

## 2011 Employer Health and Wellness Survey

**Instruction Screen:** (for the paper-based version, the following 4 paragraphs will appear in the cover letter)

The RAND Corporation, a not-for-profit policy research institute, is conducting this survey to collect information about the health and wellness program(s) offered to employees, spouses, or dependents located in the U.S. The survey is sponsored by the U.S. Department of Labor and Department of Health and Human Services, and has been approved by the Office of Management and Budget, Washington, DC 20503. (OMB No. #####-#####: approval expires on ##/##/2011)

The information gathered from this survey will be used to support a final report to the U.S. Congress on the effectiveness and impact of wellness programs, as specified in Section 1201 of the 2010 Patient Protection and Affordable Care Act. The report will inform Congress on health and wellness programs currently available among employers, and thus inform policies to improve the health and productivity of the U.S. workforce. Your participation is extremely important to ensure the completeness and accuracy of the survey.

Your information is confidential by law (P.L. 107-347, Title V and 44 U.S.C. § 3501 note). Your name and your company/organization's name will not be identified in any publications, including the final report to Congress. The information reported may be seen only by persons certified to uphold the confidentiality of this information and used only for statistical purposes. The law also prohibits the sharing of your data with other agencies, exempts the information you provide from requests made under the Freedom of Information Act, and ensures that your responses are immune from legal process.

If you have questions about this survey, please do not hesitate to contact [RAND CONTACT INFORMATION].

### Screen 2:

Are you knowledgeable about health and wellness programs provided to your employees, such as health risk assessment, lifestyle management, clinical screenings, and disease management, if offered?

(Check one.)

Yes

No → **If "No",** please forward the survey link to the individual in your organization who is familiar with the health benefits, especially about the programs listed above (if offered). Please also fill in his/her contact information below so that we may contact them directly. Thank you very much!

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

### Screen 3:

#### Instructions:

- 1. Please only include information on your employees and dependents, who are based and eligible for benefits in the United States, in this survey.**
- 2. If your employer is a subsidiary/branch of another organization, please report the data about your subsidiary/branch only and not for the parent organization.**
- 3. If your employer has subsidiaries/branches in US, please report the data only for those employees and dependents for whom your employer makes decisions regarding benefits and wellness programs.**
- 4. If the benefits and wellness programs for your employees vary by location, please report on the most typical offerings, for example those at your largest site or the most common offerings.**

<b>Section A. Wellness Program</b>
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**For all questions in this section, please include ALL wellness programs offered to your employees by either your company/organization directly, by your health plan(s), or by a third party (e.g., union). These programs may be administered by a third party administrator or a program vendor.**

**A1. Does your company/organization offer health insurance benefits to any of your active employees?**

*(Check one.)*

- Yes
- No

**A2. Are any of your active employees currently offered any of the following health and wellness programs, including those offered by your company/organization directly, by your health plan(s), or by a third party (e.g., union)? These programs may be administered by a third party administrator or a program vendor.**

- **Health risk assessment/appraisal** (a questionnaire on medical history, health status, and lifestyle; it is designed to identify the health risks of the person being assessed)
- **Lifestyle or risk factor management** (e.g., health education classes/workshops, fitness program, weight management program, healthy eating program, stress management program, cholesterol management, or smoking cessation program)
- **Clinical screening** (e.g., clinical screenings for high blood pressure, high cholesterol, cancer, and general physical examination)
- **Disease management** (management of chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease)

*(Check one.)*

- Yes
- No → **GO TO QUESTION: I1, PAGE #** (for the paper-based version)

**A3. When did your company/organization start offering its wellness program(s including those offered by your company/organization directly, by your health plan(s), or by a third party (e.g., union)? If different programs started at different times, please fill in the start year for the first program offered.**

*(Write in the year.)*

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 Year Started

**A4. Which of the following individuals are eligible for at least one of the wellness programs offered to your employees?**

*(Check all that apply.)*

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li><input type="checkbox"/> Full-time employees</li><li><input type="checkbox"/> Part-time employees</li><li><input type="checkbox"/> Retirees</li><li><input type="checkbox"/> Spouses of eligible employees</li><li><input type="checkbox"/> Domestic partners of eligible employees</li></ul> | <ul style="list-style-type: none"><li><input type="checkbox"/> Dependents of eligible employees (other than a spouse or domestic partner)</li><li><input type="checkbox"/> Other, please specify:<br/>_____</li></ul> |
|---|---|

**A5. Which of the following are used to encourage participation in at least one of the wellness programs offered to your employees? Please note that incentives may include bonuses or penalties.**

*(Check all that apply.)*

- |  |   |
|--|---|
| <input type="checkbox"/> Electronic or print materials (e.g., poster, newsletters, email, web resources) | <input type="checkbox"/> Monetary incentives (e.g., premium reduction, gym membership discount) |
| <input type="checkbox"/> Health fairs  | <input type="checkbox"/> Wellness program use as performance target for managers                |
| <input type="checkbox"/> New staff orientation   | <input type="checkbox"/> Other 1, please specify: _____   |
| <input type="checkbox"/> Personal outreach (e.g., in-person outreach, phone calls)                       | <input type="checkbox"/> Other 2, please specify: _____   |
| <input type="checkbox"/> Non-monetary incentives (e.g., recognition, awards)                             | <input type="checkbox"/> None of the above  |

**A6. Considering all the wellness programs offered to your employees, what proportion of eligible employees participated in at least one of the wellness programs in the last 12 months? If no data is available for the last 12 months, please use data for the previous program year. Estimates are acceptable.**

$$\text{Participation rate (\%)} = \frac{\text{Number of Program Participants}}{\text{Number of Eligible Employees}} \times 100$$

*(Write in the participation rate.)*

**Overall** participation rate:    %

**A7. Which of the following monetary incentives are offered to your employees to encourage participation in at least one of the wellness programs? Please note that incentives may include bonuses or penalties.**

*(Check all that apply.)*

- Merchandise or gift cards
- Discounted gym or health club membership
- Cash payment or bonus
- Lower employee contribution to health plan premium
- Higher employee contribution to health plan premium if no participation
- Lower cost sharing requirements for services covered by health plan
- Higher cost sharing requirements for services covered by health plan if no participation
- Lower Health Reimbursement Accounts (HRA) or Health Savings Accounts (HSA) contribution if no participation
- Higher HRA or HSA contribution
- Other, specify: \_\_\_\_\_
- None of the above → **GO TO QUESTION: A9, PAGE #** (for the paper-based version)

**A8. Considering all the wellness programs offered to your employees, what is the maximum possible amount of incentives and/or penalties that eligible employees will receive or pay, per full-time employee per year? What is the average amount of incentives and/or penalties among employees who received or paid in the most recent calendar/program year? What proportion of eligible employees received or paid incentives or penalties in the most recent calendar/program year? Please use cash equivalent value; convert non-cash incentives (e.g., gym membership) into cash value if needed. Estimates are acceptable.**

**Maximum** possible amount of **incentive** per full-time employee per year.....\$  ,  .00

**Maximum** possible amount of **penalty** per full-time employee per year.....\$  ,  .00

**Average** amount of **incentive** in the most recent calendar/program year..... \$  ,  .00

**Average** amount of **penalty** in the most recent calendar/program year .....\$  ,  .00

Proportion of eligible employees who received or paid incentives or penalties in the most recent calendar/program year:  %

**A9. Which of the following strategies are being considered by at least one of the wellness programs offered to your employees in the next two years?**

*(Check all that apply.)*

- Start offering monetary incentives for program participation
- Increase monetary incentives for program participation
- Start offering monetary incentives for program completion
- Increase monetary incentives for program completion
- Start offering monetary incentives for achieving changes in health results (e.g., weight loss or smoking cessation)
- Increase monetary incentives for achieving changes in health results (e.g., weight loss or smoking cessation)
- Other, specify: \_\_\_\_\_
- None of the above

## Section B. Health Risk Assessment/Appraisal

**For all questions in this section, please include health risk assessments/appraisals offered to your employees by either your company/organization directly, by your health plan(s), or by a third party (e.g., union). These programs may be administered by a third party administrator or a program vendor.**

**B1. Are any of your active employees currently offered health risk assessment(s)/appraisal(s)? A health risk assessment or appraisal is a questionnaire on medical history, health status, and lifestyle; it is designed to identify the health risks of the person being assessed.**

(Check one.)

- Yes  
 No → **GO TO QUESTION: C1, PAGE #** (for the paper-based version)

**B2. What proportion of eligible employees participated in at least one health risk assessment/appraisal in the last 12 months? If no data are available for the last 12 months, please use data for the previous program year.**

$$\text{Participation rate (\%)} = \frac{\text{Number of Program Participants}}{\text{Number of Eligible Employees}} \times 100$$

(Write in the participation rate.)

Health risk assessment/appraisal participation rate:  %

**B3. Are monetary incentives used to encourage employee participation in health risk assessment(s)/appraisal(s)? Please note that incentives may include bonuses or penalties. For the incentives or penalties associated with achieving certain **health outcomes** that are reported in health risk assessment(s)/appraisal(s), relevant questions will be asked in other sections in this survey.**

(Check one.)

- Yes, participation incentives are offered by one or more health plans  
 Yes, participation incentives are offered by your company/organization only  
 Yes, participation incentives are offered by both health plan(s) and your company/organization  
 Yes, but unsure which entity offers participation incentives  
 No → **GO TO QUESTION: C1, PAGE #** (for the paper-based version)

**B4. What is the maximum amount of the incentive or penalty that eligible employees will receive or pay per full-time eligible employee per year, based on their participation in health risk assessment(s)/appraisal(s)? Please use cash equivalent value; convert non-cash incentives into cash value. Estimates are acceptable.**

**Maximum** amount of **incentive** for health risk assessment/appraisal per full-time employee per year:

\$  ,  .00

**Maximum** amount of **penalty** for health risk assessment/appraisal per full-time employee per year:

\$  ,  .00

## Section C. Lifestyle or Risk Factor Management

For all questions in this section, please include ALL lifestyle or risk factor management programs offered to your employees by either your company/organization directly, by your health plan(s), or by a third party (e.g., union). These programs may be administered by a third party administrator or a program vendor.

**C1. Are any of your active employees currently offered the option to participate in lifestyle or risk factor management programs, such as health education classes/workshops, fitness program, weight management program, healthy eating program, stress management program, cholesterol management program, or smoking cessation program?**

(Check one.)

- Yes  
 No → **GO TO QUESTION: D1, PAGE #** (for the paper-based version)

**C2. Which of the following lifestyle or risk factor management programs are offered to your employees?**  
*Note the difference between weight/obesity management and fitness program; the former focuses on weight loss and is available to overweight/obese individuals; while the latter is for all types of employees to improve physical fitness.*

(Check all that apply.)

- |   |  |
|---|--|
| <input type="checkbox"/> Alcohol and/or drug abuse counseling<br><input type="checkbox"/> Blood sugar management<br><input type="checkbox"/> Cholesterol/lipid management<br><input type="checkbox"/> Fitness program<br><input type="checkbox"/> Healthy eating program<br><input type="checkbox"/> Health education classes | <input type="checkbox"/> Smoking cessation program<br><input type="checkbox"/> Stress management program<br><input type="checkbox"/> Weight/obesity management<br><input type="checkbox"/> Other 1, please specify: _____<br><input type="checkbox"/> Other 2, please specify: _____ |
|---|--|

**C3. What proportion of eligible employees participated in the following lifestyle or risk factor management programs in the last 12 months or the most recent program year?**

$$\text{Participation rate (\%)} = \frac{\text{Number of Program Participants}}{\text{Number of Eligible Employees}} \times 100$$

*Eligible employees are defined as those who qualify for program participation. For example, only current smokers can participate in a smoking cessation program.*

(Fill in the numbers below.)

Life Style or Risk Factor Management	<u>Participation Rate</u>	<u>Not Offered</u>
Fitness program.....	.%	<input type="checkbox"/>
Smoking cessation program.....	.%	<input type="checkbox"/>
Weight/obesity management.....	.%	<input type="checkbox"/>

**C4. Are monetary incentives used in any lifestyle or risk factor management programs, including incentives for program participation or completion? Please note that incentives may include bonuses or penalties. For the incentives or penalties associated with achieving certain **health outcomes** that are reported in health risk assessment(s)/appraisal(s), relevant questions will be asked in other sections in this survey.**

(Check one.)

- Yes, participation/completion incentives are offered by one or more health plans
- Yes, participation/completion incentives are offered by your company/organization only
- Yes, participation/completion incentives are offered by both health plan(s) and your company/organization
- Yes, but unsure which entity offers participation/completion incentives
- No → **GO TO QUESTION: D1, PAGE #** (for the paper-based version)

**C5. Which lifestyle or risk factor management programs use monetary incentives for participation or completion?**

(Check all that apply.)

- Alcohol and/or drug abuse counseling
- Cholesterol/lipid management
- Fitness program
- Healthy eating program
- Health education classes
- Smoking cessation program
- Stress management program
- Weight/obesity management
- Other 1, please specify: \_\_\_\_\_
- Other 2, please specify: \_\_\_\_\_

**C6. What is the maximum possible amount of incentive and/or penalty that eligible employees will receive or pay per full-time eligible employee per year, based on their participation in or completion of a lifestyle or risk factor management program (regardless of whether a specific health standard was met)? What is the average amount of incentives and/or penalties among employees who received or paid in the most recent calendar/program year? Please use cash equivalent value; convert non-cash incentives (e.g., gym membership) into cash value when needed. Estimates are acceptable.**

(Write in the amount for program participation or completion)	Incentive			Penalty		
	Maximum possible	Average amount	Not Offered	Maximum possible	Average amount	Not Offered
Smoking cessation program	\$	\$	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>
Weight/obesity management	\$	\$	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>
Fitness program	\$	\$	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>
Lifestyle or risk factor management* (excluding the program listed above)	\$	\$	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>

\* Including alcohol and/or drug abuse counseling, health education classes/workshops, healthy eating program, stress management program, cholesterol/lipid management.

## Section D. Incentives for Health Results

**For all questions in this section, please include ALL wellness programs offered to your employees by either your company/organization directly or by a third party (e.g., union) that offer incentives. These programs may be administered by a third party administrator or a program vendor.**

**D1. Are any of the monetary incentives associated with achieving specific health standards, such as meeting a weight loss target or stopping nicotine use?**

*(Check all that apply)*

- Yes, the incentive is provided for achieving a specific health standard on a Health Risk Assessment/Appraisal
- Yes, the incentive is provided for achieving a specific health standard as part of a lifestyle or risk factor management program
- Yes, the incentive is provided through a means *other* than a Health Risk Assessment/Appraisal or lifestyle or risk factor management program
- No → **GO TO QUESTION: F1, PAGE #** (for the paper-based version)

**D2. What is the maximum possible amount of incentive and/or penalty that eligible employees will receive or pay per full-time eligible employee per year, based on achieving specific health standards such as meeting a weight loss target? What is the average amount of incentives and/or penalties among employees who received or paid in the most recent calendar/program year? *Please use cash equivalent value; convert non-cash incentives into cash value when needed. Estimates are acceptable.***

<i>(Write in the amount for <u>meeting health standards</u>)</i>	Incentive			Penalty		
	Maximum possible	Average amount	Not Offered	Maximum possible	Average amount	Not Offered
Smoking cessation	\$	\$	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>
Weight/obesity management	\$	\$	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>
Fitness program	\$	\$	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>
Lifestyle or risk factor management* (excluding the program listed above)	\$	\$	<input type="checkbox"/>	\$	\$	<input type="checkbox"/>

\* Including alcohol and/or drug abuse counseling, health education classes/workshops, healthy eating program, stress management program, cholesterol/lipid management.

**D3. Are monetary incentives associated with achieving specific health standards offered by any of your health plans (including self-insured plans)?**

*(Check one.)*

- Yes
- No → **GO TO QUESTION: F1, PAGE #** (for the paper-based version)



**Section E. Incentives for health results offered through a health plan**

In this section, please provide information only for the health plans (including fully-insured and self-insured plans) that offer incentives for achieving health standards (e.g., weight loss or smoking cessation). If you have more than one plan that offers such incentives, please select the one with the largest enrollment among your active employees. We define this plan as MOST ENROLLED HEALTH PLAN thereafter.

**E1. Under your MOST ENROLLED HEALTH PLAN, for which of the following specific health standards can employees receive monetary incentives?**

(Check all that apply.)

- Fitness program – exercise targets
- Smoking cessation
- Weight/obesity management – weight loss

Other 1, please specify: \_\_\_\_\_

Other 2, please specify: \_\_\_\_\_

**E2. Under your MOST ENROLLED HEALTH PLAN, if an individual is not able to satisfy a health standard (e.g., obtaining a certain cholesterol level) due to a medical condition, how does the insurer or plan provide an alternative standard that the individual may meet so that s/he can qualify for the incentives?**

(Check all that apply.)

- Health plan allows a waiver of the health standard *with* a statement from a physician.
- Health plan allows a waiver of the health standard *without* requiring a statement from a physician
- Health plan allows the individual to meet a different standard (such as an individually tailored, improved cholesterol level that a physician determines is appropriate).
- None of the above
- Unsure

**E3. How does the insurer or plan of your MOST ENROLLED HEALTH PLAN disclose to plan members that alternative standards exist when an individual is not able to satisfy a health standard (e.g., obtaining a certain cholesterol level) due to a medical condition?**

(Check all that apply.)

- This disclosure is contained in the summary plan document (SPD)
- This disclosure is contained in a special mailing that goes out to all participants
- This disclosure is posted on the plan website
- Other, please specify: \_\_\_\_\_
- None of the above
- Unsure

**E4. Under your MOST ENROLLED HEALTH PLAN, what is the maximum annual incentive or penalty linked to specific health results that an eligible employee will receive or pay? Please use cash equivalent value and report the estimated annual amount per eligible individual per year.**

Maximum annual **incentive** linked to specific health results per employee: \$  ,  .00

Maximum annual **penalty** linked to specific health results per employee: \$  ,  .00

**E5. For your MOST ENROLLED HEALTH PLAN, what is the average monthly premium for employee-only health plan coverage, including both your company/organization's and employee's contributions? What is your company/organization's share of the total premium?**

*(Write numbers in box.)*

	<b>Average total premium per employee per month</b>	<b>Company/organization's share of total monthly premium</b>
Employee-only coverage.....	\$.....,.....:00.....	%.....

## Section F. Clinical Screening

**For all questions in this section, please include ALL clinical screening programs offered to your employees by either your company/organization directly, by your health plan(s), or by a third party (e.g., union). These programs may be administered by a third party administrator or a program vendor.**

**Please include only information on screenings offered at the workplace, not those accessible through your employees' physicians.**

**F1. Are any of your active employees currently offered clinical screening(s) at the workplace?** For example, these may include screening for high blood pressure, high cholesterol, cancer, and general physical examinations.

(Check one.)

- Yes  
 No → **GO TO QUESTION: G1, PAGE #** (for the paper-based version)

**F2. Which of the following clinical screening(s) are offered to your employees at the workplace?**

(Check all that apply.)

- |  |   |
|--|---|
| <input type="checkbox"/> Blood Glucose<br><input type="checkbox"/> Blood Pressure<br><input type="checkbox"/> Body Weight/Body Mass Index (BMI)<br><input type="checkbox"/> Body Fat Percentage<br><input type="checkbox"/> Bone Density<br><input type="checkbox"/> Cancer Screening<br><input type="checkbox"/> Cholesterol/Lipids | <input type="checkbox"/> General Physical Exam<br><input type="checkbox"/> Psychological Stress<br><input type="checkbox"/> Tobacco Use<br><input type="checkbox"/> Vision<br><input type="checkbox"/> Hearing<br><input type="checkbox"/> Other, please specify: _____ |
|--|---|

**F3. What proportion of eligible employees participated in at least one clinical screening offered at the workplace in the last 12 months?** *If no data are available for the last 12 months, please use data for the previous program year.*

$$\text{Participation rate (\%)} = \frac{\text{Number of Program Participants}}{\text{Number of Eligible Employees}} \times 100$$

(Write in the participation rate.)

Clinical screening participation rate:    %

**F4. Are monetary incentives used to encourage employee participation in any of the clinical screenings offered at the workplace?** *For the incentives or penalties associated with achieving certain **health outcomes** that are determined in clinical screenings, relevant questions are asked in other sections in this survey.*

(Check one.)

- Yes, participation incentives are offered by one or more health plans  
 Yes, participation incentives are offered by your company/organization only  
 Yes, participation incentives are offered by both health plan(s) and your company/organization  
 Yes, but unsure which entity offers participation/completion incentives  
 No → **GO TO QUESTION: G1, PAGE #** (for the paper-based version)

**F5. What is the maximum amount of incentive and/or penalty that eligible employees will receive or pay per full-time eligible employee per year, based on participation in clinical screenings?** *Please use cash equivalent value; convert non-cash incentives into cash value. Estimates are acceptable.*

**Maximum** amount of **incentive** for **clinical screening** per full-time employee per year: \$ ,  .00

**Maximum** amount of **penalty** for **clinical screening** per full-time employee per year: \$ ,  .00

## Section G. Disease Management

**For all questions in this section, please include ALL disease management programs offered to your employees by either your company/organization directly, by your health plan(s), or by a third party (e.g., union). These programs may be administered by a third party administrator or a program vendor.**

**G1. Are any of your active employees currently offered disease management programs?** These include programs that manage chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease. (Check one.)

- Yes  
 No → **GO TO QUESTION: H1, PAGE #** (for the paper-based version)

**G2. Which of the following conditions are included in the disease management programs offered to your employees?**

(Check all that apply.)

- |   |  |
|---|--|
| <input type="checkbox"/> Asthma<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> COPD/Emphysema<br><input type="checkbox"/> Coronary Artery Disease<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Failure<br><input type="checkbox"/> Low Back Pain<br><input type="checkbox"/> Program Not Disease-specific<br><input type="checkbox"/> Other, please specify: _____ |
|---|--|

**G3. What proportion of eligible employees participated in at least one disease management program in the last 12 months?** *If no data is available for the last 12 months, please use data for the previous program year.*

$$\text{Participation rate (\%)} = \frac{\text{Number of Program Participants}}{\text{Number of Eligible Employees}} \times 100$$

(Write in the participation rate.)

Disease Management Program participation rate:    %

**G4. Are monetary incentives used to encourage participation in any of the disease management programs offered to your employees?**

(Check one.)

- Yes, participation incentives are offered by one or more health plans  
 Yes, participation incentives are offered by your company/organization only  
 Yes, participation incentives are offered by both health plan(s) and your company/organization  
 Yes, but unsure which entity offers participation/completion incentives  
 No → **GO TO QUESTION: H1, PAGE #** (for the paper-based version)

**G5. What is the maximum possible amount of incentive that eligible employees can receive per full-time eligible employee per year, based on participation in disease management programs?** *Please use cash equivalent value; convert non-cash incentives into cash value. Estimates are acceptable.*

**Maximum** amount of **incentive** for disease management: \$  ,    .00

**Maximum** amount of **penalty** for disease management: \$  ,    .00

## Section H. Program Evaluation and Costs

**H1. Does your company/organization, or your health plans, or a third party routinely evaluate your wellness program effectiveness?**

(Check one.)

- Yes  
 No

**H2. How much does your company/organization invest internally in the wellness program every year?**

**Note:** These include the salaries of program staff, equipment and facility costs, costs of employee time, overhead administrative costs, and other materials and supplies. Estimates are acceptable.

Annual **internal** investment in wellness programs: \$    ,    , 0 0 0

**H3. How much does your company/organization pay wellness vendor(s), or health insurer(s), or third party administrator(s) that also provide wellness programs, for wellness-related services every year? Please exclude insurance premiums or claim payments.**

(Please indicate approximate amount.)

Annual fees paid to wellness vendor(s) or health plan(s): \$    ,    , 0 0 0

**H4. Please provide your best estimate of the benefits of your wellness program in relative and monetary terms for each of the following? Please fill in the gross benefits estimates, i.e., estimates not reflecting program costs.**

(Please check all that apply and fill in estimates.)

Program impact	Increase	Decrease	Percent Change	Impact in Monetary Terms	No data available
Medical costs	<input type="checkbox"/>	<input type="checkbox"/>	%	\$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , 0 0 0	<input type="checkbox"/>
Absenteeism	<input type="checkbox"/>	<input type="checkbox"/>	%	\$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , 0 0 0	<input type="checkbox"/>
Productivity	<input type="checkbox"/>	<input type="checkbox"/>	%	\$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , 0 0 0	<input type="checkbox"/>
Other 1, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	%	\$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , 0 0 0	<input type="checkbox"/>
Other 2, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	%	\$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , 0 0 0	<input type="checkbox"/>

**H5. Which of the following barriers reduces the ability of your wellness program to improve health behaviors and health outcomes of your employees?**

*(Check all that apply.)*

- |  |  |
|--|--|
| <input type="checkbox"/> Lack of financial resources                 | <input type="checkbox"/> Federal regulatory restrictions   |
| <input type="checkbox"/> Lack of staff resources                     | <input type="checkbox"/> State regulatory restrictions     |
| <input type="checkbox"/> Lack of employee awareness                  | <input type="checkbox"/> Regulatory uncertainty            |
| <input type="checkbox"/> Lack of management support                  | <input type="checkbox"/> Other 1, please specify:<br>_____ |
| <input type="checkbox"/> Lack of business case for wellness programs | <input type="checkbox"/> Other 2, please specify:<br>_____ |

**→ GO TO QUESTION: J1, PAGE #** (for the paper-based version)

**Section I. NO PROGRAM**

**11. In the past 5 years, were any of your employees offered any of the following programs that have been discontinued, including those offered by your company/organization directly, by your health plan(s), or by a third party (e.g., union)?** *These programs may be administered by a third party administrator or a program vendor.*

- **Health risk assessment/appraisal** (a questionnaire on medical history, health status, and lifestyle; it is designed to identify the health risks of the person being assessed)
- **Lifestyle or risk factor management** (e.g., health education classes/workshops, fitness program, weight management program, healthy eating program, stress management program, cholesterol management, or smoking cessation program)
- **Clinical screening** (e.g., clinical screenings for high blood pressure, high cholesterol, cancer, and general physical examination)
- **Disease management** (management of chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease)

*(Check one.)*

- Yes → **GO TO QUESTION: I3, PAGE #** (for the paper-based version)  
 No

**12. Please rate the importance of the following reasons why your company/organization does not offer health risk assessment/appraisal, lifestyle or risk management, clinical screenings, or disease management programs.**

*(Check one box in each row.)*

Not     Slightly     Moderately     Very     Extremely     Don't  
Important   Important   Important   Important   Important   Know

a. Lack of employer awareness/knowledge of wellness programs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Wellness programs not cost-effective.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Lack of financial resources.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Lack of staff resources.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Lack of management support.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Lack of employee interest.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Employees healthy and productive; no perceived need for a program.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Other: _____.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

→ **GO TO QUESTION: I7, PAGE #** (for the paper-based version)

**13. What programs were offered but discontinued later?**

*(Check all that apply.)*

- Health risk assessment/appraisal
- Lifestyle or risk factor management (e.g., health education classes/workshops, fitness program, weight management program, healthy eating program, stress management program, cholesterol management, or smoking cessation program)
- Clinical screening
- Disease management



**14. What lifestyle or risk factor management programs did you offer but discontinue later?**

(Check all that apply.)

- |   |  |
|---|--|
| <input type="checkbox"/> Alcohol and/or drug abuse counseling | <input type="checkbox"/> Stress management program               |
| <input type="checkbox"/> Cholesterol/lipid management         | <input type="checkbox"/> Weight/obesity management               |
| <input type="checkbox"/> Fitness program                      | <input checked="" type="checkbox"/> Other, please specify: _____ |
| <input type="checkbox"/> Healthy eating program               |  |
| <input type="checkbox"/> Health education classes             | <input type="checkbox"/> None of the above                       |
| <input type="checkbox"/> Smoking cessation program            |  |

**15. When did your discontinued programs start, and when were they terminated? If they started or ended at different times, please fill in the start year for the first program component, and/or the end year of the last program component.**

Started in year     Ended in year

**H6. Please rate the importance of the following reasons why your company/organization discontinued health risk assessment/appraisal, lifestyle or risk management, clinical screening, or disease management programs.**

(Check one box in each row.)

	<u>Not</u> <u>Important</u>	<u>Slightly</u> <u>Important</u>	<u>Moderately</u> <u>Important</u>	<u>Very</u> <u>Important</u>	<u>Extremely</u> <u>Important</u>	<u>Don't</u> <u>Know</u>
a. Low program participation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Wellness programs not cost-effective.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Lack of financial resources.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Lack of staff resources.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Lack of management support.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Lack of employee interest.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Employees healthy and productive; no perceived need for a program.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Change in leadership or company ownership.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Other: _____.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**17. Is your company/organization considering offering any of the following programs within the next 5 years?**

- **Health risk assessment/appraisal**
- **Lifestyle or risk factor management** (e.g., health education classes/workshops, fitness program, weight management program, healthy eating program, stress management program, cholesterol management, or smoking cessation program)
- **Clinical screening**
- **Disease management**

(Check one.)

- Yes  
 No

## Section J. OTHER BENEFITS

**J1. Do any of your active employees currently have access to on-site vaccinations such as flu shots, including those offered by your company/organization directly, or by your health plan(s), or by a third party (e.g., union)? These programs may be administered by a third party administrator or a program vendor.**

(Check one.)

- Yes  
 No → **GO TO QUESTION: J3, PAGE #** (for the paper-based version)

**J2. Which on-site vaccinations are offered?**

(Check all that apply.)

- Flu Shots/Influenza  
 Pneumovax/Pneumococcus vaccine/pneumonia vaccine  
 Other, please specify: \_\_\_\_\_

**J3. Which of the following additional health and wellness related benefits are currently available to your active employees?**

(Check all that apply.)

- |  |   |
|--|---|
| <input type="checkbox"/> Absenteeism management                        | <input type="checkbox"/> Locker room with showers available at worksite                           |
| <input type="checkbox"/> Employee assistance program                   | <input type="checkbox"/> Other exercise opportunities (walking trails, inviting staircases, etc.) |
| <input type="checkbox"/> Gym or health club membership discount        | <input type="checkbox"/> Healthy food available at worksite                                       |
| <input type="checkbox"/> Nurse advice line                             | <input type="checkbox"/> Other 1 → Please specify: _____  |
| <input type="checkbox"/> Occupational health/safety program            | <input type="checkbox"/> Other 2 → Please specify: _____  |
| <input type="checkbox"/> On-site clinics                               | <input type="checkbox"/> None of the above  |
| <input type="checkbox"/> Unpaid fitness breaks                         |   |
| <input type="checkbox"/> Paid fitness breaks                           |   |
| <input type="checkbox"/> Indoor fitness facility available at worksite |   |

## Section K. Employer Background

**K1. What percent of your full-time active employees are women?**

(Write in the percent of employees.)

% of employees who are women

**K2. What percent of your full-time active employees are 50 years or older?**

(Write in percent of active employees)

% of active employees 50 years or older

**K3. What is the average salary of your non-executive active full-time employees?**

(Check one.)

- |   |  |
|---|--|
| <input type="checkbox"/> Smaller than \$25,000 per year | <input type="checkbox"/> \$75,000 - \$100,000 per year   |
| <input type="checkbox"/> \$25,000 - \$50,000 per year   | <input type="checkbox"/> Greater than \$100,000 per year |
| <input type="checkbox"/> \$50,000 - \$75,000 per year   |  |

**K4. What is the total number of full-time and/or part-time employees in your company/organization, or the U.S. branches/sites your reported data for, respectively?**

*(Write number in each row.)*

a. Full time employees.....,.....,.....
b. Part time employees.....,.....,.....

**REMARKS: Please use this space for any explanations that may be essential in understanding your reported data.**

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**Person to contact regarding this report:**

Name: \_\_\_\_\_

Company: \_\_\_\_\_

Street: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Extension: \_\_\_\_\_

Email Address: \_\_\_\_\_

**If you have any questions, please contact:** (for the web-based version)

**Please return the completed survey in the enclosed pre-paid envelope to:** (for the paper-based version)

[RAND CONTACT INFORMATION]

**THANK YOU!**