Health for Life Program Overview: Core Components

Cultural Support

Senior management support has been recognized since the program inception in 2004. This includes the global chief executive officer and all the country level CEOs an site leaders in North America. Various health initiatives spearheaded by the CEO included the construction of state-of-art fitness centers at major locations in North America. In addition, a on-site third party wellness vendor has been dedicated to manage all aspects of the day to day delivery program with a dedicated budget to deliver all aspects of the program. This includes a on-site program manger and program coordinators at various locations in North America. Strategic wellness committees and wellness champions are also utilized to support the culture of health and drive program improvement and engagement. A robust communication plan and strategy is in place to support all wellness initiatives to ensure all employees in North America have access and knowledge about the Health for Life program.

Integrated Programs

With numerous health plans and claims administrators interfacing with benefit eligible employees, it is essential to create a comprehensive health management relationship with these relevant partners. The Health for Life program is dedicated to working with these health partners to integrate data and promote cross-referrals for employees to ensure seamless delivery and optimal results in such areas as chronic condition and disease management programs. A health partner summit was hosted in 2008 to establish increased relationships and communications. Health assessment data integration is the focus in 2010 to ensure the remaining health plans start accepting the data and utilize for targeted intervention into their programs. Since the summit, various lifestyle intervention programs and resources from these partners have been utilized to compliment the Health for Life program.

Targeted Lifestyle Behavior Change and Chronic Condition Management Programs

Targeted lifestyle programs include: tobacco cessation, back care, eating, stress, weight management, cholesterol, blood pressure and physical activity. This facilitative approach guides individuals through the process of health behavior change and builds the independence, self-efficacy and self care skills employees need to succeed. From self-paced mail programs to one-on-one phone counseling with a personal health coach, the program offers maximum flexibility to ensure success. This approach builds participation by making it easy for employees to access programs where they live and work. Chronic condition and disease management programs are available to every employee and dependant living with a chronic illness through the various health plans. These include diabetes, chronic obstructive pulmonary disease, asthma, coronary artery disease, congestive heart failure and other pertinent programs. In addition, a back care pilot will be implemented in June 2010 to address this specific need within the organization. This is based on the fact that musculoskeletal disease is the number one diagnosis based on medical claims paid for the organization.

Health for Life Program Overview: Core Components

Health Risk Assessment and On-Site Biometric Health Screenings

Electronic and mail based Health Risk Assessments (HRA) aligned with on-site biometric health screenings testing for total cholesterol, high-density lipoprotein, glucose, blood pressure, height and weight. Access to on-line suites with a variety of tools such as personal action plans, access to vendor partner programs, health education centers, newsletters, healthy recipes, health calculators, articles and other wellness related resources. In 2009, approximately 73% of all eligible employees completed the health risk assessment and screenings. Since program inception, 80% of employees have completed at least one HRA since 2004.

On-Site Behavioral Change Programs and National Challenges

Regularly offered programs include health fairs, lunch & learns, preventative screenings, seasonal campaigns and much more . All programs are employee focused and designed to encourage long-term lifestyle and behavior changes in a variety of topic areas. Since 2006, a national weight loss challenge is hosted every year to place focus on this prevalent risk factor. In 2010, 1274 employees enrolled in the challenge which concluded on May 14, 2010. A $2000 grand prize will be awarded via a raffle to all participants that qualify by meeting a 5% weight loss goal. In addition, gift cards are also distributed during the program to facilitate program adherence during different stages of the program. On-site weigh ins are hosted at certain intervals and weekly tip sheets are provided to encourage and inform employees. Since 2006, over 28,000 lbs have been lost. A detailed case study highlighting the 2010 challenge is presented in the documentation portion of the application.

Comprehensive Communication Strategy

A comprehensive marketing and communication strategy is in place to inform employees about the Health for Life programs and educate them on why wellness is a core strategy for improving both employee and company health. Some of the most successful channels and tactics include: (1) On-site program management team including a dedicated wellness staff that assesses the needs and culture of the program and leads all site level programming and communications. (2) Wellness champion network of volunteer employees that assist with certain program components to ensure all site locations receive quality programming and have the opportunity to participate in the most fundamental program components. (3) Professional communication pieces such as program launch brochures are mailed to all employees homes each year that provide a detailed overview of the program. These pieces are endorsed and signed by executive management including sponsorship from executive UAW leadership. Other communication elements include electronic postings on intranets and employee center sites, LED displays, email distributions, plant newsletters, flyers and bulletin boards. To ensure ownership and identity, Health for Life branding is important to create a connection between the company mission and program deliverables.

Incentive Strategy Evolution: Developed in collaboration with bargained labor leadership

2004: HRA and Health Screening Completion
Non Bargaining Group: $100 cash payment
Bargaining Group: Not eligible in 2004

2005 & 2006: HRA and Health Screening Completion
Non Bargaining Group: $100 cash payment
Bargaining Group: $10 gift card and $10,000 in cash prizes in raffle drawings

2007: HRA and Health Screening Completion
Non Bargaining Group: $100 cash payment
Bargaining Group: $25 gift card

2008: HRA and Health Screening Completion
Non Bargaining Group: $100 cash payment and Healthy People Rewards
Bargaining Group: $25 gift card

2009 & 2010: HRA, Health Screening Completion and Tobacco Intervention
Non Bargaining Group: Reduced medical plan contribution and Healthy People Rewards
Bargaining Group: $25 gift card

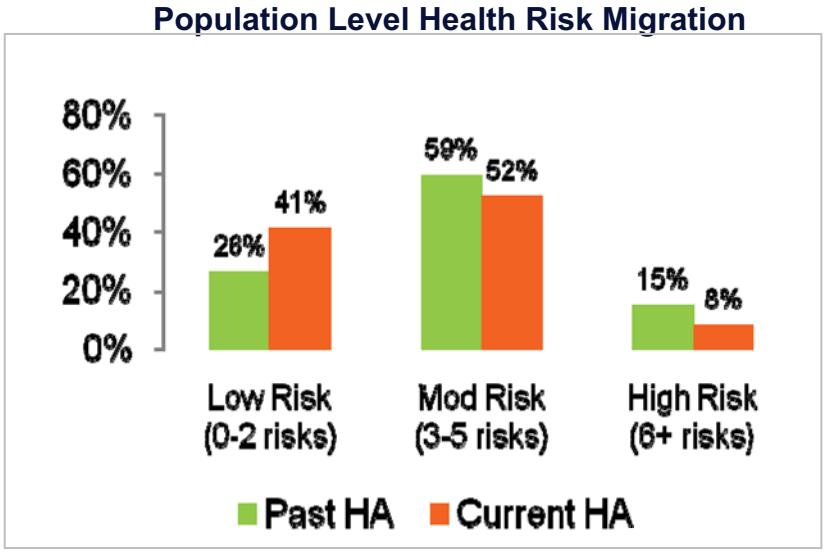
Medical Plan Contribution: NBU employees are eligible for a **reduced medical plan contribution rate of 16% versus 20% of plan costs if they participate in the HRA, health screening *and* attest to no tobacco use or complete a tobacco cessation program if they utilize tobacco products**. The cessation coaching program and appropriate nicotine replacement therapeutics are covered by the program to support the intervention.

Healthy People Rewards program is offered to all NBU employees and provides an opportunity to earn up to an additional $150 in cash for meeting certain biometric criterion. **Participants receive $50 for each criterion that is met. The qualifying criterion include total cholesterol below 200, blood pressure below 130/85 and body mass index below 27.5**. Employees who have a medical condition that prevents them from meeting criterion are still eligible for rewards based on establishment of HIPAA-compliant alternatives.

Population Level Health Risk Migration

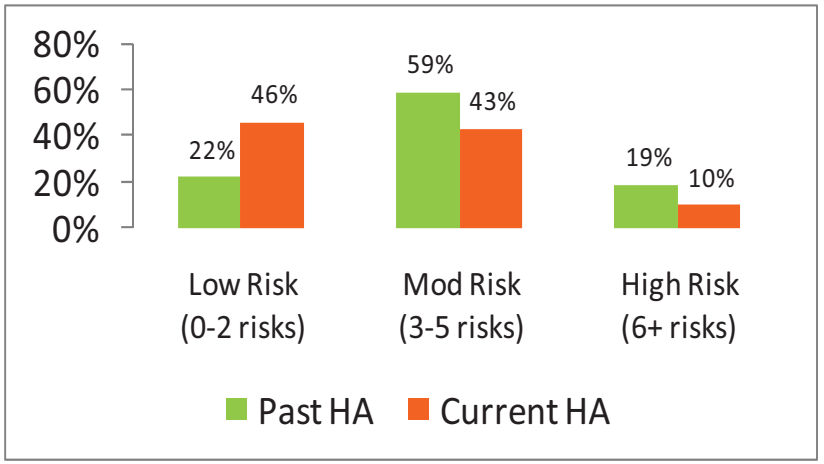
Since program launch in 2004, average number of health risks has decreased from 3.7 risks to 3.0 risks, a decrease of 17.5%. During this time period the percent of HRA participants with two or fewer health risks increased from 26% to 41%, the percentage with three to five risks decreased from 59% to 52%, and the percentage with six or more risks decreased from 15% to 8% . Impacts on specific health risks include:

- 33% decrease in **tobacco** risk from 18% at risk to 12% at risk
- 23% decrease in **back** risk from 48% at risk to 37% at risk
- 23% decrease in **exam** risk from 65% at risk to 50% at risk
- 21% decrease in **exercise** risk from 47% at risk to 37% at risk
- 17% decrease in **stress** risk from 65% at risk to 54% at risk
- 13% decrease in **nutrition** risk from 67% at risk to 58% at risk



Intervention Level Health Risk Migration

Of those eligible to participate in coaching programs, 25% enrolled in programs in the most recent program year (2009). Compared to their previous HRA prior to coaching, average number of health risks decreased from 3.9 risks to 3.2 risks, a decrease of 18%. During this time period the percent of HRA participants with two or fewer health risks increased from 22% to 46%, the percentage with three to five risks decreased from 59% to 43%, and the percentage with six or more risks decreased from 19% to 10% .



Case Study of Culture Impact
~2010 National Weight Loss Challenge~

The National Weight Loss Challenge is a comprehensive weight loss and management program conducted from January 18, 2010 – May 14, 2010. This particular initiative was implemented to mitigate national and company trends in increased obesity status despite the comprehensive Health for Life programs.

Based on the 2009 HRA results, close to 78% of participants demonstrated overweight or obese status and weight risk alone accounted for approximately 34% of estimated avoidable health care costs.

The purpose of the program was to engage employees in a fun and effective program that addressed a condition that most people have struggled with most of their lives. All employees were eligible to participate in the challenge. The target audiences were employees that wanted to address weight management at any level. This included employees who wanted to lose 5 lbs to those that wanted to lose substantial amounts of weight. The budget amount that was dedicated for this program was approximately $30,000.

Due to continued evaluation of the various program design elements from previous challenges, the 2010 version demonstrated a significant improvement in both participation and engagement metrics compared to the 2008 and 2009 program deliveries. As demonstrated in the chart below, the 2010 results have exceeded the previous two years results combined.

Phase 1 Program Results

	Total Registered	Total Completed	Total Weight Lost	Average Weight Loss	5% Cut
2010	**1274**	**755**	**8096.97 lbs**	**10.72 lbs**	**418**
2009	658	322	2162 lbs	6.73 lbs	109
2008	758	481	3895 lbs	8.1 lbs	175

Weight Loss Challenge Program Features

Phase 1: The Weight Loss Phase: This 18 week phase challenged employees to lose weight with the final goal set at losing at least 5% of their initial starting weight.

Phase 2: The Maintenance Phase: Currently in progress. Employees that lost at least 5% of their initial starting weight in Phase 1 automatically qualifies for the maintenance phase. This 12 week phase challenges employees to maintain or better their final weight from Part 1.

Timing: The start time of the challenge was important to take advantage of an increase in employee health awareness due to the New Year resolution idea that has become part of the culture for most people. The Phase 2 Maintenance portion began immediately after Phase 1. This was scheduled purposely so employees would not lose any momentum. The length of time per phase was 18 weeks for Phase 1 and 12 weeks for Phase 2. Duration was an important element to keep employees engaged and allow enough time for behavior change and results.

Official Weigh-Ins: Weigh-ins were performed at each location by either the on-site Health for Life program team or a designated wellness champion. Each weigh in was spaced 4 weeks apart.

Support: Various educational and awareness components were provided during the challenge to motivate and educate employees. Every week a tip sheet was created and distributed to all participants. on topics like portion control, serving sizes, food journals, macro-nutrients, motivation and more.

Goals: Phase 1 and Phase 2 had clear objectives for all participants. In Phase 1, employees were challenged to lose weight during the 18 week period. A goal was set for employees to strive and lose at least 5% of their initial starting weight. The 5% or more target was established after various consultations with dieticians, nutritionists including a popular national weight management organization. It was important to set a target percentage that was achievable, healthy and safe. In Phase 2, employees that lost 5% or more of their starting weight would advance into the maintenance phase. The goal for this phase is to maintain or better at least 5% weight loss from the final weight demonstrated during Phase 1.

Incentives: To create excitement and drive participation, incentives were built into the program at different levels.

$25 Gift Card - 2.5% MIDPOINT AWARD
$25 gift card for achieving at least a 2.5% weight loss by the midpoint of the challenge during Phase 1.

$25 Gift Card - 5% FINAL AWARD
$25 gift card for achieving at least a 5% total weight loss by the end of the challenge during Phase 1.

$2000 GRAND PRIZE RAFFLE
$2000 cash award raffle drawing for all employees that complete the challenge and achieve at least a 5% total weight loss during Phase 1.

$500 MAINTENANCE GRAND PRIZE RAFFLE
Maintain at least 5% weight loss through the summer and be entered into a raffle to earn $500 in cash during Phase 2.

Impact on Productivity Costs

Measures of absenteeism and presenteeism are critical when tracking the successes of a worksite health promotion program. Like many organizations, Volvo relies on a standard paid-time-off bank for a significant portion of its employees which makes measurement of productivity impacts difficult.

To enable assessment of productivity impacts, measures of work days and productivity lost due to poor health were embedded into the HRA. As part of a broader outcomes study conducted in 2008, for individuals who took the HRA at least twice between 2004 and 2007, self-reported productivity measures assessed change in time away from work (absenteeism) and productivity impairment due to the employee's poor health (presenteeism).

Self-reported absenteeism decreased from an average of 2.04 days to an average of 1.87 days per program participant representing an 8% decrease in absenteeism, or 1,087 total days. Self-reported productivity improved from an average of 93.65% to an average of 94.04%, representing a 0.4% increase in on-the-job productivity (presenteeism), or 6,009 total days.

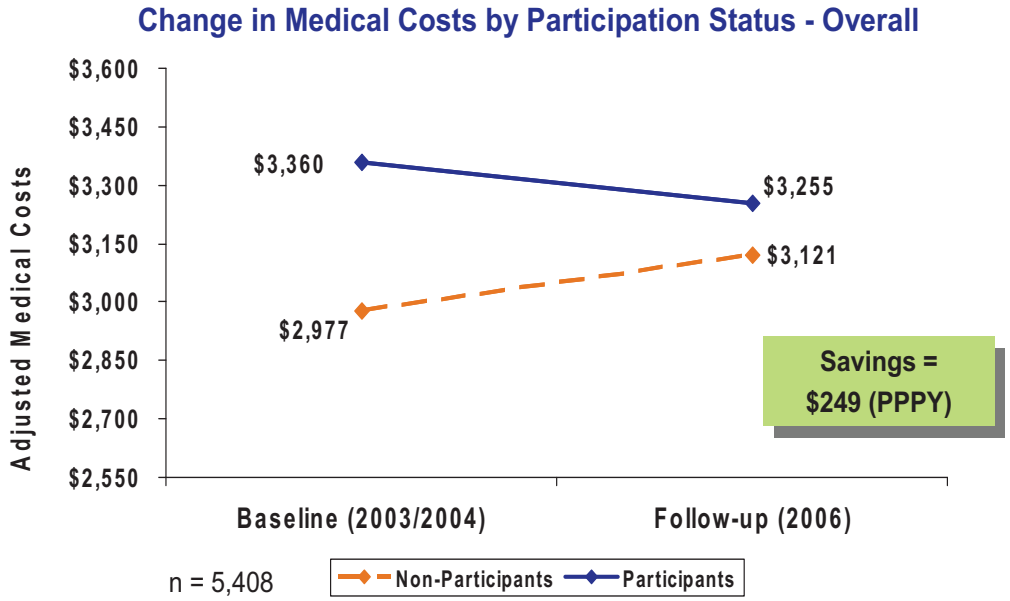
When converted to days of time lost, absence and on-the-job productivity loss declined by a total of 7,096 days for those with repeat data. Productivity outcomes were monetized using methods reported elsewhere[1], with productivity-related cost savings of $242 per participant demonstrated.

[1] *Riedel JE, Grossmeier J, Haglund-Howieson L, Buraglio C, Anderson DR, Terry PE. Use of a normal impairment factor in quantifying avoidable productivity loss because of poor health. J Occup Environ Med. Mar 2009;51(3):283-295.*

Impact on Medical Costs

Since Volvo employees are served by a variety of health plans and multiple third-party administrators, data integration is challenging and costly. Rather than bear the cost of one integrated data management system, Volvo commissioned a custom data analysis two years after program implementation. Researchers integrated all medical claims and health plan enrollment data into one data repository along with all program participation data through the end of 2007. Pharmacy claims data were not available on the entire study population for the duration of the study period so were excluded from the analysis. Data were integrated at the person-centric level to allow assessment of cost trends for each person in the analytic data file. After claims were adjusted for inflation and changes in health benefit plan design, claims were logged to ameliorate the skewness of the data. All individuals who had claims data from two years prior to program launch through two years after program launch were included in the analysis and separated into participant and non-participant groups. A generous participation definition was used so anyone with at least one program "touch" (be it the HRA, a coaching program, or a one-time lunch and learn) was considered to be a program participant during the study.

Cost savings were calculated using a "differences in differences" approach described elsewhere.[2,3] This approach represents a quasi-experimental study design, comparing participant health care costs to non-participant health care costs. Multivariate regression models were used to control for group differences in age, gender, health plan enrollment, union status, and baseline health care utilization. After adjusting for health plan design changes and inflation, medical costs for employees who did not participate in the program increased by 5%, while medical costs for program participants decreased by 3%. The study yielded a medical-only cost savings of $249 per participant.

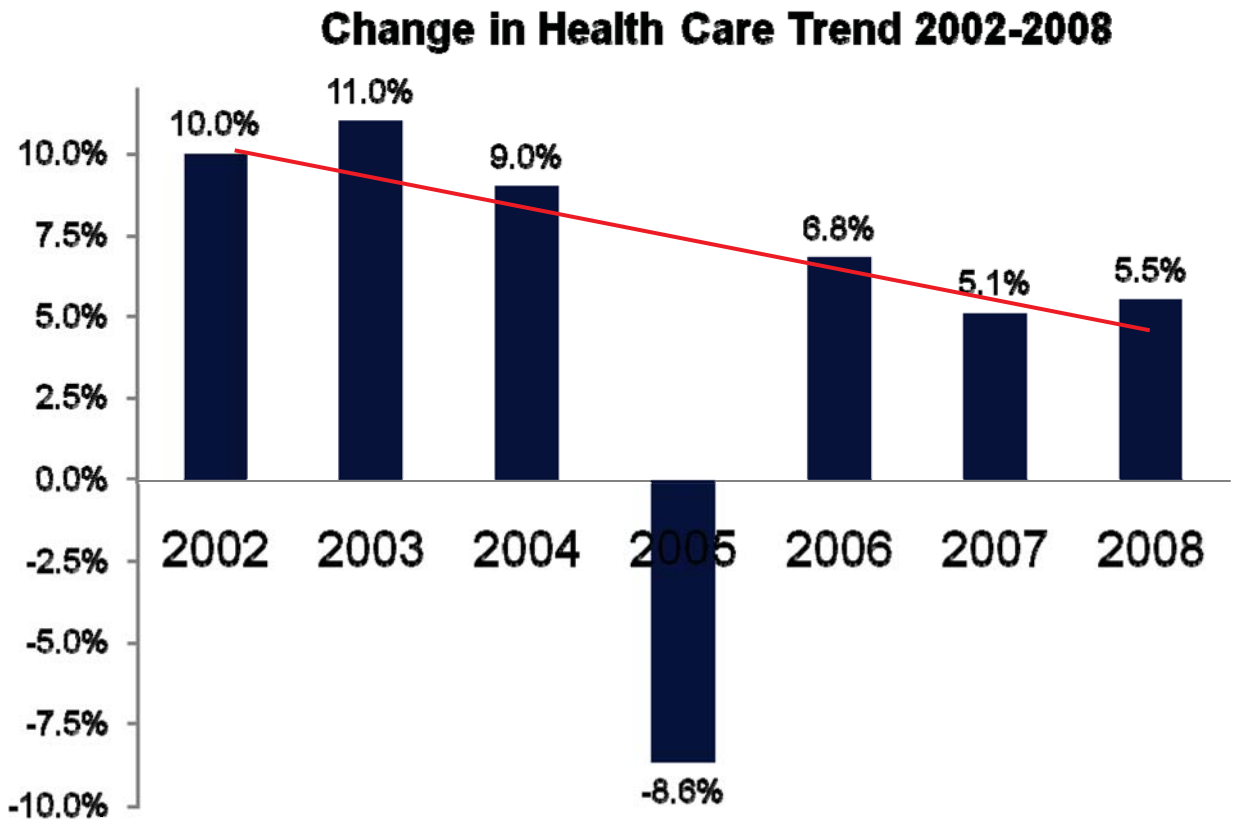


[2] *Serxner S, Gold D, Meraz A, Gray A. Do employee health management programs work? Am J Health Promot. Mar-Apr 2009;23(4):1-8, iii.*

[3] *Serxner S, Noeldner SP, Gold D. Best practices for an integrated population health management (PHM) program. Am J Health Promot. May-Jun 2006;20(5):suppl 1-10, iii.*

Impact on Health Care Trend

In addition to the quasi-experimental study, senior management also is interested in assessing total impact on health care cost trends. Prior to program launch, Volvo's health care spending increased at double-digit rates each year. Total health care trend was at 10% in 2002 and 11% in 2003. In 2004 (the year Health for Life was launched), the total health care cost trend decreased to 9%. The health care trend in 2005 was negative at -8.6%; in 2006, the trend was positive at 6.8%; in 2007, it was 5.1%; and in 2008, it was 5.5%.



Return on Investment (ROI)

Return on program investment was calculated using a benefit-cost ratio. Based on a medical savings of $249 per participant and productivity savings of $242 per participant, the Health for Life program was associated with a total savings of $3.1 million. When compared against all costs invested in the program, the company achieved the level of savings needed to recoup its costs after only two years of implementation.

Program/Investment Costs Included:

- Health Risk Assessment
- Online health portal
- Comprehensive communications
- Onsite biometric screening
- Onsite program management staff
- Fitness center management
- Onsite classes
- Special events
- Financial incentives
- Phone, mail, online coaching programs
- Health awareness campaigns
- Data integration
- ROI study

Total Savings Included:

Medical Savings
6,393 participants x $249 = $1,591,857

Productivity Savings
6,009 days x $218.48* = $1,312,846

Absences Savings
1,087 days x $218.48* = $237,488

TOTAL SAVINGS = $3,142,191

* Average total compensation, including wages/salary plus benefits, from the "Employer Costs for Employee Compensation Summary". United States Department of Labor: 05-2279. Available at: http://www.bls.gov/ncs/ecf/home.htm