The Wellness Program Myth

Why Employers Must Move Beyond Current Approaches to Realize the Goal of Improved Health and Lower Costs

Summer 2013

ABSTRACT/SUMMARY

- Employers are spending billions on wellness each year to reverse the trend of poor employee health and rising healthcare costs.
- The corporate wellness industry has exploded over the past decade to meet growing employer demand for these services.
- There is little evidence to suggest that wellness as it is currently implemented is delivering on the promise of better health and lower costs. Chronic conditions have been on the rise for more than a decade and are projected to continue to increase.
- While current programs are underperforming, at best, there is promise in new approaches to wellness that include better population segmenting, more targeted interventions and a greater focus on penalties rather than incentives.

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Christian speaks frequently to professional organizations about managing healthcare costs with both insurance plan designs and wellness programs. He has been featured several times in the *Dallas Business Journal* for his innovative plan designs and wellness solutions.

INTRODUCTION

Wellness is a nearly $2 billion industry in the United States, and is projected to grow at a rate of almost 10 percent per year over the next five years. There are approximately 7,500 providers of corporate wellness services in the United States today.[1]

The growth in the industry in the last decade—and its projected growth in the years to come–can mainly be attributed to years of double digit healthcare premium increases. Employers looking to stem the tide of future cost increases correctly focused on areas where they stood to gain the most—preventing or reducing chronic disease. The theory was sound: Since the majority of healthcare costs can be attributed to conditions that are largely linked to people's lifestyle choices, providing employees with the information to understand and modify their risks would improve both health and the bottom line.

When looking at the state of our nation's health today, it's clear that this theory has not become a reality for most American employers. While companies often tout gains from their programs like fewer sick days or increased productivity, the decline of the nation's health on an aggregate basis and continued rise in premiums indicate that current wellness strategies are not producing the kind of sweeping change that was promised. In fact, in the same timeframe that corporate wellness has exploded as an industry, and employers have invested more money in their employees' health in the form of higher premiums plus wellness offerings, there have been sharp increases in chronic diseases nationwide.

According to the Centers for Disease Control and Prevention, chronic diseases like diabetes and heart disease are responsible for seven out of 10 deaths and more than 75 percent of healthcare expenditures in the United States today. Four common, modifiable behaviors—tobacco use, insufficient physical activity, poor eating habits, and excessive alcohol use—are responsible for much of the illness, disability, and premature death related to chronic diseases.[2] A 2008 Society of Human Resource Management (SHRM) study revealed that typical wellness programs offered today provide information to address three out of four of these behaviors (physical activity, nutrition and smoking cessation) in some capacity.[3] Yet despite employers' growing investment in these programs, chronic diseases are on the rise.

> “Wellness is a nearly $2 billion industry in the United States.”

This apparent disconnect between greater investment in corporate wellness and a simultaneous increase in chronic diseases (and thus healthcare costs) begs a pragmatic and objective look at current wellness offerings. As health reform mandates take effect in the coming years, most employers are anticipating an additional rise in costs, which means that now—more than ever—every single dollar invested in wellness must have a demonstrable return.

The Wellness Evolution: How Did We Get Here?

Corporate wellness is not a new concept. In the 80s employers began building on-site fitness centers or giving employees discounted gym memberships because there was a general agreement that more exercise would equal healthier and more productive employees.

Next came disease management vendors, who promised health improvements by combing through insurance claims and identifying conditions for which employees might need help complying with treatments. These vendors reached out to employees via telephone to discuss conditions and offer coaching.

In the 90s these programs evolved to include on-site wellness fairs and screenings alongside disease management programs and coaching, but typically failed to get employees connected to the healthcare provider.

Today, large U.S. employers (1,000+) spend an average of $169 per employee, per year on wellness programming plus an average of $400 per year on incentives.[4] Employers generally offer the same program to their entire employee population, participation is voluntary, and employees pick and choose which activities are of interest to them.

Typical program components include:

- Health Risk Assessments
- On-site biometric screening events
- Flu shot clinics
- Weight management tools
- Tobacco cessation tools
- Literature on specific health conditions, nutrition and physical activity

Wellness Program and Incentive Spending 2009-2011			
Year	Average Incentive	Average Program Cost	Total Cost Per Employee
2009	$260	$108	$368
2010	$430	$154	$584
2011	$460	$169	$629

Source: Fidelity Investments and the National Business Group on Health Joint Survey, October 2009.

Despite decades of commitment to greater employee knowledge about wellness, employers have seen premium increases hover around the 10 percent mark, their programs have gotten more expensive and the incentives they offer are getting more and more lucrative.

Surprisingly, in spite of this greater investment, there has not been an increased focus on actually quantifying program success in terms of financial and/or health outcomes. More than 65 percent of large employers say they don't set any measurable goals for their programs.[5]

Wellness vendors, on the other hand, commonly cite various return on investment (ROI) calculations as indicators of success for their programs. These formulas generally rely on things like fewer sick days and/or soft dollar concepts like presenteeism, which are difficult to quantify. ROI formulas are typically a return against the cost of the wellness program itself, and not examined in the context of the greater healthcare spend. It is common for three to one measures to be displayed for programs costing upwards of $100 per year. This can be misleading because these formulas don't factor in the average healthcare cost of approximately $10,000 per employee, per year, which by all indications will continue to increase.[6] Given the dramatic rise of chronic conditions that can be directly attributed to lifestyle choices, current approaches to both wellness and ROI calculation will require a much closer look from employers.

The Nation's Declining Health: What's Causing the Chronic Disease Epidemic?

While there are many contributing factors to the rise in chronic conditions over the last few decades, a look at the changing work environment offers tremendous insight into the decline of employee health, specifically.

From 1960 to 2010 the steady rise in sedentary or light activity occupations made regular physical activity a scarce proposition for most Americans. A seemingly small change in caloric burn (120-140 per day), has led to an average weight gain of several pounds per year, per person.[7] Beyond the type of work Americans are doing the question of how much work is also important. Today Americans work an average of 47 hours per week—164 more hours per year than 20 years ago.[8]

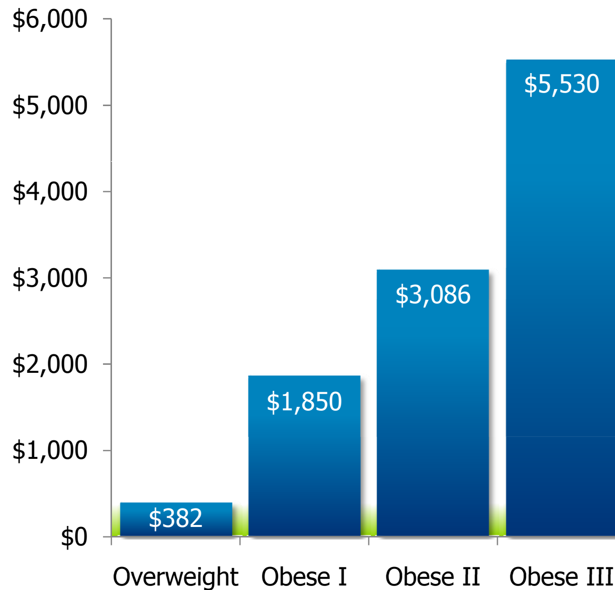
This phenomenon helps explain—in part—the dramatic rise in two of the major causes of poor health and increased healthcare costs in the United States today: obesity and its close counterpart, Type II diabetes.

About 74 percent of the adult U.S. population age 20 years and older is either overweight or obese.[9] The medical costs associated with obesity are estimated at $168.4 billion, or 16.5 percent of national spending on medical care.[10] Overweight and obesity increase healthcare costs incrementally, up to $5,530 more per year for an extremely obese person.

Obesity affects a person's total health and has implications for every part of the body. Please see chart to the right, *Incremental Yearly Medical Costs of Excess Weight*. Heart disease, some cancers, liver disease, gynecologic problems, poor lung function and more are linked to obesity. Type II diabetes is the most costly of these related conditions in terms of actual healthcare spend and long-term complications. Today, eight percent of the population is diabetic and another 35 percent is considered pre-diabetic.[11]

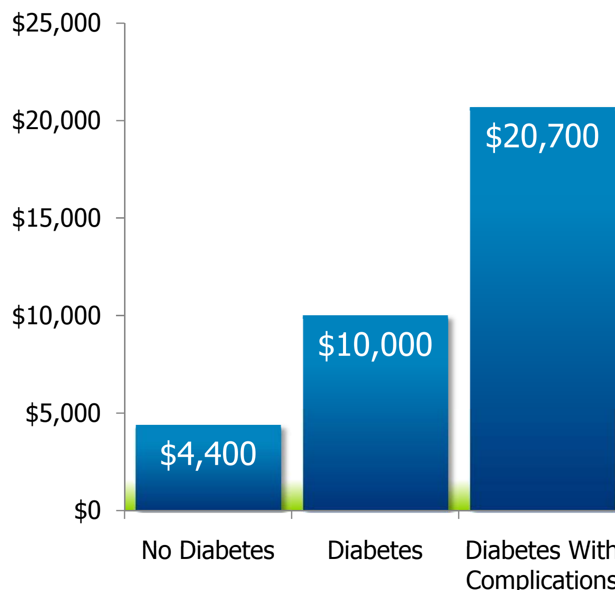
Beyond the physical impact to a diabetic in terms of quality of life and long-term health, the financial impact of diabetes on the healthcare system cannot be overstated. A person who is a diagnosed diabetic and is controlling the condition with medication and lifestyle has *five times* the healthcare costs of the average person. A diabetic with complications costs the system *ten times* as much as the average person. Please see chart to the right, *Cost of Diabetes*.

INCREMENTAL YEARLY MEDICAL COSTS OF EXCESS WEIGHT



Source: Moriarty et al., JOEM Vol 54 (3), March 2012.

COST OF DIABETES



Source: United Healthcare Report: The United States of Diabetes: Challenges and Opportunities in the Decade Ahead, Nov. 2010.

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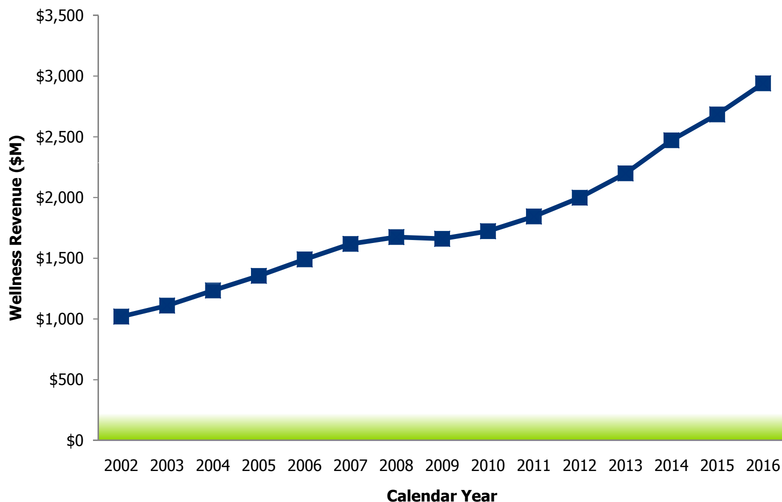
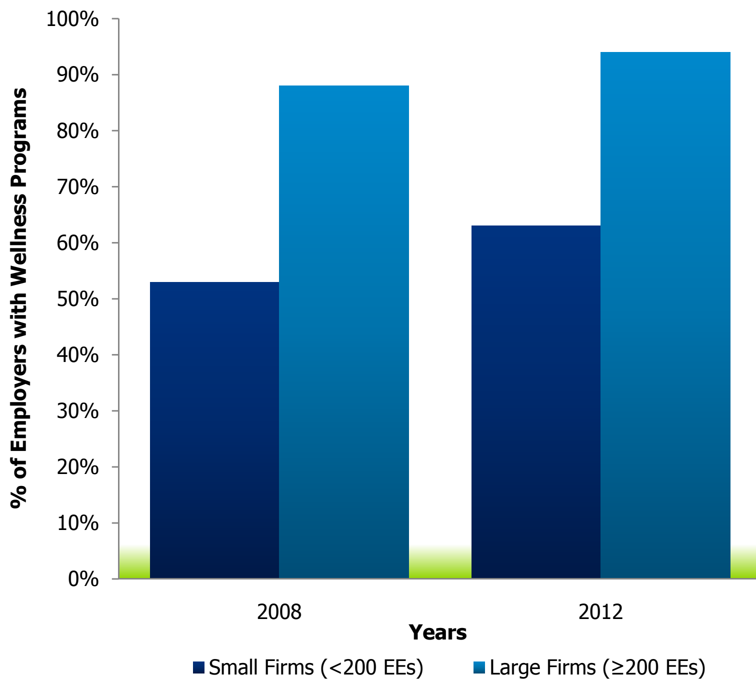
CORPORATE WELLNESS REVENUE GROWTH



Source: IBIS World Industry Report OD4621: Corporate Wellness Services in the U.S., December 2011.

PERCENT OF EMPLOYERS OFFERING WELLNESS PROGRAMS



Source: Moriarty et al., JOEM Vol 54 (3), March 2012.

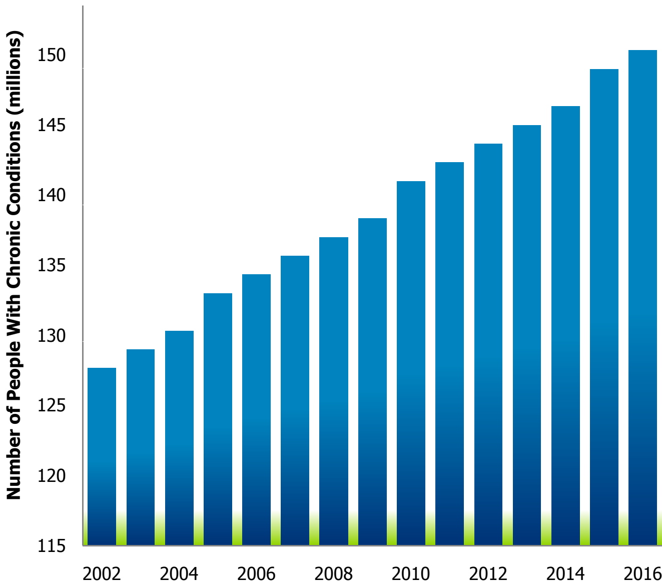
> "In 2016, corporate spend on wellness programs is projected to increase by 70 percent over the 2011 levels."

When the rise of diabetes and chronic conditions over the last decade is compared to the growth of the wellness industry, the results are startling. Despite a greater investment in wellness and a substantial increase in employers who offer such programs, both chronic conditions and diabetes increased dramatically, and are projected to continue rising in the years ahead. Not surprisingly, healthcare costs also continued to rise over the same period. Please see chart to the left, *Corporate Wellness Revenue Growth.*

By looking at the information to the left in the top chart, the key takeaway is that in 2016 corporate spend on wellness programs is projected to increase by 70 percent over the 2011 levels.

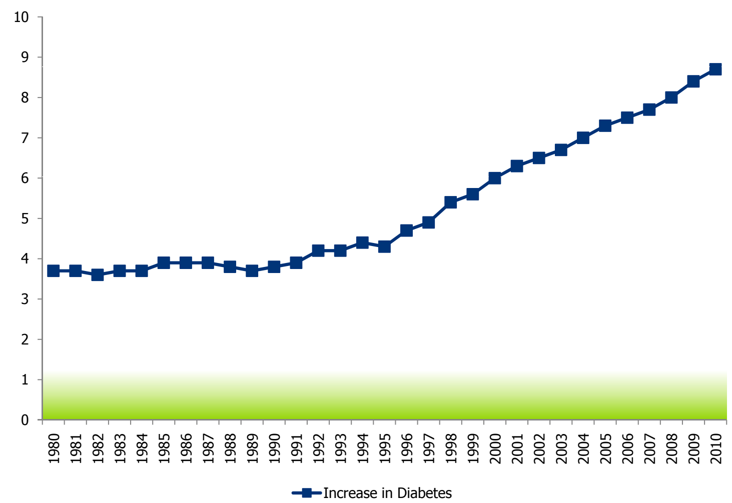
Currently large firms represent 68 percent of employees with health coverage and small firms represent 32 percent. Based on this distribution, in 2008 77 percent of employees had access to a wellness program. In 2012, access increased to 84 percent of all employees with health coverage. Please see chart to the left, *Percent of Employers Offering Wellness Programs.*

PEOPLE WITH CHRONIC CONDITIONS



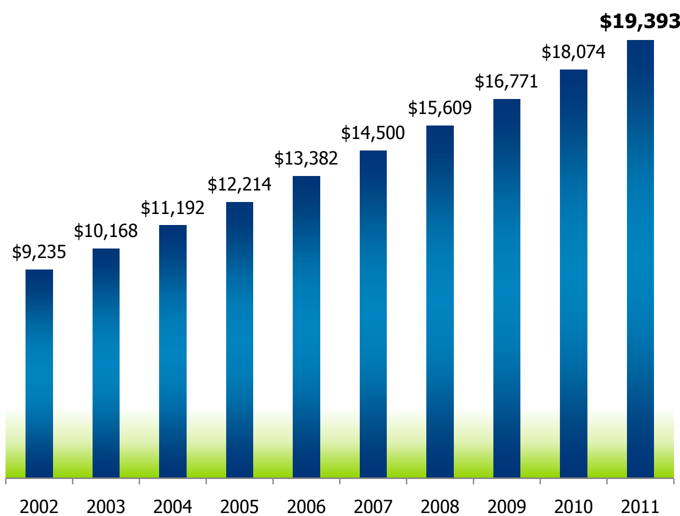
Source: Moriarty et al., JOEM Vol 54 (3), March 2012.

PREVALENCE OF DIABETES



Source: United Healthcare Report: The United States of Diabetes: Challenges and Opportunities in the Decade Ahead, Nov. 2010.

HEALTHCARE COSTS FOR AMERICAN FAMILIES DOUBLE IN LESS THAN NINE YEARS



Source: Milliman Research Report. May 2011.

Chronic conditions continue to rise at a steady rate each year, as seen in the chart to the left, *People With Chronic Conditions.*

The prevalence of diabetes has grown by 135 percent since 1980, as seen in the chart above, *Prevalance of Diabetes.*

This past decade of declining health coinciding with dramatic growth in the wellness industry reveals a flaw in how wellness programs are currently implemented. Driven by the need to keep costs down, and be relevant to all employees, current wellness models are targeted toward the middle of the bell curve. These programs use a shotgun approach to touch as many people as possible with information about risk factors, rather than a rifle approach to single out the most costly employees and ensure they make actual health improvements.

> Wellness programs typically focus on employees only and don't target spouses.

Additionally, wellness programs typically focus on employees only and don't target spouses. According to Lockton's Infolock® data, a spouse's annual cost is $5,600 per member, per year compared to $4,199 for an employee on a per member per year basis. Considering this differential, as seen on the chart on the previous page, *Healthcare Costs for American Families Double in Less Than Nine Years*, it is more important than ever to include spouses in the wellness program.

Given rising medical premiums, growing diagnoses of chronic conditions, the disproportionate cost impacts of obesity and Type II diabetes, and the lack of focus on spouses in wellness programming, it has become clear that a different approach is in order.

The Way Forward: How Do We Improve Program Design?

If employers in the post health reform era are to continue shouldering the primary financial burden of providing health insurance coverage, then wellness programs must be redesigned to accomplish the intended goal of better risk and cost management.

To be effective, future wellness programs will require a dramatic shift in who is targeted, what type of programming is provided, and how success is measured.

While there will always be companies for whom wellness is simply a culture-improving endeavor and one of many employee benefits, those employers who continue to look to wellness as a long term cost/risk management strategy should focus on four new strategies:

1. Identify high-risk employees
2. Utilize more targeted, high-touch, behavioral skill building programs rather than knowledge-based programs
3. Consider implementing penalties instead of incentives to keep employees accountable
4. Measure program success/ROI based on Total Net Value

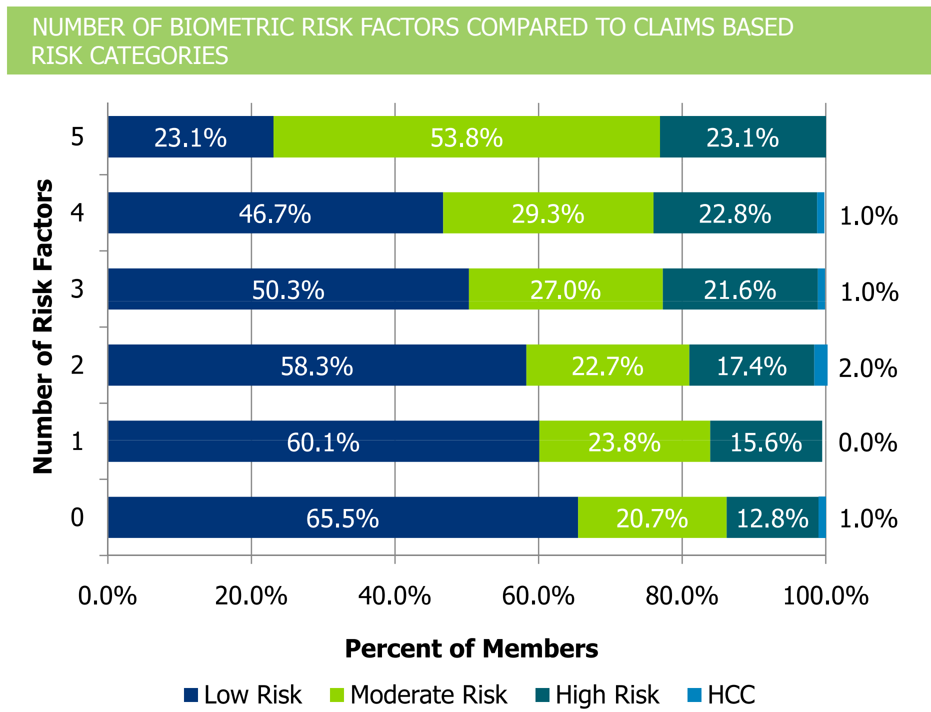
Identify High-Risk Employees

Broad approaches to wellness programming that aim to reach every employee are clearly not working, as shown by the nation's declining health. But designing an individual program for every employee would clearly be too costly and difficult to implement. A compromise is to better segment the employee population into risk profile groups. Programming can then be created to address the different categories of risk within that population.

A first step toward better targeting is to examine both claims data and biometric screening data to understand and identify health concerns within that population. By incorporating biometric screening data into traditional claims analysis, employers will have a better picture of future health risks. Claims data alone reveals what risks or conditions employees *already have*, assuming these employees have actually visited a physician and received a diagnosis. Biometric screenings reveal conditions employees may develop, which might be avoided with early intervention. As an example, it is estimated that one in four people with diabetes are NOT aware they have the condition.[12] See example below, in blue.

Even more powerful than examining the data in any given year is studying this data in the same employee population (cohort) year over year to see how risks are tracking over the long term. The following chart presents a sample analysis of an employee population that segments employees from low risk to high risk by comparing both claims and biometric screening data.

NUMBER OF BIOMETRIC RISK FACTORS COMPARED TO CLAIMS BASED RISK CATEGORIES



Source: InfoLock® data sample

For example, a middle-aged employee that has not visited a doctor in years but whose screening at work identifies high blood pressure, high cholesterol, elevated glucose and out-of-range body mass index (BMI) is potentially a diabetes case or heart attack in three to five years. With no claims data to analyze, only a biometric screening could help an employer "predict" this future expense and help the employee when improvements are still possible.

Utilize More Targeted, High-Touch, Behavioral Skill Building Programs Rather Than Knowledge-Based Programs

Traditional wellness programs have focused on delivering information with the idea that this information will suddenly spark a change in behavior. The target behavior may be smoking, diet quality or physical activity, to name a few.

However, current health trends indicate that providing information has little effect on an individual's behavior. In order to impact behavior, new skills must be built.

One of the emerging solutions that meets the criteria of "targeted and high touch" is the behavioral skill-building program. While this type of coaching may sound similar to failed coaching programs of old, these new programs differ in a few key areas:

- Ph.D. behavioral psychologists manage staff and supervise delivery.
- Programs are research-based
- Interaction between coach and participant is frequent
- Identifying barriers to success and skill building are both emphasized
- Focus is on the long-term health outcome: six to 12 months rather than six to 12 weeks

True behavior change programs are grounded in theoretical models and focus on building behavioral skills that target an individual's level of readiness for change. These programs are based on the simple premise that making good point of contact decisions when it comes to food or cigarettes is not a function of willpower or even knowledge, but rather employing learned skills that facilitate the desired behavior.

An example of building behavioral skills would be having an eating plan or menu before walking into the lunch buffet at work as opposed to approaching the lunch buffet and trying to employ your willpower. Individuals typically have a specific set of challenges (travel, children, work dinners, etc.) that keep them from wellness goals, and a behavioral skill-building program can be tailored to address these specific challenges. Simply providing literature about components of a healthy meal is not working. Many people already know what they should be eating, the key is actually giving them the skills to consistently make better nutrition choices.

While behavioral programs are ideal when delivered in person, they have also been successful when delivered via phone. Proper training and supervision are key—true behaviorists receive hundreds of hours of training under the supervision of Ph.D. psychologists, as well as frequent continuing education.

In terms of cost, these programs vary greatly depending on the quality of behaviorists and amount of time spent with participants. The highest levels of behavioral support—and therefore the most expensive—are only necessary for individuals with substantial risk factors. A good starting point for pricing of this type of service is $15 to $100 dollars per person, per month—depending on the specifics of the program.

In addition to behavioral programs being grounded in research, these new programs are more likely to succeed in a wellness environment that is more outcomes focused. While high touch programs are more expensive than today's mass scale, information-based programs, the penalty driven/outcomes model of wellness allows for financing of more expensive wellness programs through the savings generated in the short term by penalties. Essentially, those employees who don't participate or don't meet metrics help subsidize other employees who need high-touch help for their risk factors and are willing to put in the effort to utilize the resources made available by their employer.

> "Many people already know what they should be eating, the key is actually giving them the skills to consistently make better nutrition choices."

It's important to note that the new breed of behavioral skill building programs are in the very early stages of employer adaptation and do not have strong metrics in an employer setting. However, several studies of behavioral programs in other environments show clear value enhancements. See Appendix B for case studies on programs that focused on diabetes management and nutrition/weight loss.

Current Information-Based Wellness Programs vs. Behavioral Skill-Building Programs

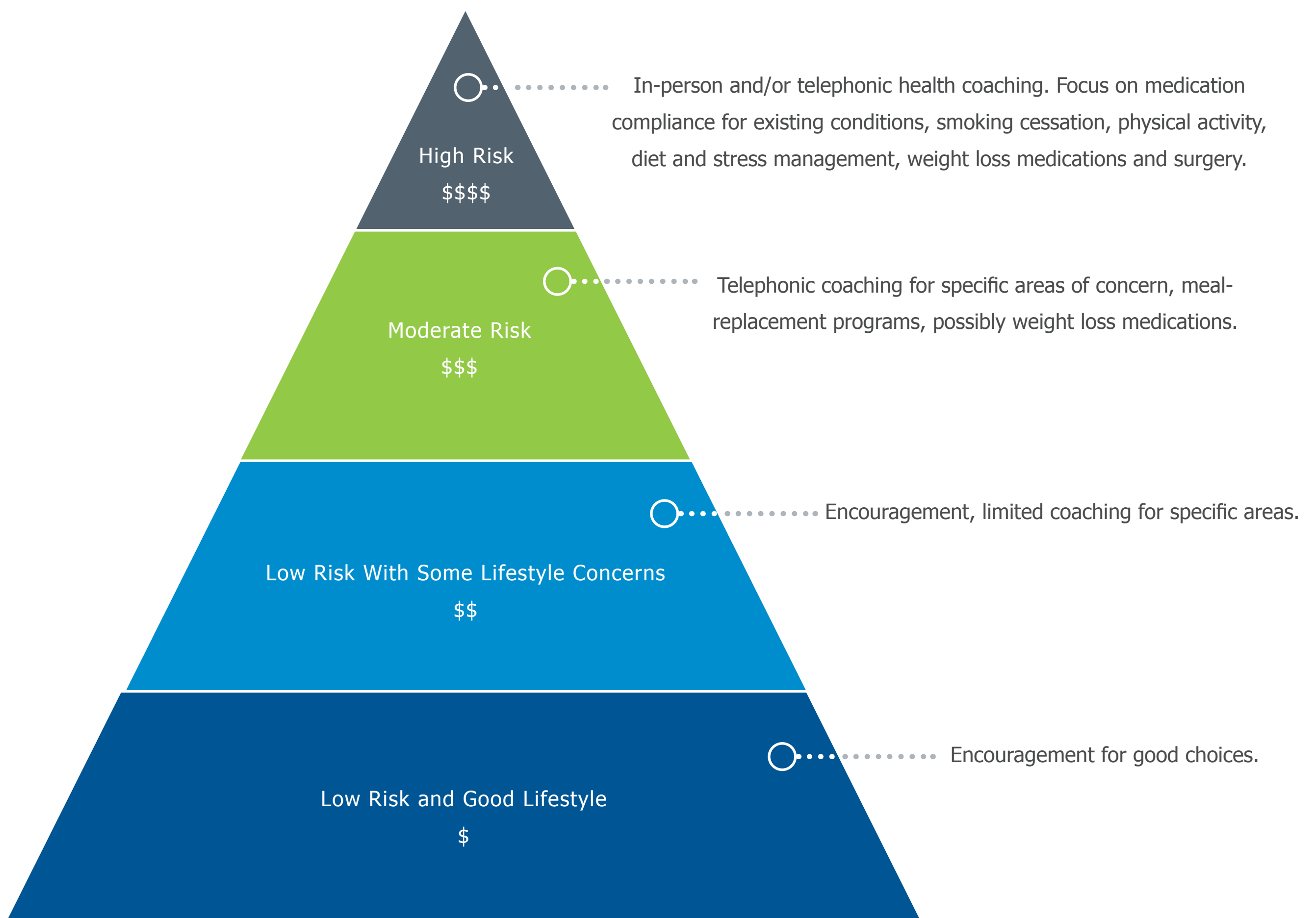
How Do the Two Compare?

	Standard Education	Behavioral Skill-Building Program
Philosophy	Provide facts, figures and education, and people will change behavior.	A process of identifying barriers and building skills to overcome barriers for long term. Accepting that set-backs are normal part of process.
Materials	Education composed primarily of facts. Typically directive and globally focused.	Facts and figures combined with exercises to build specific skills around decision making.
Timing	Often isolated sporadic events: pamphlets, flyers, e-mail blasts.	Series of scheduled lessons usually delivered over the course of months.
Readiness Staging	None	Participants are staged for readiness levels based on their motivation and self-efficacy to produce change.
Tailored discussions based on an individual's specific challenges.	None	Specific to what problems people are having and how their work and home life affects that challenge.

Along with the flawed assumption that information alone will spur behavior change, wellness has historically been approached as though all employees can benefit equally and therefore each employee in a program is given the same resources.

Yet research shows that in a typical employee population, 0.6 percent of the people drive 29 percent of the cost.[13] In the best programs, the highest risk people are singled out for more intense intervention, because these individuals represent greater potential for savings to the plan if their conditions are either managed well or prevented altogether.

Here's a sample illustration of how an employee population could be segmented and targeted based on results from a health risk assessment and/or biometric screening:



Consider Implementing Penalties Over Incentives

As discussed earlier, current wellness models are expensive and becoming more generous with incentives. When added to the cost of program administration, incentive costs may actually turn wellness program ROI negative—defeating any financial reason for putting a program in place.

Paying an increased cost (incentive) for activities has its roots in theories of behavioral economics. Research shows that incentives can drive motivation and behavior.[14] However, the reality of using employer-paid incentives to change human health behavior patterns over the long term has several critical shortcomings. Perhaps the greatest of these is that the incentive curve is highly elastic—what constitutes an incentive for one person is not appealing at all to another.[15] Additionally, a short-term incentive (say, cash) for completing a 20-minute health risk assessment is a much easier "sell" than a long-term incentive like premium reductions for accomplishing substantial weight loss or other risk factor reduction.

What shows more promise but is not nearly as common in wellness programming is a disincentive, or penalty-driven model. Only 19 percent of employers currently take this approach.[16] This type of program generally requires employees to pay a penalty for either non-participation or non-compliance with specific wellness measures, typically in the form of higher healthcare premiums. Penalties were first made possible by the 2006 joint ruling by the Departments of Labor, Treasury and Health and Human Services that allowed employers to offer different premiums (up to a 20 percent differential) to employees based on their health results. The health reform legislation increased the allowed differential to 30 percent starting in 2014.

> "Penalties better attempt to bring into balance the financial scales of benefit to cost for the employer."

Economic theory supports the notion that charging a penalty vs. paying an incentive is more effective in changing behaviors,[17] and there are added benefits from the corporate payer perspective. A penalty model paired with a health outcomes program more effectively

matches the risk posed to the health plan to the specific individual posing that risk. Moreover, penalties better attempt to bring into balance the financial scales of benefit to cost for the employer. As risk has steadily deteriorated over the years employers have borne the lion's share of the costs. We know that the majority of these costs (75 percent by CDC estimates) are lifestyle related. By holding employees more accountable for their willingness to make lifestyle changes, the short and medium term savings generated by charging those who don't meet certain metrics can be "reinvested" back into the wellness program to help those employees who are ready to make health improvements and need the resources to do so.

> "Rewarding a 10-20 percent improvement helps employers avoid penalizing the same high-risk employees over and over again."

It's important to note that a penalty-driven model gives wellness a *dramatically* different look and feel than current models in place today. Most of these programs are "feel good," culture-boosting initiatives that are often viewed as just another component of a robust employee benefits package. Penalty-driven programs, in contrast, are highly outcomes-focused.

A sample penalty model is an employer who implements five key metrics for the company's annual biometric screening, plus measures tobacco usage. These metrics include:

- Blood pressure
- Triglycerides
- Glucose
- HDL cholesterol
- Waist circumference

Employers sometimes express concern over whether it is legal to require employees to meet certain health standards to qualify for incentives (such as premium discounts) or be assessed penalties (higher premiums). Such programs are, in fact, legal if they meet specific criteria.

A program is considered a HIPAA Wellness Program if the associated reward (or penalty) is both:

- Related to a healthcare plan (premium discount or deductible waiver)
- Contingent upon the health plan member satisfying a standard that is related to a health factor

In addition, a program must meet these five requirements to operate within HIPAA nondiscrimination rules:

1. Beginning in 2014, the reward or penalty may not exceed 30 percent of the total cost of the employee's coverage. Federal agencies have proposed a 50 percent threshold for tobacco use. (For additional information on requirements, please contact your Lockton account team for a copy of *Employer's Guide to Wellness Programs*.)
2. The program must be reasonably designed to promote good health.
3. Individuals who cannot attain the plan's desired goal (or should not try) due to a health condition must be given an alternative standard to attain the reward or avoid the penalty.
4. The plan must notify individuals about the availability of alternative standards.
5. Individuals who are eligible for the program must have the opportunity to qualify for the reward (or avoid the penalty) under the program at least once each year.

For a case study of one employer's success with a penalty-driven program, see Appendix A.

Calculate Program Success Using Total Net Value

Wellness programs are sold to employers as one strategy to improve the health of their population and reduce disease. The success measures currently used (ROI, for example) do a poor job measuring the actual performance of the programs against those goals.

ROI does not take into account any healthcare costs—or associated cost increases—in its calculation. ROI is typically calculated as a return against the cost of the wellness program itself—not in the context of a company's overall healthcare spend.

A better picture of program return is Total Net Value (TNV), which looks at the total savings from the program divided by the total medical/pharmacy costs the employer spends annually.

Total Savings From Wellness Program

Total Medical and Pharmacy Costs

Total Net Value to Employer

For example, under the typical method of calculating ROI, an employer with healthcare/pharmacy costs of $40 million and a wellness program that costs $500,000 cites savings of $1.5 million per year (as measured in fewer sick days, for example)—an impressive 300 percent return. But when this same savings is calculated in the context of the total annual healthcare spend of $40 million, the return on the wellness investment is closer to 3.8 percent. This is still a substantial savings, but a much more reasonable calculation of the actual return an employer is getting.

The 3.8 percent TNV is reflective of the true costs and return of the program, and is therefore a more effective barometer for success in a program. While significant, the 3.8 percent TNV does not inflate the financial efficacy of a wellness program the way ROI does. ROI also makes it difficult for employers to weed out the programs that produce little change in employee health because of a myopic focus on a return against wellness dollars, rather than a return against the cost of the entire health and welfare program.

Conclusion

Like so many industries and products in the United States today, corporate wellness is constantly evolving. Years of declining health indicate that these programs have been limited—at best—in terms of both health and cost impact. Employers can't be faulted for this result. For decades the wellness programs available have been very restricted in the ability to compel employees to change behavior. The legal rulings of the last 10 years have paved the way for these programs to become much more outcomes focused, and to better tie employee health measures with a clear financial consequence.

Employers that provide health benefits to employees in the post health reform era are now faced with critical decisions about how to handle risk and how to move forward with wellness, if at all. While no single wellness program has yet proven to be a true panacea against rising costs, economic theory, behavioral studies and clinical evidence all suggest that a more impactful program is one that directly aligns employee costs with employee risk.

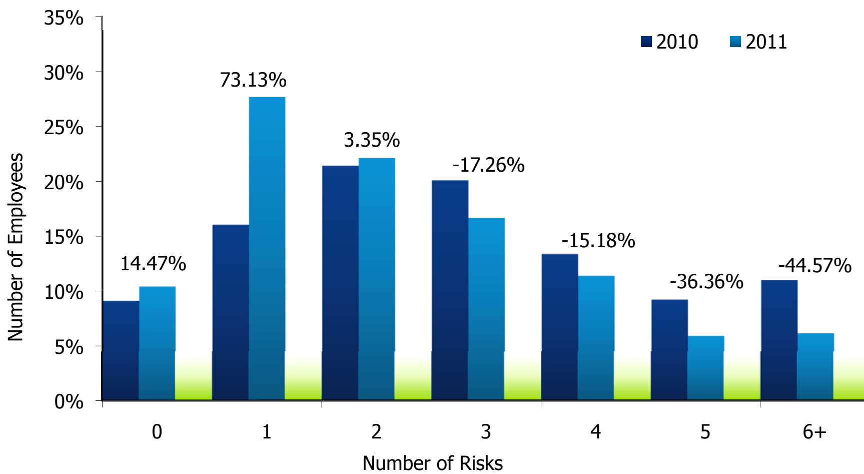
It's time to move corporate wellness forward by pairing new thinking about incentives and penalties with these emerging program designs.

APPENDIX A

Case Study of Disincentive on Outcomes-Based Program:

A 2,500 employee, multi-site hospital group introduced its first employee wellness program in 2010. The program provided a $200 annual employee contribution incentive for participation, and 34 percent of employees participated that year. In 2011, the company offered a larger disincentive ($500) for participation in the current program, and introduced the idea of an outcomes-based/disincentive program that would take effect in 2012. Approximately 50 percent of employees participated that year. In 2012 the company implemented the outcome-based wellness program with a 20 percent disincentive ($1,440 per year). The program measurements included BMI, tobacco use, blood pressure and cholesterol. All of these were valued at $30 per metric met.

2010-11 COHORT POPULATION RISK FACTOR DISTRIBUTION WITH PERCENT CHANGE
68.91% BENEFIT ENROLLED PARTICIPATION



- 68.9 percent of population participated in program
- 60 percent of the population with 3 or more risk factors reduced at least 1 risk
- 39 percent of the population remained constant with 2 or less risk factors
- 17 percent of the population remained unhealthy with 3 or more risk factors
- 8 percent of the population increased risk factors

In terms of dollars received from disincentives, this number increased from more than $500,000 in 2011 to $1.8 million in 2012 on a program that cost $250,000. The company "reinvested" the disincentive dollars received into additional wellness resources for employees. The company planned to continue the momentum behind their program with the introduction of an HSA plan in 2013, followed by full-replacement HSA in 2014, an increase of the disincentive to 30 percent, plus the introduction of spouses to the outcomes/disincentive wellness model.

APPENDIX B

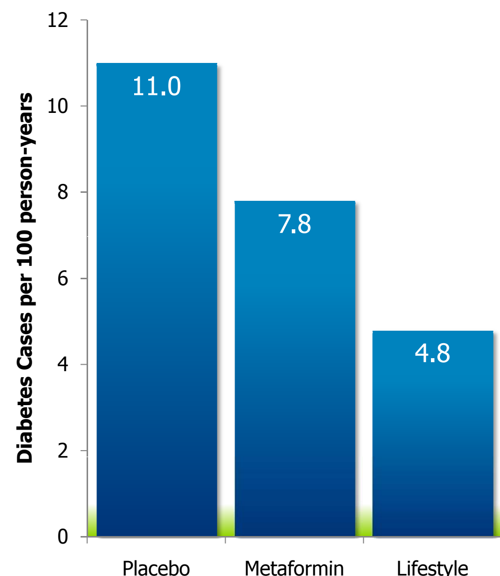
Case Studies of Successful Behavioral Skill-Building Programs

Diabetes Prevention Program

An example of a highly successful behavioral program that was translated into a commercially available product is the Diabetes Prevention Program (DPP).

This 2002 study enrolled individuals at high risk for developing diabetes. These participants were randomly assigned to three groups that received information-only (control), medication (metformin) or behavioral-based dietary changes plus increases in physical activity. After an average of 2.5 years of follow-up, the medication group had a 31 percent reduced risk of developing diabetes compared to

DPP STUDY RESULTS
THIS DOES NOT LOOK GOOD . . .



the control group. The behavioral-based group had a 58 percent reduction in the risk of developing diabetes. This result showed that developing behavioral skills around diet and physical activity not only works and can be more successful than medication, but it can also dramatically reduce developing a negative health outcome (diabetes in this case).

Since the release of these findings the CDC successfully piloted the DPP program in several YMCAs across the United States. Starting in 2012 more than 50 YMCAs across the country have begun to offer the Diabetes Prevention Program, whose costs are covered by some insurance plans.

Weight Watchers Program

This 2011 international study compared overweight/obese patients that received standard care from their physician with patients who were referred to a commercial weight loss counseling program—in this case Weight Watchers. The goal of the study was to determine if commercial weight loss programs are an effective solution for physicians to recommend, particularly given the growing need to deliver weight loss programming on a mass scale.

All 772 participants were recruited from physician practices in the UK, Germany and Australia. The group was randomly assigned to either the control group (physician care only) or a weight loss group that attended weekly Weight Watchers meetings. All participants were older than age 18 and had a BMI of 27-35 plus at least one other risk factor such as Type II diabetes or high blood pressure. Weight loss was measured over a 12-month period.

Results showed that participants who attended weekly weigh-in meetings, received behavioral counseling on nutrition and physical activity and had the support of a peer group, achieved twice the weight loss of the control group that received only standard physician care over the same time period¬: an average of 11 pounds for the Weight Watchers group. These participants also showed greater improvements in insulin and HDL/total cholesterol ratios.

Those in the standard care group lost an average of five pounds after receiving counseling on weight loss from their physicians. These physicians were encouraged to use national weight loss guidelines when consulting with patients, and also directed patients to literature and other information about effective weight loss methods.[15]

In the United States, Weight Watchers holds 20,000 meetings per week. The average cost per participant, per year is approximately $235 for access to online tools and education. The company also offers meetings at employer offices, upon request, and costs for meetings and tools may be covered by the employer, employee or both.[19]

In June 2012 the U.S. Preventive Services Task Force put its “stamp of approval” on these types of community behavioral intervention programs by including them in a list of national recommendations for reducing obesity in America.[20]

Jenny Craig

This U.S.-based study demonstrates behavioral intervention and coaching with the addition of meals provided to participants. It compared traditional weight loss counseling programs, like Weight Watchers, to Jenny Craig, which provides both counseling and meals to its members.

This randomized controlled trial looked at 442 overweight or obese women (body mass index, 25-40) aged 18 to 69 years (mean age, 44 years) conducted at U.S. universities over two years. The program involved in-person, center-based counseling or telephonic, one-to-one weight loss counseling over a two-year period. Behavioral goals were an energy-reduced, nutritionally adequate diet, facilitated by free, prepackaged food items in a planned menu during the initial weight loss phase, as well as increased physical activity. Participants assigned to usual care received two individualized weight loss counseling sessions with a nutrition/dietetic professional and monthly follow up.

The result was that women who received the counseling with prepared meals lost approximately eight percent of their body weight—three times the weight loss of the women who received usual care and only had access to weight loss counseling. The women with access to prepared meals also had greater weight loss maintenance after two years of follow up.[21] Jenny Craig currently offers center-based programs at 725 locations across the United States and internationally.

Resources

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