a problem.

KAREN POLLITZ: Alright.

ED HOWARD: Let me just follow up on something else that you raised and that had to do with the saving of health costs out of these programs. Whether it's a trillion dollars or a mere $550 billion, CBO isn't buying it. I wonder what kind of comments any of our panelists might have about the sort of lukewarm scoring response to what's in these bills. It's not just wellness programs. It's the whole prevention business as well.

KATHY BUTO: Maybe it's my background in CBO that helps me answer this question and working for many years with the HCFA actuaries now CMS actuaries. First of all, everyone needs to keep in mind and you all know this is that CBO is looking at federal costs and federal benefits.

Often that means Medicare. So if you think about some of the productivity savings and etc., those accrue really in

the private sector. So that's at least one pillar of the reason why you don't see some of the benefits.

The other thing that CBO worries about is if the private sector's already doing some of this and the federal government adds incentives, will there just be a shift without any additional benefit to society. So you know CBO, that's the way they think about these things.

The third thing is, and I experienced this when I was at Medicare and we were looking at tobacco cessation programs, at the time and it's not true now but it was then, it was very difficult to tell what tobacco cessation programs Medicare should cover or certify as having good or a lack of recidivism rates that really, in essence, meant that you were spending the money at two or $300 a pop per beneficiary, you might be a smoker and yet not getting really sustained benefit.

Now we have a lot more information than we had then but the whole issue of evidence-based interventions is critical to this. That's why, at least at our company, we've really focused on the metrics, the long-term sustainability of some of the interventions because if you just say prevention and wellness without the specificity, you don't get the kind of return you should from some of these programs.

I think that just knowing the CBO mentality, they're very skeptical of throwing something broad out there without

specificity. I know the Workplace Wellness Act had some of that specificity built in so that we could actually tie a subsidy to programs that worked.

So those are just some of the reasons that CBO scoring, which drives our CEO crazy because he keeps saying why don't they see the benefit? We have it here and this company has it and so on. It's really, some of it is the peculiarity of CBO scoring.

CLAIRE MCANDREW: Hi. I'm Claire McAndrew from Families USA. I want to thank you all for a really excellent discussion. We've had a lot of discussion here about what the appropriate amount of an incentive is and the research maybe isn't quite at the level yet where you want it but one thing we do know from research is that increasing co-pays even nominally or other health costs even nominally for low-income populations can really be a deterrent to seeking care.

So some of that really concerns me about these programs the way they're set up especially when you look at the proposal for the individual market penalties is that they're regressive in the sense that someone who makes $100,000 and someone who makes $10,000, their penalty levels are the same amounts since they're based on premiums.

So it just seems that all the work we've put into and people have put into these subsidies, we're going to see to

help make coverage affordable, seems to kind of contradict that. So I was wondering if there was any way that you all could see to make these programs a bit less regressive in that sense.

Well the same time that you say it's regressive, I would say that it is bigger incentive for a low-wage worker. It could be a bigger incentive for a low-wage worker than a higher wage worker at the same time. So it depends on how the incentive is structured at the end of the year. A $500 incentive is going to be more money for a low-wage worker than it is for a higher wage worker.

So I think we all need to find ways to make these programs work for all employees. We have six nondiscrimination laws. We have one that specifically addresses low-wage workers. It permits employers to charge less premium for low-wage workers not high-wage workers. That's the only other place in federal law that we can positively discriminate. So we all need to focus on those kinds of efforts as well to ensure these programs work.

ED HOWARD: Go ahead Karen.

KAREN POLLITZ: Well in the Senate bill though, the individual market 10-state demos specifically, exempts the subsidy protection from this wellness reward or penalty. So it's possible that we're structured as a reward. I suppose

that a healthy low-wage worker could pay even less but a sick low-wage worker could pay tremendously more the way the Senate bill is written that again may not be the intent. That's what the words say on the page.

The other thing that's going on, which is sort of interesting and CBO didn't catch this either so I don't know if they're just focused on it or not but the affordability of workers who are offered coverage can nonetheless come into the exchange and get subsidies if what they have to pay for their share of the employer-sponsored plan is unaffordable and that's defined as a threshold what they pay divided by their income. That affordability measure is blind to the wellness adjustment.

So it's possible again, not the intent necessarily but you think about insurers that maybe want to kind of continue underwriting under the new world reform, it's possible for them to go into small groups and sort of apply these wellness adjustments in a way that could boost low-wage unhealthy workers out of the job-based plan and into the publicly subsidized individual market. So that could be another problem as well.

NANCY TAYLOR: Given the fact that we have some states that are currently doing that, I think it'd be a good idea for Families USA and Karen to go in and look and see what is exactly happening.

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CLIARE MCANDREW: —Like Rhode Island and other states like that.

NANCY TAYLOR: Has it been causing this problem in those states that have these programs in effect already?

CLAIRE MCANDREW: I'm not sure. I mean I would like to see information. There might be some in your packets that I'd like to look at but just who participates in these programs and if there has been any research on different income groups, the different levels and how they're affected because I think a lot of times, the discussion around this is focused on large corporations a lot of times that have high-wage workers.

I think that with the individual market provisions and the bill, we could see a whole new world much larger than what's going on in a few states of these lower wage workers being subjected to, I mean rewards would be one thing but possibility penalties because I think the law does open up that situation.

ED HOWARD: Well I don't think there is material in the packets about this.

NANCY TAYLOR: I have materials. I have materials on the states that are currently doing this. So we ought to look at them before we make judgments.

ED HOWARD: We'd be happy to post appropriate parts of that as we go along. We have just a few minutes left. I want

to ask you to pull out your blue evaluation forms and fill them out as you hear the last part of these discussions. There are a couple of things that have come up that I want to follow up on if I can. They do come out of not just the discussion but some of the statements that are made by proponents and opponents in the materials.

Steve Bird, whose name's been taken very often in the course of the discussion, says in the Op-Ed piece from *The Wall Street Journal*, that's included in your materials, that 70 percent of health care costs are the direct result of behavior.

We've heard, I think it was Nancy LeaMond who talked about factors like genetic predispositions and the lack of healthy alternatives like exercise opportunities. How much of this 70 percent is really amenable to the kind of wellness programs that we're talking about here? Is the 70 percent real? Anybody?

KATHY BUTO: I mentioned two big ones, smoking and diet. Exercise would be a third one, those three, huge, huge opportunity for personal intervention to address all three of those. They drive a lot of health care costs.

ED HOWARD: It's not just behavior. It's behavior that's subject to modification presumably?

KATHY BUTO: Well eating is behavior Ed. I hate to tell you. A lot of behavior modification is focused on things

like nutrition and exercise right now as well as smoking. I mean there are behavioral aspects to all of these.

ED HOWARD: Yes, go ahead?

FRED GOLDSTEIN: Yes. I'm Fred Goldstein with U.S. Preventive Medicine and we're a private company in this space doing these types of programs. I just wanted to address that question you just had. There was a recent study out of Europe, I believe, that showed that you could reduce your risk of most chronic illnesses, and these, you're talking about up to 80-percent just by reducing your smoking, controlling your weight, eating appropriately, and getting adequate exercise.

ED HOWARD: But my question is how much of that is subject to behavior modification?

FRED GOLDSTEIN: Quite a bit I think and that's the issue. I mean what we've got to look at is a couple of things. Let me just address a couple you brought up. The GINA issue, I as a company that wants to tell the individual to do the right thing, to get the treatment they need, to get the service they're supposed to get, many of those tests and screenings are directly impacted by their risks.

If they have a family history of something, I need to be telling them earlier go get yourself tested. Go get a screening. With these new regs, I can't do that.

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Secondly, on the high deductible plans, you mentioned the $381 or somebody did, we are seeing companies throughout the United States move to much, much higher deductible health plans.

They're saying we can't afford it. We're going to make a greater piece of the payment out of the employee but they're now saying well I'm going to do that anyhow but let me put in a wellness program and incent them to reduce those co-pays by giving them the option to participate in these various activities that we have.

If they didn't have that wellness option, they're going to make the co-pays and set them that high anyhow. You're going to see companies continue to move in that direction because the costs are going out of control.

The last thing I'd like to make a point about is we have a chance here to fix the health care system but we're only going to do it if we keep people healthy. We cannot afford the ongoing increasing prevalence of chronic disease in this country. I don't care if it's single payer or a trillion payer system.

The only way to do that is to incent the individual, empower the individual, give the individual the responsibility and the resources to make those decisions to live a healthier life. If we don't change this trend, we won't be able to

afford the system. We'll spend 50 percent, 70 percent, 100 percent of our GDP on health care. I'd just like to close with that. Thank you.

ED HOWARD: Only health policy analysts would like that I guess. In light of that, I wonder Kathy Buto talked about the use of carrots instead of sticks. Ken Thorpe, the dean of chronic illness these days, talks in an excerpt from the National Journal blog, that you have in your materials, about how carrots work best for most employers but there's also a piece about the program from Scott's Miracle Grow quoting the fellow who runs the program as saying we tried carrots. Carrots don't work.

So the man with the stick in his hand has a very effective program to reduce their costs he thinks but folks like Johnson & Johnson have a very different approach. You don't need to change the law to do what Johnson & Johnson is doing. You presumably need to change the law to allow enhanced use of the kinds of sticks, if you will, which is why I ended up with that kind of comparison. Nancy, where am I going wrong?

NANCY TAYLOR: I think in order for you to provide incentives to targeted people, you would need to change the law or permit the regulations to move forward. So I don't think that the law merely presumes sticks. I think it also presumes

carrots and carrots can work. I've heard all sorts of possible activities that may go on in the future that would hurt certain populations. Let's find each one of those and find a way to solve that problem.

So I do think the HIPAA regs do work. I think that there are reasons that a lot of people want to codify them. I represent employers as do others of my colleagues that are here. They want stability in the offering of their health benefit plans to their employees. They have made a commitment to continuing offering health benefits to their employees.

It is their number one cost pressure and they do want to help their employees be healthy because healthy workers are productive and are happier in their jobs and do well. They want to continue those efforts. So we need to find ways to have stability to these kinds of efforts and to make them work.

One of the issues I do want to raise is I've heard people say that if these tools are used, they may ultimately result in the denial of services under the underlying plan. Let's write something and make sure that doesn't happen. That's not the intent of these programs. The intent of these programs are to provide incentives or to provide access to or encouragement of in whatever ways will work to programs that will help improve health.

ED HOWARD: Well that sounds like a pretty good generalization. Wait, we have time for one last question.

DEREK SCHOLES: Sorry to stop it before the end of it. I did want to respond to some of the negative comments against GINA and how somehow, with allowing an employee or an enrollee to withhold their family history information or somehow be restricted for some of these wellness programs. What I've heard so far—

ED HOWARD: Excuse me, could I just ask you to identify yourself?

DEREK SCHOLES: Oh, I apologize, Derek Scholes. I'm with the American Heart Association. What I've heard so far is smoking cessation programs, programs to increase physical activity, diet, nutrition, and HA of course, is supportive of all of these.

What I don't understand, what baffles me is why you need to have someone's family history information in order to be able to, if someone is a smoker obviously it's clear they would benefit from the smoking cessation program. If they're not a smoker, clearly it's not.

The other thing I would point out is that a family history is extremely complex. There may be a form where you fill in your grandfather died of cancer but it may not say whether he worked in a toxic environment.

He might have been a chain smoker, worked, so family history is very difficult to do any kind of analysis of family history within the context of a simple form, which is why there are degrees in this. This is why people become genetic counselors to have these long analyses to take all this extra information. So my simple question is why there's aspiration for family history information.

ED HOWARD: Please go ahead Kathy.

KATHLEEN BUTO: First of all, the exercise and nutrition, smoking cessation discussion was around behavior modification. So what can you do to change a risk factor that you have some control over? The issue of family history has to do with some of those other considerations in your family history that might have an impact on your choices be it early on or at the time to manage a risk factor where you might have a predisposition in family history, it really shocks me.

You're with the American Heart Association that that wouldn't be an issue with the American Heart Association because heart disease in particular is one, which can be addressed and managed very effectively with, I know, I have a history of a lot of heart disease and heart fatality in my family, I started early because of that and my awareness of it in managing that condition.

So I'm really sort of surprised but that is the reason and there is a distinction between the things you really can control and your awareness of your risk factors related to family history.

DEREK SCOLES: Just to clarify, AHA absolutely supports analysis of family history. For anyone who's interested, you can go to, on the website, the Surgeon General has a tool to allow you to analyze your family history for free. What the tool encourages you to do is to take this analysis and then take it to your doctor and ask what that means for you.

The question isn't whether family history is useful. It is the question is whether you should be telling your doctor whether you should be finding out this information and reporting it to your insurance company or your employer.

ED HOWARD: Well we can go back and forth on this for a long time but I think we've come to a pretty good stopping place. I apologize to all of you who took the time to write questions on cards that we didn't get rid of, I mean answer [laughter].

Frankly, there are more than we can ask our panelists to try to do in writing afterwards. So we're going to have to come back to this at some point.

To that end, by the way, we are planning to kick off the 2010 briefing series with a session co-sponsored by our

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friends at AARP and the Blue Cross/Blue Shield Association looking at aging as a factor in charging people different premiums.

So something of the same discussion will be continued. You might get a chance to ask some of your questions then. Thank you for your attention. Don't forget to fill out the blue evaluation forms. Thanks to AARP for its support of this briefing and ask you to thank me in thanking our panel. You know what I mean, for a great discussion [applause].

[END RECORDING]