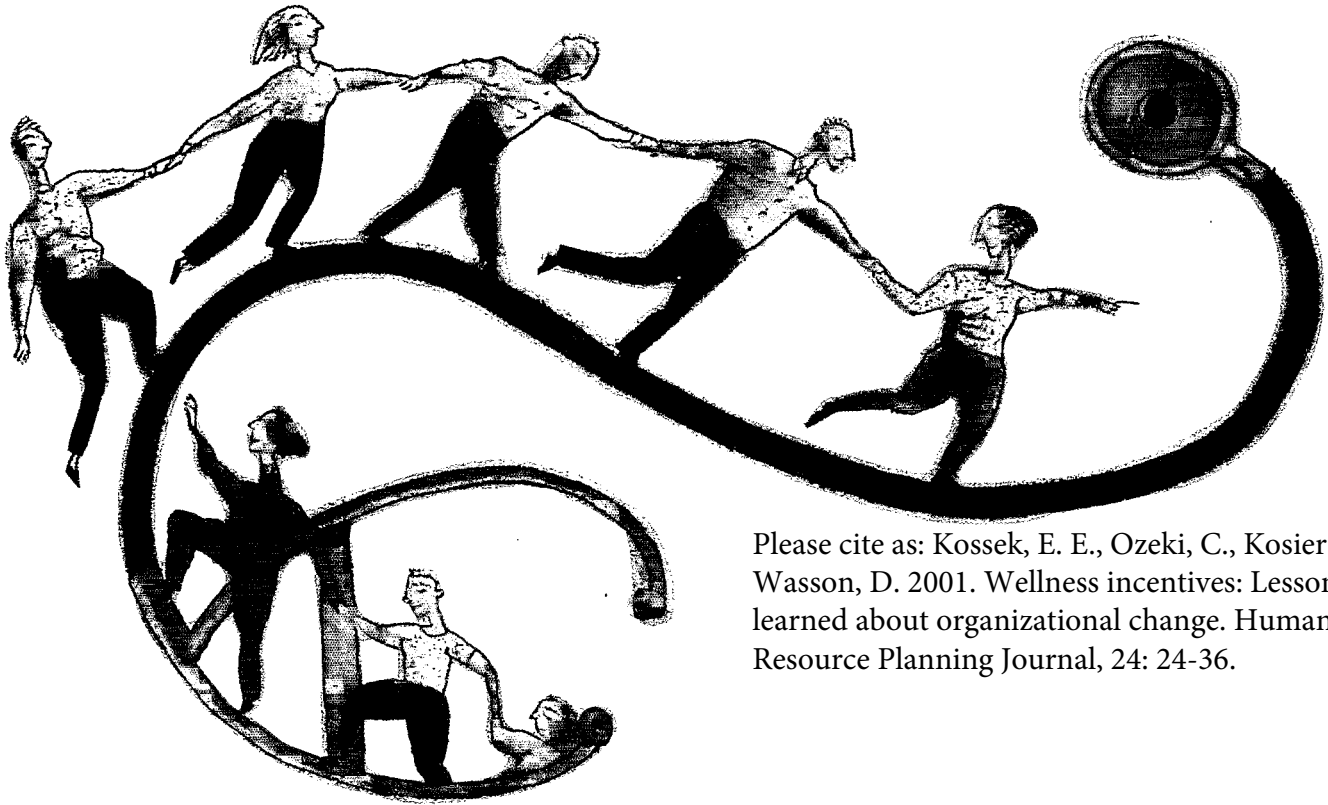


Wellness Incentives: Lessons Learned about Organizational Change

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Wellness incentive programs designed to reward a healthy lifestyle and reduce demand for medical benefits are often assessed on a “cost only basis.” A main lesson learned from this study of 243 employees’ responses to wellness incentives is that wellness should be viewed as a “collaborative organizational change effort,” with cultural change implications for both employee and employer. The program offered insurance premium reductions or increases in co-payments, and coupons to apply to flexible benefits based on annual evaluations of health and fitness by medical staff, wellness classes, access to fitness

facilities, and assistance with weight loss and smoking cessation. The results showed that employees who were healthier, higher paid, and those who were hired after incentives started were significantly more likely to think the program was fair, and had more favorable perceptions of distributive and procedural justice. After controlling for healthiness, demographics, and employment background, employees who thought the program was procedurally just were more likely to have higher job satisfaction. Healthier workers did not necessarily have significantly fewer doctor visits, higher job satisfaction, or lower absenteeism than those following less healthy lifestyles.

Many employers today are adopting HR strategies such as wellness incentives to contain rising health care costs, which often can represent up to a third or higher proportion of labor costs (Gemignani, 1998; McCaffery, 1992). Wellness incentives reward good employee health and fitness and are primarily seen as part of a labor cost reduction strategy. Although most are mainly evaluated on a cost reduction basis, this study shows it may be more effective for employers and employees to view wellness incentives as a joint organizational change initiative. From the employee perspective, incentives require individuals to be more accountable for their personal health on and off the job, and shift benefits away from being viewed as an entitlement. From the employer perspective, incentives imply a cultural shift – away from passively paying for benefits and overlooking motivation of employees' personal health and fitness. To be successful, wellness incentives require active employer involvement in promoting a healthier workforce and an implementation perspective focusing as much on organizational change as on cost reduction.

WELLNESS INCENTIVE PROGRAMS: A GROWING BEST PRACTICE

Wellness programs designed to monitor and improve employee health have been hailed as a way to reduce health care costs by changing demand for services rather than improving the medical system (Kizer, Pelletier, & Fielding, 1995). Wellness programs typically consist of some combination of fitness promotional activities, health education programs, regular wellness assessments, and screening for serious health conditions. Examples of commonly assessed wellness behaviors include employee reports of seatbelt use, smoking, sleep, alcohol consumption, and physical measurement of blood pressure, body fat, blood cholesterol, and fitness such as speed in walking a mile (Haltom, 1995; Brotherton, 1998). Wellness and health promotion initiatives have been adopted by most (90%) large companies (Employee Benefit Plan Review, 1998) and nearly two-thirds (61%) of firms with fewer than 250 workers (Litvan, 1995). Research reviews generally indicate positive effects from wellness incentive programs. Improvements have been recorded in smoking cessation, weight loss, and the reduction of coronary heart disease risk factors, as well as in nonmedical areas such as absenteeism, employee morale, and retention

(Pelletier, 1995). With wellness now seen as contributing to the bottom line, many firms have introduced incentives such as deductions on co-payments to motivate workers to become healthier (Haltom, 1995). One survey of major employers found that 39 percent of organizations with health promotion initiatives used incentives to encourage healthy lifestyle choices (Brotherton, 1998), up from 18 percent in 1993 (Haltom, 1995). According to a report by the Employee Benefit Research Institute, wellness incentive programs have been proven to be at least partly responsible for slowing the increase in health insurance premiums (McShulskis, 1997a).

Despite increasing adoption and growing evidence that these initiatives reduce labor costs, relatively little research has examined workers' reactions to pioneering changes that increase worker responsibility for controlling employer costs for health benefits (Gerhart & Milkovich, 1992). This study begins to fill this gap by analyzing the results of a wellness incentive program. The program offered insurance premium reductions or increases in co-payments, and coupons to apply to flexible benefits based on annual medical evaluations of healthiness and fitness, wellness classes, access to fitness facilities, and assistance with weight loss and smoking cessation. The issues addressed include: Do employees with healthier lifestyles have fewer doctor visits and absences? Do employees view wellness incentives as fair and just? Are there differences between the reactions of new hires who accepted employment knowing that they would be covered by incentive-based benefits, and existing workers who faced a benefits change? Do healthier or higher paid workers view incentives more fairly than others? Do workers who perceive incentives as less fair have lower job satisfaction and higher absenteeism?

PERCEPTIONS OF FAIRNESS OF MOVING AWAY FROM BENEFITS EN- TITLEMENT: RESEARCH HYPOTHESES

We measured three aspects of employee fairness reactions: attitudes regarding the general fairness of wellness incentives as an HR policy, and distributive and procedural justice. Traditionally, most employees have received equal health benefits simply by virtue of their employment with the company. By introducing financial incentives to promote healthy behavior, some could argue that employers have unilaterally changed an established employment deal. Instead



of benefits being contingent on organizational membership (i.e., most full-time employees are entitled to benefits by virtue of being employed), benefits receipt now has an implicit merit-based component. Employees who are less fit can pay more for benefit coverage than those who are healthier. This approach represents a shift away from an entitlement view of equal health care benefits, and a fundamental change in the psychological contract. Psychological contract refers to the implicit beliefs an employee holds regarding reciprocal obligations between himself or herself and the employer (Rousseau, 1996). When an organization adopts a new HR policy, employees may view this policy as supporting or countervailing the perceived psychological contract of employment. If the new policy does not fit with employee expectations of what is fair in the employment relationship, they may react negatively. A psychological contract violation is associated with reduced job satisfaction, turnover, and a reduction in effort (Morrison & Robinson, 1997).

Distributive and procedural justice are commonly studied concepts in the fairness literature (Folger & Konovsky, 1989). Distributive justice refers to the perceived fairness of outcomes, while procedural justice refers to the perceived fairness of the procedures that lead to those outcomes (Greenberg, 1994). Sometimes even when outcomes are less favorable to an individual, he or she may still regard a program as fair in its procedures and administration (Greenberg, 1987). Research on reactions to HR policy suggests a "self-serving bias" in fairness perceptions. Employees who are more likely to be favorably affected by HR policy changes are consistently more likely to view them as fair both in terms of outcomes and procedure.

Distributive justice reactions tend to be the strongest for HR policy changes that serve one's direct interests (Greenberg 1997, 1994). In one of the few studies conducted on the fairness of proposed employee benefit changes, Grover (1991) found that workers who had children or were more likely to bear children in the future were more likely to perceive parental leave policies as fair (1991). A new parental leave policy

better served the interests of employees who had or were planning to have children than those whose children were grown or who did not intend to raise children. Similarly, we believed that there would be a positive relationship between job satisfaction and health. Employees who had healthier lifestyles were more likely to hold the most positive attitudes toward wellness incentive programs rewarding good health, because these programs serve their interests.

H1: Employees who are healthier as measured by the annual medical fitness and health evaluation will have more positive attitudes regarding the general fairness of wellness incentives and their procedural and distributive justice than those following less healthy lifestyles.

Employees who are more likely to be favorably affected by HR policy changes are consistently more likely to view them as fair both in terms of outcomes and procedure.

Key Employment Variables Influencing Fairness Perceptions

Comparing New Recruits to Existing Employees: Joiners and Stayers

We thought that an important consideration in understanding employee perceptions of the fairness of the new wellness incentive program was whether employees had the new wellness system thrust upon them as a change to their employment conditions, or whether they had the opportunity to accept employment well knowing that their fitness might affect their level of contribution to health insurance benefits. From the employer perspective, the easiest way for employers to change employee psychological contracts is to hire new people who will not harbor expectations based on previous experiences with company employment practices (Rousseau, 1996). We believed that those who joined the firm after the program was introduced would have more positive attitudes about its fairness than those who had previously been under a more traditional health benefits system at the same organization.

H2: Employees who joined the organization after wellness incentives were introduced will hold more positive attitudes regarding their general fairness and procedural and distributive justice than employees with experience with a previous traditional health benefits policy.

Pay Level and Fairness Perceptions

Besides fitness and commencement of employment with the company, we believed income level might relate to the perceived fairness of the incentive program. Lower paid workers are more likely to have less disposable income to buy memberships at health clubs, purchase fresh fruits and vegetables and fitness supplies such as home treadmills and special vitamins, and may be less likely to afford the costs of paying dependent care while exercising. Most importantly, benefit co-payments will adversely affect a much larger proportion of total earnings for those at the bottom of the compensation tier than those at the top. We believed lower income workers would be more likely to perceive wellness incentives negatively, because the failure to receive rewards would influence them financially to a greater proportional extent (regressive impact) than higher income workers.

H3: Pay level will be negatively related to attitudes regarding the fairness of wellness incentives, with lower paid workers less likely to hold positive attitudes regarding the general fairness of wellness incentives, and in terms of procedural and distributive justice.

Relationship Between Healthiness and Fairness Perceptions to Job Satisfaction, Absenteeism, and Doctor Visits

An underlying assumption of wellness incentive programs is that healthy employees make healthy companies that have higher productivity and healthier work environments (Rosen, 1991). Given these assumptions, we wanted to examine the degree to which employee healthiness and fairness perceptions were linked to work attitudes and behaviors. Some researchers argue that healthier employees miss work less and have lower use of medical services, because they are less likely to get sick. Healthy employees also are believed to have better work attitudes as a result of a spillover from physical health to mental health (Rosen, 1991).

H4: Healthier workers as measured by the annual medical fitness and health evaluation will have higher job satisfaction, fewer absences, and fewer doctor visits.

Employer efforts to improve productivity by wellness incentive programs could potentially backfire, if employee attitudes regarding the

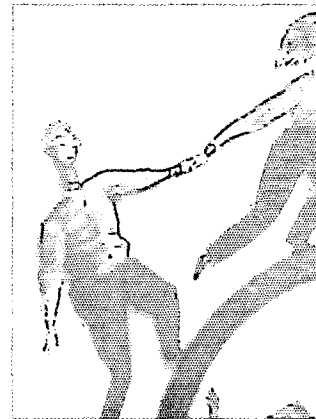
fairness of wellness incentives negatively impact productivity-related factors. Unhappiness with the fairness of the wellness program could negatively spill over to affect overall job satisfaction, because wellness incentives are a subset of one's job conditions. Previous research on justice perceptions in the context of compensation found that fairness perceptions were positively related to pay satisfaction (Miceli, 1993), a component of job satisfaction. Studies also suggest that satisfaction with medical benefits is related to job satisfaction (Judge, Hanisch & Drankoski, 1995). We hypothesized that employees who perceived the program as less fair would also have lower job satisfaction.

Absenteeism is a work behavior that can affect productivity, because if employees are not at work they cost the company in terms of lost work time and negative impact on the morale and productivity of co-workers. Absenteeism has been viewed as a form of psychological withdrawal from the workplace (Johns, 1987) and with varying results has been linked to job satisfaction and most strongly related to one's intention to terminate employment (Nicholson & Martocchio, 1995). Because employee perceptions of fairness and violation of psychological contracts have been associated with reduced job satisfaction, turnover, and a reduction in effort (Morrison & Robinson, 1997), we thought that workers who thought the policy unfair might feel the company owed them some compensation, which they could psychologically recoup by missing work.

H5: Employees who view the wellness program as less fair as a general policy, and in terms of distributive or procedural justice, will have less favorable work attitudes (job satisfaction) and behaviors (higher absences) than employees with contrasting fairness perceptions.

METHOD

Organization setting and HR policy. The study was conducted at a nonunion midwestern hospital that had instituted a new program aimed at reducing health care costs by improving the health of its employees. In addition to wellness classes, access to fitness facilities, and assistance with weight loss and smoking cessation, the program involved annual evaluations of health and fitness levels. Each participant was assigned a



wellness score based on responses to questions regarding his or her lifestyle, including seatbelt use, smoking, sleep, and alcohol consumption, as well as four physical measures: blood pressure, body fat, blood cholesterol levels, and fitness as measured by speed in walking or running a mile. The categories included reflect areas considered likely to affect future health care costs and are similar to measures reportedly used in other firms' wellness assessments (e.g., Haltom, 1995; Brotherton, 1998). In order to prevent charges that the wellness program had potentially illegal adverse impact, medically based adjustments were made to the scores to reflect the fact that women and older people generally perform less well on some of these measures. After these adjustments were made, those scoring at the high end received an incentive in the form of an insurance premium reduction of \$25 per person per pay period, resulting in up to an additional \$650 per year available to use for other options through the company's flexible benefits program. Those scoring at the low end were faced with an increase of an equal amount in their health care premiums. Individuals scoring in the range defined as average experienced no change. *Employee communications* stressed that the program was an alternative to raising insurance contributions for all employees as a result of higher health care costs.

After the program had been adopted for a year, employees were surveyed on reactions to the program. Responses were matched to personnel and insurance company records so that the relationship between health, attitudes, absences, pay, and doctor visits could be evaluated.

Sample. A random sample of 524 employees was selected based on employment records. Of the original group, 243 full-time employees, or 46 percent of the sample, returned usable data. Reflecting hospital demographics, 75 percent of the respondents were female, 4.5 percent were minorities, and 28.8 percent were managers or professionals. Using confidential codes known only to the researchers, survey responses were matched to employee and insurance company records on wellness scores, attendance, pay, and the number of doctor visits for the year.

MEASURES

Both archival objective data and survey response data were collected. All survey items utilized five-point Likert-type scales with labels

for "strongly disagree" at 1 and "strongly agree" at 5 as anchors. Higher scores reflect more positive attitudes.

Employee healthiness. Wellness assessment scores were composite figures developed by a respected medical assessment team. Healthiness was determined based on results for four physiological measures (blood pressure, body fat/muscle tissue ratio, cholesterol level, and fitness level) and a detailed survey collecting self-reported health- and safety-related behaviors. Greater weight was placed on objective measures. Survey items were developed based on a review of the wellness promotion literature and assessed exercise/fitness, nutrition, stress, tobacco use, alcohol use, and motor vehicle safety. A sample item: "I always buckle my seatbelt while I am driving or riding in a motor vehicle."

Archival personnel record data. Figures for the number of doctor visits were obtained from the company's health insurance provider. These data are for the employees only and exclude visits by dependents. Data on absences and hourly pay rates for the previous year were obtained from personnel records. Hourly pay rates were divided into six categories: under \$10, \$10 to \$20, \$20 to \$30, \$30 to \$40, \$40 to \$50, and \$50 and above. We also consulted personnel records to obtain information on when individuals joined the company. Individuals who had joined the firm before the program was adopted were classified as stayers (coded as 2); those who joined later were coded as joiners (1).

Fairness measures: Perceived fairness, procedural and distributive justice. In order to assess overall reactions to the program's fairness, we developed a three-item measure (alpha .77) that asked employees about their perceptions of the substantive fairness of the wellness incentive program. A sample item: "It is not fair for staff members who live healthy lifestyles to pay the same for company health insurance as those who don't" (reverse scored).

Measures of employee perceptions of procedural and distributive justice were based on work by Leventhal (1976, 1980) and Greenberg (1994). Items were adapted to the health care benefits context as appropriate. The distributive justice scale, adapted from Greenberg (1994), consisted of three items (alpha .87). A sample item: "The cost of the health care system is fair to staff members." The nine-item procedural justice scale (alpha .88) is based on work by

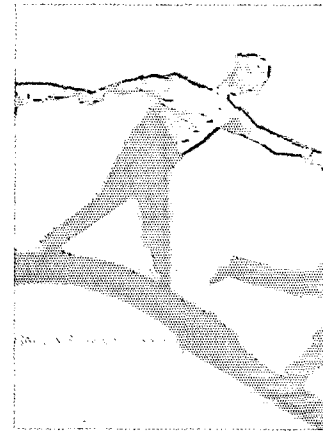


TABLE 1

Descriptive Statistics

Variable	Mean	s.d.	1	2	3	4	5	6	7	8	9	10	11	12
1. Healthiness/ Wellness score	.88	9.18												
2. Absences	5.24	13.96	.00											
3. Doctor visits	10.50	14.60	-.12	.53*										
4. Distributive justice	3.19	1.01	.27*	-.06	-.03	(.87)								
5. Procedural justice	2.03	.31	.11	-.07	.00	.51*	(.88)							
6. Fairness	3.34	1.05	.35*	-.02	-.08	.39*	.33*	(.77)						
7. Pay rate	2.39	.89	.13	-.10	.00	.28*	.17*	.29*						
8. When joined	1.82	.39	-.18*	.15	.16*	-.12	-.06	-.12	.21*					
9. Job satisfaction	3.99	.70	-.04	-.06	.01	.20*	.28*	.22*	.23*	.08	(.90)			
10. Age	39.87	9.58	-.25*	-.12	.10	.07	.07	.00	.31*	.29*	.20*			
11. Gender	1.75	.44	-.05	.17**	.13	-.05	-.11	-.05	-.31*	-.13	-.02	-.18*		
12. Race	1.95	.21	.06	.05	-.03	.10	-.10	.10	.12	.10	.06	.00	.06	

* denotes significant at the .05 level N = 242

Leventhal (1976, 1980), and tapped two types of reactions: impressions of personal treatment or social sensitivity shown by the organization (four items) and responsiveness to concerns about the program or outcomes (five items). Sample items include: "I like the way that they treat me when I have to deal with anything regarding the health benefit program," and "When I disagree with something regarding the program, there is an appeal process that is fair."

Job satisfaction. Job satisfaction was measured using a 17-item scale (alpha .90) based on the Job Diagnostic Instrument (Hackman & Oldham, 1979). A sample item: "I feel fairly satisfied with my job."

Employee demographics. Demographic information was collected from the survey, which included questions on race, age, and gender. For purposes of the analysis, dummy codes were created, with men coded as 1 and women coded as 2. Because minorities comprised only five percent of the sample, only white and nonwhite comparisons were made. Whites were coded as 2 and all others were coded as 1.

ANALYSIS AND RESULTS

Means, standard deviations, and correlations for all major variables are summarized in Table

1. Alphas for multi-item scales are reported on the diagonal in parentheses. Table 2 shows results from separate hierarchical regressions with the fairness variables as dependent variables. The wellness assessment was entered in the first block, demographics in the second block, and the employment background variables (joiner or stayer) in the third block. Two additional hierarchical regressions were run, with job satisfaction and absenteeism as the dependent variables, that entered wellness in the first block, demographics in the second block, employment variables in the third block, and the three fairness variables in the fourth block to examine the relationship between perceptions of fairness and job satisfaction and absenteeism (see Table 2).

The means show that respondents as a group were neutral about whether the wellness program was fair, with a mean of about 3.3 on a five-point scale. The mean for the distributive justice scale was about the same: Employees neither agreed nor disagreed that the outcomes of the system were fair. The mean for the procedural justice scale was lower, 2.0, indicating that people did not entirely agree that the system was procedurally fair. Gender, race, and age were not significantly correlated with fairness perceptions.

TABLE 2

Results of Multiple Regression Analysis

		DEPENDENT VARIABLES														
		Fairness			Distributive Justice			Procedural Justice			Job Satisfaction			Absences		
Step	Independent Variables	Change R ²	in R ²	B	Change R ²	in R ²	B	Change R ²	in R ²	B	Change R ²	in R ²	B	Change R ²	in R ²	B
1	Control Wellness/ Healthiness	.12*	.12*	.30*	.07*	.07*	.23*	.01	.01	.09	.00	.00	-.09	.00	.00	.03
2	Employee Characteristics	.13*	.01		.10*	.03		.04*	.03		.05*	.05*		.04	.04*	
	Gender			.05			.04			-.05			.08			.16*
	Race			.05			.05			-.10			.07			.03
	Age			.05			.12*			.06			.15**			-.14
3	Employment Variables	.20*	.06*		.17*	.07*		.06*	.03		.08*	.03*		.08*	.04*	
	When Joined			-.12*			-.17*			-.08			.04			.21*
	Rate of Pay			.27*			.27*			-.16*			.12			-.06
4	Attitudes Toward Plan										.15*	.08*		.09*	.00	
	Fairness												.11			.03
	Dist. Justice												.02			-.06
	Proc. Justice												.22*			.01

N = 242; R² values are reported for each step. Beta values are reported for the final step. *denotes significant at the .05 level

Hypothesis 1 was supported: Employees who were rated as the healthiest in their annual fitness evaluations were significantly more likely to perceive the wellness incentive program as fair in terms of distributive justice and as a new employment deal (see Table 2).

After assessing healthiness but before testing the other hypotheses, we felt it was important to examine the influence of demographic background variables of gender, age, and race. While we had no strong a priori hypotheses, we believed analyses should consider demographic variables of age, gender, and race before further examination of fairness perceptions and links to job satisfaction and absences. As discussed in our method section, because women and older people tend to perform less well on the physiological measures, the wellness assessment scores were adjusted for these groups to ensure no adverse impact. The gender adjustment was apparently complete, as there is no relationship between gender and wellness scores. There is also no relationship for race. Although older

workers did have significantly more favorable perceptions of distributive justice, these results may actually reflect older workers' likely higher pay, because of higher tenure and the strong linkage between pay and years of service. These pay level linkages are further examined later in the discussion of hypothesis 3. Overall, demographic variables did not explain much of the variance in reactions, even after controlling for healthiness (see Table 2).

Hypothesis 2 was partially supported. Joining employees were younger and healthier. By entering wellness and age into the regression equation first we were able to control for this prior to assessing fairness. Even after controlling for fitness, we found a significant relationship between whether an employee joined before or after the program had been announced and attitudes regarding the perceived fairness of the program and distributive justice, but not procedural justice. Those who joined later were significantly more likely to view the wellness program as fair. This appears to support partially the view that

those who did not undergo a change in employment conditions regarding benefits had more positive attitudes about incentives.

Hypothesis 3 held that rates of pay would be positively related to perceptions of fairness. Looking at the simple correlations reported in Table 1, we find that both procedural and distributive justice perceptions are more favorable as pay rates rise. The effect is stronger for distributive justice. In Table 2, we look at this relationship while controlling for healthiness by entering the wellness assessment score first into a regression equation. Even controlling for outcomes, pay rate is still a significant predictor of reactions to the program, with higher paid workers reporting more favorable views on all three fairness dependent variables.

Hypothesis 4 held that healthier workers would have better work attitudes and positively influence productivity by having lower absenteeism and fewer doctor visits. Looking at the correlations in Table 1 and the regressions in Table 2, we find no significant relationships between employee wellness levels and absences, and the number of doctor visits. Interestingly, however, the number of doctor visits is significantly related to days absent, so presumably at least some of these absences are related to illness and doctor visits.

Hypothesis 5 held that workers who thought the wellness policy was less fair would have lower job satisfaction and higher absenteeism. Even after taking into account other variables such as healthiness demographics, rate of pay, and when hired, employees who thought the program was less fair procedurally had significantly lower job satisfaction, but not necessarily lower absenteeism.

DISCUSSION

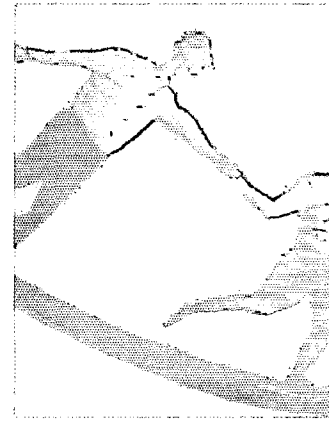
Managing Incentives as an Organizational Change Process

Overall, employee groups significantly differed in their responses to incentives rewarding general fitness by offering deductions or increases in co-payments, and flexible benefit coupons. Employees who were healthier, higher paid, and those who had joined the company after the program had been introduced were more likely to think incentives were fair, distributively just, and, to a lesser extent, procedurally just. Lower level, less fit employees, and those who had been with the firm prior to incentives not only

perceived them as less fair, but also were more likely to have lower job satisfaction, reflecting the potential unintended downside of incentives.

This study suggests organizations should manage the introduction of wellness incentive programs as a collaborative organizational change process. Research is needed on the design and implementation of HR and employee interventions to manage honestly these expectations such as employee involvement in policy development, active communication, opportunities for real voice, and organization-wide gain-sharing for medical savings. Studies are needed on the most effective changes to benefits and wellness policies, and how to create acceptance of these changes, as the continuing trend of skyrocketing benefit costs could hurt U.S. competitiveness in the long run. Research is needed on how to design and implement policies where employers and employees view themselves as joint stakeholders who share common interests in improving the value and efficiency of health care benefit utilization. This is unlikely to occur unless employers take action to address not only the demand for medical services, but also the supply side by encouraging insurers, doctors, and the government to share a stake as well. Without such collaboration across stakeholder groups, some employees are likely to view wellness incentive programs as unfair, no matter how carefully implemented.

Although the idea of incentives to contain health care costs may seem rational to employers, our results show they may not be so easy to implement. Employees and employers may differ in interests and responses to wellness incentives. Goals and principles that may seem noncontroversial from the employer perspective, such as employees should be rewarded for lowered use of medical services and held accountable for their health costs, may be viewed negatively by some individuals who may believe their health care needs are not being met or that employers have unilaterally changed the terms of employment. Wellness incentives should be designed as far more than a labor cost reduction initiative. The unintended consequences of these programs suggest that viewing and implementing them as a joint organizational change initiative where the concerns of employee groups and those of the employer are considered and reframed as a win-win issue (i.e., reducing health care costs saves jobs and improves lives) may be more fruitful.



Psychological Contract of Employee Benefits

This study adds to the literature on HR innovation by assessing the fairness of a change to the psychological contract regarding receipt of employee benefits. To date, the distributive and procedural justice literature and the psychological contract literature have not been that strongly integrated. By examining both concepts in this study, we add to integration between organizational behavior and human resource management perspectives. Organizational justice researchers argue that no single absolute standard for deciding fairness exists in any given situation. (Shepard, Lewicki & Minton, 1993). The context in which the HR decision occurs must be examined. Wellness incentives are being introduced at a time of fundamental change in the employment relationship, with a movement away from job security, established pay raises and promotions, and life-long careers. By shifting the health care focus from sickness to wellness, employers are symbolically attempting to wean employees away from the entitlement mentality (Haltom, 1995). Though employers may say that such actions will strengthen the new employment relationship partnership in support of overall business goals and profitability (cf. Haltom, 1995), some employees may be distrustful that this change largely serves the employers' interests at their expense. Indeed, a recent survey of over 400 employers found that cost is the prevailing concern of employers when selecting health benefits and fewer than half monitor performance standards (i.e., benefits wellness effectiveness) (Bulletin to Management, 1999).

Policy Considerations

Surprisingly, healthier workers did not necessarily have significantly fewer doctor visits than those following less healthy lifestyles. Regarding the lack of significant differences in doctor visits based on healthiness, future research should assess the reasons and severity of the doctor visits. It may be that healthy employees go to the doctor for preventative or less severe purposes, while the less healthy go when they are reacting to an illness. The issue of doctor visits has been addressed in an innovative intervention called The Birmingham Project where escalating health care costs led to a joint community intervention among employers in Birmingham, Alabama. Contrary to what most

EXHIBIT I

Wellness Incentive Programs: Policy Tips for Employers

- Have management define how a fitness culture supports workplace productivity and worker well-being on and off the job. Do not take a cost-reduction-only focus.
- Take a long-term payback perspective.
- Partner with community and other employers: Engage in Community-Based Fitness Promotion where the medical system, local regulations such as no smoking laws, environmental changes, and educating employees to promote health are linked.
- Communicate rationale about why and how the health incentives are implemented and allow for employee input and voice on procedural design.
- No employees can be excluded from coverage or charged more for benefits based on health status (see U.S. federal government HIPAA guidelines: Health Insurance Portability and Accountability Act).
- Train and reward supervisors who support fitness behaviors (e.g., allowing breaks for exercise, making workplace less stressful).
- Integrate disability programs with wellness incentives.
- Measure not only cost reductions but other positive outcomes such as number of exercise hours, number of smokers who quit, participation in local sports activities.
- Negotiate discounts to fitness clubs.
- Offer healthy meals for lunch and take-home dinners.
- Develop targeted wellness interventions to at-risk groups that are voluntary.
- Support electronic house calls and nurselines where employees can get low-cost preventative help over the phone or by e-mail. After this preventative contact, encourage doctor visits to catch serious health care problems early.
- Work to make a more effective health care delivery system; do not only focus on benefits consumption.
- Use carrot-but-not-stick approaches (e.g., rewarding employees who don't smoke or use tobacco is legal; penalizing smokers is not).
- Obesity may be considered a disability under ADA and should not be penalized.
- Give special assistance to low-income and other employee groups with specific needs to avoid making incentives regressive in impact.
- Legal Wellness Promotion Criteria may include the following voluntary employee behaviors they can control, as long as other employees without these behaviors are not charged more for benefits:
 - Completing a fitness assessment each year
 - Agreeing to wear seatbelts
 - Checking blood pressure
 - Earning Exercise Points
 - Not using sick time (excluding taking care of a sick child, spouse, or parent)

employers practice – the discouragement of benefits utilization as in this study – regular medical office visits were actually encouraged as an early prevention (Pelletier, 1993), and part of a long-term approach to cost reduction as opposed to a short-term one. Exhibit 1 summarizes other suggested policy considerations for employers suggested by this research.

Note that after controlling for healthiness, and demographic and employment background, employees who thought the program was procedurally just were more likely to have higher job satisfaction. These findings suggest the importance of communicating rationale about how the health incentives are implemented and allowing for employee input on procedural design.

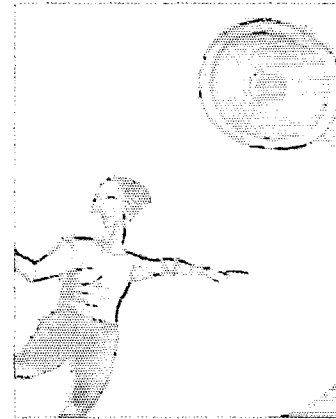
Employers risk hurting their workplace climates if wellness incentive policies are not viewed as just. For example, previous research shows that procedural justice perceptions are significantly related to trust in supervisors and organizational commitment (Folger & Konovsky, 1989). Although little published research has been conducted on the relation of justice perceptions to changes in health benefits, general justice research on fairness in HRM shows it is important that employees perceive they have a real voice in and opportunity to influence HR policies (Miceli, 1993). Our results show that it is critical that employers introducing these programs strive to develop and publicize implementation procedures that all employee groups understand and view as fair, in order to avoid the social creation of “winners” and “losers.” Employees already following a healthy lifestyle, for example, might find it easier to maintain or improve their fitness condition than workers following a less healthy lifestyle who would likely have to make major, often difficult to achieve, life changes (e.g., lose weight, improve fitness, stop drinking, manage stress better).

The fact that existing employees with previous experience with traditional benefit plans viewed the policy less favorably than those who had joined the organization since the policy was introduced shows the importance of managing changes in benefits as a change to the psychological contract (Rousseau, 1996). Any change to benefits policy that alters their receipt from being an entitlement for all workers has the potential to be viewed negatively by existing employees and as “employer take-aways.” Employers should take note of this study’s suggestion that employees

are likely to view new medical benefits incentives as a fundamental change to the employment relationship and a possible cultural violation of company fairness to workers.

Our results on the relationship between employee outcomes and fairness perceptions were consistent with those from other justice studies (e.g., Folger & Konovsky, 1989), which generally find that evaluations of perceptions of distributive justice are more closely related to actual employee outcomes than procedural justice. An employer may need to provide additional support to employees’ families in managing the change process. Wellness incentive programs are an example of the growing trend toward greater adoption of voluntary individual psychologically oriented HR policies to manage work and home life. For such programs to be successful, the social contexts in which they are used on and off the job are important influences. Employers need to create health benefit systems that enable as large a proportion as possible of the workforce to succeed in health improvement. Encouraging lunchtime workouts, walking and biking to work where possible, and the purchase of family memberships at health clubs are just some of the possible supportive actions employers can take. Certainly making efforts to reduce workplace and family stress, fear of job loss, overly high workloads, and ensuring a truly safe work and family environment are also critical (and perhaps largely generally unattended to). In the short run, these actions will improve job satisfaction, but may cost more. In the long run, however, significant cost savings can be garnered, as The Birmingham Project found (Pelletier, 1993).

It is also suggested that wellness programs should not be designed as regressive in impact. Considerations need to be made to support the lower paid. Although all employees in the study were subject to the same rewards for wellness, the deductions on benefits for fitness had more of a regressive impact on the take-home pay of the lowest paid workers. Our findings of an inverse relationship between level and acceptance of innovative HR policies are consistent with earlier work. In a study of employee acceptance of eight work innovations, including reactions to flexible benefits and a fitness center, Kossek (1989) found that higher level employees (correlated strongly with pay) had more positive attitudes toward all innovative HR policies, regardless of actual use. Such policies served to



symbolize the progressiveness of management, and higher status employees are more likely to identify with management's interests.

Using the Carrot or the Stick: HIPAA on Incentives Versus Disincentives

Recent nondiscrimination guidelines issued in April 1997 under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) imply that rewards for healthiness are acceptable, but penalties are not. Many companies continue to find ways to ensure that those who engage in unhealthy behaviors, such as smoking, contribute more for their health care by offering discounts to healthier employees (Brotherton, 1998). It may be years before more definitive guidelines on the links between HIPAA and wellness incentive programs are developed, and the courts have not fully tested HIPAA's nondiscrimination clauses. One expert suggests that employers make sure that everyone is able to achieve the criteria for an incentive (Brotherton, 1998). For example, employers should make sure that a medical problem would not prevent an employee from meeting certain criteria. In order to prevent legal liability, employers are advised to separate the wellness incentive program from the health plan.

Employers Need to Take a Long-Term View & Target Wellness Interventions

Our findings do not seem to indicate that efforts to increase the overall wellness level of employees can be expected to lead to significant short-term benefits for employers, but this cannot be taken as conclusive proof that "wellness doesn't work." The long-term impact may be more positive. The vast majority of literature on employee health management programs is theoretical or limited totally to self-reported data and no control groups (Wolfe, Parker & Napier, 1994). By having some empirical data on absences and doctor visits, this study is an improvement, but future work should also have a control group.

An implication of our study is that targeted wellness plans may be more effective than those that focus on overall employee health for the general workforce. Analysis of adverse selection

of benefits suggests that a small fraction (five percent) of employees consume 80 percent of the health benefits (Gardner, Gardner & Butler, 1999). Given this relationship, a stronger case can be made for management strategies that focus health protection and productivity enhancement on high-risk workers and targeted populations. Instead of the prevailing employer approach to benefits management, which follows the biomedical or insurance model aimed at reducing demand for all services and adverse selection of policy use, researchers argue that benefits management and wellness programs can be improved by applying the "integrated worker specific model" where attention is specifically offered to those most at risk for an illness such as heart disease (Gardner et al., 1999). Care must be taken to offer voluntary help and education in a nondiscriminatory way – with no impact on employment status.

Impressive results have been reported for these wellness programs that target specific at-risk groups and provide them with additional support and information. Some employers have reduced health care expenditures by providing hotlines and other information regarding health and health care, and by offering disease management programs for individuals with chronic problems like diabetes, high blood pressure, and hypertension (Haltom, 1995; Germignani, 1996). Providing prenatal information and support, particularly in high-risk pregnancies, is also effective in cutting health care costs (McShulskis, 1997b).

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Biographical Sketches

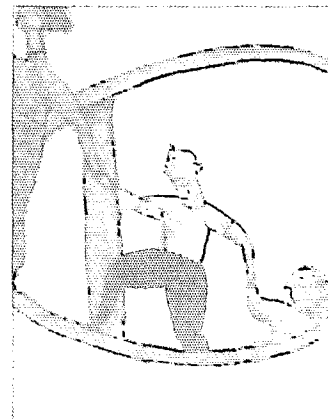
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