

## Optimizing Enrollment in Employer Health Programs: A Comparison of Enrollment Strategies in the Diabetes Health Plan

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**D**espite extensive recruitment efforts by health plans, state and local governments, and other stakeholders, many eligible individuals do not voluntarily enroll in health promotion or insurance benefit programs designed to improve health outcomes.<sup>1</sup> Employers are increasingly sponsoring wellness programs as a way to possibly decrease costs and increase productivity across a large component of the workforce.<sup>2</sup> However, despite the use of various approaches, enrollment in wellness programs often remains low.<sup>3,5</sup> Although many of these programs and benefits may improve access and outcomes among the subset of persons who are enrolled, with limited reach they are unlikely to improve the health of the overall targeted population.<sup>6</sup>

Many employer health programs use a voluntary enrollment approach, which employees must actively join in order to be enrolled. However, voluntary program enrollees may have different demographic characteristics than the underlying population, in terms of gender, age, race/ethnicity, income, risk for chronic conditions or disability, and other factors.<sup>7</sup> Voluntary program enrollees may also have different clinical characteristics than the underlying population, potentially representing either the “worried well” who may have less need for services or a sicker subgroup motivated to enroll because of the severity of their underlying condition. A recent review of enrollment into a variety of public benefit programs identified multiple barriers to voluntary enrollment and suggested automatic enrollment of all eligible participants as a preferential strategy.<sup>8</sup> There is little current, “real-world” data on patient-level differences comparing “voluntary” and “automatic” enrollment approaches. Such information may be useful in the design of future health promotion or insurance benefit programs.

Data from the rollout of the SHP at 11 self-insured employers of the Diabetes Health Plan (DHP)—the first disease-specific health insurance plan for employees and their covered dependents with diabetes or prediabetes—provides a unique

### ABSTRACT

#### Background

Many health programs struggle with low enrollment rates.

#### Objectives

To compare the characteristics of populations enrolled in a new health plan when employer groups implement voluntary versus automatic enrollment approaches.

#### Study Design

We analyzed enrollment rates resulting from 2 different strategies: voluntary and automatic enrollment. We used regression modeling to estimate the associations of patient characteristics with the probability of enrolling within each strategy. The subjects were 5014 eligible employees from 11 self-insured employers who had purchased the Diabetes Health Plan (DHP), which offers free or discounted copayments for diabetes related medications, testing supplies, and physician visits. Six employers used voluntary enrollment while five used automatic enrollment.

The main outcome of interest was enrollment into the DHP. Predictors were gender, age, race/ethnicity, dependent status, household income, education level, number of comorbidities, and employer group.

#### Results

Overall, the proportion of eligible members who were enrolled within the automatic enrollment strategy was 91%, compared with 35% for voluntary enrollment. Income was a significant predictor for voluntary enrollment but not for automatic enrollment. Within automatic enrollment, covered dependents, Hispanics, and persons with 1 nondiabetes comorbidity were more likely to enroll than other subgroups.

Employer group was also a significant correlate of enrollment. Notably, all demographic groups had higher DHP enrollment rates under automatic enrollment than under voluntary enrollment.

#### Conclusions

For employer-based programs that struggle with low enrollment rates, especially among certain employee subgroups, an automatic enrollment strategy may not only increase the total number of enrollees but may also decrease some enrollment disparities.

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### Take-Away Points

The Diabetes Health Plan included variation in enrollment strategy across employer groups, with some using voluntary enrollment and others using automatic enrollment.

- Utilizing voluntary enrollment, 35% of eligible employees were enrolled, and annual income  $\geq$ \$125,000 and black race were associated with much higher rates of enrollment.
- Utilizing automatic enrollment, 91% of eligible employees were enrolled, and dependents and employees of Hispanic ethnicity were somewhat more likely to be enrolled than other employees.
- Automatic enrollment strategies can increase overall enrollment and provide participants with the opportunity to “opt out,” and may also decrease some enrollment disparities.

opportunity to assess the effectiveness of these 2 enrollment strategies. The DHP is offered by different employer groups, some using a voluntary enrollment approach requiring employees to sign up, others an automatic enrollment approach that directly enrolls all eligible employees. We hypothesized that the automatic enrollment strategy would enroll a larger and more representative sample of the underlying population, compared with the voluntary enrollment strategy.

## METHODS

### Study Design, Setting, and Participants

The Diabetes Health Plan (DHP), initiated in 2009, represents an innovative approach to care for individuals with diabetes or prediabetes.<sup>9</sup> Purchased by several medium and large self-insured employers across the United States, the DHP eliminates or reduces co-payments for medications and physician visits in order to incentivize evidence-based care. Eligible employees and their eligible covered dependents have the option of maintaining their standard plan or switching to a DHP plan. The latter adds DHP benefits to the standard plan while maintaining the same premium cost to the employee. The DHP also includes enhanced access to wellness programs at no additional cost to the employee. **Table 1** shows the variations in features between the DHP and the standard plan.

In addition to these program benefits, the DHP was originally designed by the health plan to include several requirements to be met each year in order to maintain enrollment for the following year. These “compliance criteria” were ultimately determined by each employer, but potentially included a combination of the following: laboratory evaluations such as biannual A1C testing, annual cholesterol blood testing and/or annual microalbuminuria screening, biannual primary care visits, annual retinal exams, biannual mammography, and/or colon cancer screening for persons aged 50 years or more. Required tests were offered free to the enrolled DHP member.

Although the DHP enrolled both employees with diabetes and prediabetes, the current analysis is limited to the sample with diabetes. In order to be considered eligible for the DHP, an employee (or dependent) with diabetes had to meet at least 1 of the following criteria during the prior 1 year: (1) 1 or more medical claims with an *International Classification of Diseases, Ninth Revision, Clinical Modification*

(ICD-9-CM) diagnosis code of 250.xx from a doctor’s office, clinic visit, or inpatient hospital stay; (2) any glycosylated hemoglobin (A1C) value of  $\geq$ 6.5%, fasting plasma glucose  $>$ 125 mg/dL, or 2-hour oral glucose tolerance test  $\geq$ 200 mg/dL; (3) any prescription filled for insulin or an oral antidiabetic agent other than metformin; (4) direct referral from a medical provider or as a result of onsite biometric screenings.

When the DHP was first introduced in early 2009, all participating employer groups offered the plan under a voluntary enrollment strategy. Some employers limited DHP eligibility to persons who had existing diagnoses of diabetes and these persons could voluntarily enroll. Other employers offered on-site biometric screenings to detect new cases of diabetes, and allowed those with either new or existing diagnoses to voluntarily enroll.

Employer groups initially offering the DHP in late 2009 and 2010 had the option to enroll employees using an automatic enrollment approach. Each employer identified the eligible employees based on the criteria described above and notified them of their eligibility. Eligible individuals were automatically enrolled in the DHP at the beginning of the next enrollment period unless they made an active decision to opt out in favor of having a standard health plan. The opt-out process was relatively simple for individuals who preferred to remain in the standard health plan, usually involving a short form that could be returned to their designated DHP representative.

Using a cross-sectional design, we compared the 6 employer groups that offered voluntary enrollment and the 5 groups that used automatic enrollment to evaluate differences in an employee’s likelihood of DHP enrollment. As shown in **Figure**, we restricted the sample to persons who: (1) had no gestational diabetes; (2) were continuously enrolled with the health insurer 1 year before and 1 year after the DHP was offered; (3) were between the ages of 18 and 64 years at baseline; (4) were not missing key demographic variables or information on employee/dependent status; and (5) had enrollment status in the DHP

that could be confirmed. This resulted in our analytic sample of 1549 persons who had the option of voluntary enrollment and 3465 persons who were automatically enrolled but had been given the opportunity to “opt out.” The Institutional Review Board at UCLA reviewed and approved this study.

**Variables**

The outcome variable for this analysis was enrollment in the DHP. Enrollment data was provided by the health insurer, and individual-level information about reasons why employees did or did not enroll was not available. Predictor variables for this analysis included gender, age group (aged 18-34, 35-44, 45-54, and 55-64 years), and employee vs covered dependent ( $\geq 18$  years) status, all of which were member-reported and were acquired from the eligibility file provided by the health insurer. Other variables included education level (high school graduate or less, some college, bachelor’s degree, and above), race (white, Hispanic, black, Asian, other), and annual household income ( $< \$30K$ ,  $\$30K-\$49K$ ,  $\$50K-\$74K$ ,  $\$75K-\$124K$ ,  $\geq \$125K$ ), all of which were obtained by the health insurer from a third-party consumer marketing services firm that derived them from a combination of census data, an algorithm analyzing first and last names, and an income database. A count of comorbidities was derived from administrative claims data provided by the health insurer; it included each of 15 conditions based on ICD-9-CM codes: hypertension, hyperlipidemia, coronary artery disease, congestive heart failure, atrial fibrillation, end-stage renal disease, osteoarthritis, rheumatoid arthritis, cancer, chronic obstructive pulmonary disease, stroke, peripheral vascular disease, dementia, and schizophrenia and other mental health diagnoses (eg, depression, anxiety).

**Statistical Analysis**

We compared the unadjusted differences in enrollment within the voluntary and automatic enrollment groups. Using a multivariate logistic regression model to control for demographic and health variables, we determined the marginal predicted probabilities of being enrolled in the DHP. In addition to controlling for various demographic characteristics, we also included “enrollment method” to control for those who were offered the plan under voluntary versus automatic enrollment.

Finally, we conducted the same analysis using employer fixed effects with stratified models to compare the associations estimated among employer groups who

**Table 1. Features and Costs by DHP and Standard Plan**

Feature	DHP	Standard Plan
Office visit copays		
Primary care	\$0	\$20
Specialist (eg, endocrinology)	\$0-10	\$30
Premium cost to the employee	Standard	Standard
Prescription copays		
Metformin, statins, ACE/ARB	\$0	\$5-15
Lab tests	Covered	Covered
Online tracking	Included	Availability varied
Diabetes disease management	Included	Availability varied
Weight management	Included	Availability varied

ACE indicates angiotensin-converting enzyme; ARB indicates angiotensin receptor blockers; DHP indicates diabetes health plan.

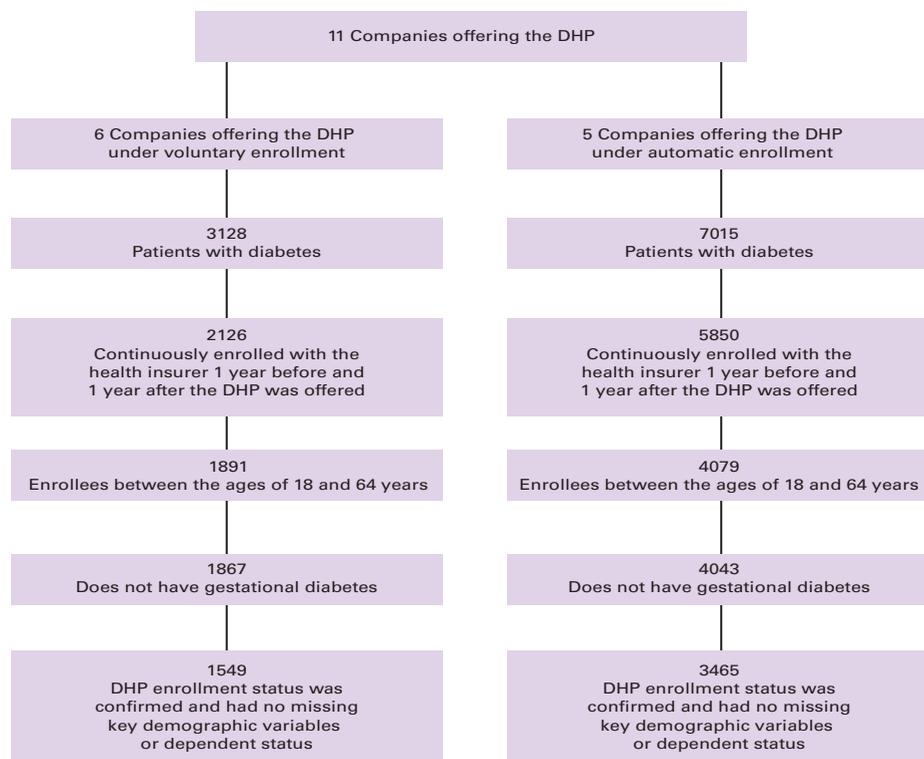
offered voluntary enrollment with those who offered automatic enrollment. We chose this specification because of the inherent flexibility, as fixed effects control for any confounding of patient-level effects with employer characteristics, and stratification allows enrollment strategy to fully interact with the other predictors in the model.

**RESULTS**

None of the employer-level characteristics were significantly different between the automatic and voluntary enrollment groups (Table 2). Of persons meeting our study criteria (aged between 18 and 64 years and continuously enrolled in a UnitedHealth plan for 2 years), 8.7% had diabetes. Of the 1549 eligible persons in the voluntary enrollment group, only 35% enrolled in the DHP, by opting into the program. Of the 3465 persons in the automatic enrollment group, 91% enrolled in the DHP, by not opting out. Chi-square tests revealed significant unadjusted differences by race/ethnicity in the voluntary enrollment groups, with a higher percentage of white and Hispanic individuals and a lower percentage of black individuals represented among those enrolled (Table 3). There were also differences by income and education in the voluntary enrollment groups, with a higher percentage of individuals with annual household income  $\geq \$75K$ , a lower percentage with a high school diploma or less, and a higher percentage with a bachelor’s degree enrolled in the DHP compared with the sample that did not enroll. Among the automatic enrollment groups, there was a higher percentage of men among DHP (Table 3). There was also a higher percentage of Hispanic individuals among the enrolled as compared with the nonenrolled.

Within the pooled regression controlling for demographics and enrollment strategy, we found that indi-

■ **Figure.** Data Flow Chart for 11 Companies Offering the DHP



DHP indicates Diabetes Health Plan.

■ **Table 2.** Baseline Employer-Level Characteristics of Voluntary DHP Enrollment and Automatic DHP Enrollment

Employer-level characteristic	Voluntary Enrollment Groups (n = 6)	Automatic Enrollment Groups (n = 5)	P
Mean number of employees (SD)	8661 (3586)	11,117 (13,988)	.69
Mean employee age (SD)	30.5 (4.5)	40.9 (14.2)	.12
Mean % female (SD)	45.5 (3.6)	49.3 (6.5)	.26
Mean employee salary (SD)	\$65,513 (5505)	\$65,037 (6377)	.90
Mean % of employees with diabetes (SD)	3.8 (2.3)	5.7 (1.6)	.15
<b>Race/ethnicity distribution of employees</b>			
Mean % white (SD)	61.1 (8.3)	64.1 (17.8)	.72
Mean % Hispanic (SD)	16.7 (9.0)	14.8 (18.0)	.83
Mean % black (SD)	12.1 (14.7)	7.7 (5.6)	.55
Mean % Asian (SD)	2.0 (1.2)	1.9 (1.5)	.91

viduals within an automatic enrollment setting were 58 percentage points more likely ( $P < .01$ ) to enroll than those in a voluntary enrollment group. In the stratified adjusted analyses with all predictor variables simultaneously included (Table 4), within voluntary enrollment groups we found that black individuals were more likely to be enrolled in the DHP (+8 percentage points,  $P = .01$ )

compared with white individuals. We also found that covered dependents were less likely to be enrolled in the DHP than employees ( $-10$ ,  $P < .001$ ), and individuals with annual household incomes of  $\geq \$125K$  were more likely to be enrolled in the DHP than individuals with incomes of under  $\$30K$  ( $+17$ ,  $P = .04$ ). Individuals in the aged 45-54 years group were also more likely to be enrolled in the

**Table 3.** Unadjusted Percent of DHP Eligible Patients With Diabetes From Either the Voluntary Enrollment Group or the Automatic Enrollment Group

Characteristics	DM Patients Offered Voluntary DHP Enrollment			DM Patients Offered Automatic DHP Enrollment		
	Enrolled (34.6%; N = 536)	Not Enrolled (65.4%; N = 1013)	P of $\chi^2$ Tests of Unadjusted Differences	Enrolled (91.2%; N = 3160)	Not Enrolled (8.8%; N = 305)	P of $\chi^2$ Tests of Unadjusted Differences
<b>Gender</b>						
Male (ref)	64%	60%	.11	54% <sup>a</sup>	42%	.00
Female	36%	40%	.11	46% <sup>a</sup>	58%	.00
<b>Age group</b>						
18 - <35 (ref)	4%	6%	.20	3%	3%	.75
35 - <45	17%	14%	.14	9%	7%	.29
45 - <55	42% <sup>a</sup>	34%	.00	29% <sup>a</sup>	18%	.00
55 - <64	37% <sup>a</sup>	47%	.00	60% <sup>a</sup>	72%	.00
<b>Race Group</b>						
White (ref)	58% <sup>a</sup>	53%	.04	66%	70%	.14
Hispanic	17% <sup>a</sup>	12%	.02	12% <sup>a</sup>	7%	.01
Black	18% <sup>a</sup>	28%	.00	13%	15%	.53
Asian	1%	1%	.97	1%	2%	.18
<b>Relationship</b>						
Employee (ref)	77% <sup>a</sup>	72%	.02	74% <sup>a</sup>	81%	.01
Dependent	23% <sup>a</sup>	28%	.02	26% <sup>a</sup>	19%	.01
<b>Household income</b>						
Under 30 (ref)	9%	12%	.09	8%	8%	.83
30 - 49	29% <sup>a</sup>	34%	.04	29%	28%	.73
50 - 74	26%	27%	.66	29%	31%	.41
75 - 124	24% <sup>a</sup>	19%	.02	26%	22%	.17
125 and over	5% <sup>a</sup>	2%	.00	3%	3%	.63
<b>Education level</b>						
HS or less (ref)	40% <sup>a</sup>	45%	.05	48%	48%	.93
Some college	48%	48%	.88	45%	45%	.93
Bachelor's and above	10% <sup>a</sup>	5%	.00	4%	5%	.43
<b>No. of non-diabetes comorbidities</b>						
0 (ref)	12%	13%	.73	8%	11%	.12
1	23%	24%	.68	19% <sup>a</sup>	12%	.00
2	35%	36%	.94	32%	31%	.63
3	16%	16%	.79	22%	23%	.58
≥ 4	14%	11%	.19	19%	23%	.06
<b>Employer group</b>						
1 (ref for voluntary groups)	9%	9%	.74			
2	15% <sup>a</sup>	7%	.00			
3	9% <sup>a</sup>	5%	.01			
4	21% <sup>a</sup>	63%	.00			
5	26% <sup>a</sup>	14%	.00			
6	21% <sup>a</sup>	2%	.00			
7 (ref for auto-enroll groups)	—			56% <sup>a</sup>	83%	.00
8	—			6%	5%	.55
9	—			30% <sup>a</sup>	9%	.00
10	—			4% <sup>a</sup>	2%	.02
11	—			4% <sup>a</sup>	1%	.04

<sup>a</sup>P < .05.

**Table 4.** The Adjusted Predicted and Marginal Probabilities of Being Enrolled in the DHP From Either the Voluntary Enrollment Group or the Automatic Enrollment Group

Characteristics	DM Patients Offered Voluntary DHP Enrollment		DM Patients Offered Automatic DHP Enrollment	
	Predicted and Marginal Probabilities of Being Enrolled	P	Predicted and Marginal Probabilities of Being Enrolled	P
<b>Gender</b>				
Male (ref)	0.33		0.92	
Female	+0.04	.13	-0.01	.15
<b>Age group</b>				
18 to <35 (ref)	0.28		0.94	
35 to <45	+0.06	.26	+0.00	.93
45 to <55	+0.10	.03	+0.01	.58
55 to <64	+0.06	.23	-0.06	.02
<b>Race Group</b>				
White (ref)	0.33		0.90	—
Hispanic	-0.02	.52	+0.05	.00
Black	+0.08	.01	+0.02	.21
Asian	-0.05	.61	-0.03	.59
<b>Relationship</b>				
Employee (ref)	0.37		0.91	
Dependent	-0.10	.00	+0.02	.02
<b>Household income</b>				
Under 30 (ref)	0.32		0.92	
30-49	+0.04	.38	-0.01	.50
50 -74	+0.01	.86	-0.03	.16
75-124	+0.02	.61	+0.00	.89
125 and over	+0.17	.04	-0.01	.86
<b>Education level</b>				
HS or less (ref)	0.33		0.91	
Some college	+0.01	.71	+0.01	.45
Bachelor's and above	+0.08	.17	-0.03	.35
<b>No. of non-diabetes comorbidities</b>				
0 (ref)	0.32		0.88	
1	+0.01	.79	+0.06	.00
2	+0.02	.53	+0.04	.09
3	+0.02	.71	+0.03	.13
≥ 4	+0.08	.06	+0.02	.36
<b>Employer group</b>				
1 (ref for voluntary groups)	0.38		—	
2	+0.20	.00	—	
3	+0.14	.03	—	
4	-0.24	.00	—	
5	+0.12	.01	—	
6	+0.50	.00	—	
7 (ref for auto-enroll groups)	—		0.87	
8	—		+0.03	.16
9	—		+0.11	.00
10	—		+0.10	.00
11	—		+0.07	.01

DHP (+10,  $P = .03$ ) compared with individuals between 18 and 35 years of age. Examining the automatic enrollment groups, we found no significant differences by patient income or education, but Hispanics were more likely to remain enrolled in the DHP than white individuals (+5,  $P < .001$ ), and covered dependents were more likely to remain enrolled in the DHP than employees (+2,  $P = .02$ ). Individuals aged between 55 and 64 years were less likely to remain enrolled in the DHP (-6,  $P = .02$ ) compared with individuals aged between 18 and 35 years.

Finally, statistically significant differences in enrollment by employer group were observed within both the voluntary and automatic enrollment groups. In particular, rates of DHP enrollment among employers using the voluntary enrollment approach varied from 14% to 88%.

## DISCUSSION

In summary, enrollment rates varied *within* the groups of employers using voluntary and automatic enrollment approaches, as well as *between* employers using voluntary enrollment and those using automatic enrollment approaches. In the voluntary enrollment groups, black individuals and high-income individuals were more likely, and covered dependents less likely, to “opt in.” In the automatic enrollment groups, Hispanic individuals and covered dependents were less likely to “opt out.” We also observed significantly higher rates of enrollment across all subgroups in the automatic enrollment approach as compared with voluntary enrollment.

The 2 enrollment strategies that we compared require very different levels of patient engagement and initiative. In workplaces offering voluntary enrollment, eligible individuals must take personal initiative to enroll. They must first become aware of the program and then proceed through the proper channels or complete tasks required for enrollment (ie, contact the appropriate representative to request an application form for enrollment, then complete and return the form). However, employees who are automatically enrolled are only required to take any action if they choose **not** to participate.

In addition, the reasons for not being enrolled under each strategy are likely very different. There are numerous potential barriers to entry in a voluntary enrollment system, which may include poor communication about the program, lack of understanding of the program, and/or the opportunity cost of the time associated with the enrollment process. Within an automatic enrollment system, employees who choose to opt out may do so because they have an existing competing insurance plan, are in-

sured under another family member’s plan, or for another financial or health reason.

We found that covered dependents were significantly less likely than employees to be enrolled within voluntary enrollment, but were significantly more likely to be enrolled under the automatic enrollment strategy. Covered dependents were required to meet the same eligibility requirements as eligible employees. It is possible that covered dependents were less likely to be aware of the DHP and voluntarily enroll, since they may not have received promotional communications distributed at the workplace. On the other hand, covered dependents may be less likely to have typical “opt out” reasons such as a better benefit through a spouse or a choice of a different health insurance plan. Therefore, they may be less likely to opt out under automatic enrollment.

We also found that affluent individuals (annual household incomes of \$125K or more) were much more likely to voluntarily enroll in the DHP than individuals with annual household incomes of less than \$30K. Co-payment reductions are more likely to influence adherence among individuals for whom the out-of-pocket cost of medications is a greater burden.<sup>10</sup> To the extent that program-related resources are disproportionately devoted to higher income groups, the DHP goal of reduction in cost-related nonadherence may be less pronounced with use of a voluntary enrollment approach.

Among racial/ethnic groups, we found that Hispanics were least likely to make an “active” enrollment choice about their health insurance by opting out. This is consistent with prior studies showing lower levels of initiating use of outpatient health services by Hispanics compared with other racial/ethnic groups.<sup>10-11</sup> Language barriers or beliefs about healthcare have been listed as possible causes of these differences.<sup>12-13</sup> An automatic enrollment approach may be one way to overcome racial disparities in employer health program participation. Research has shown that the type of health insurance an individual is offered has the strongest effect on healthcare utilization among Hispanics, as rates of preventive care used among Hispanics were much greater among those enrolled in HMO as opposed to fee-for-service plans, suggesting that co-payment or coinsurance costs may be a major deterrent for seeking preventive care.<sup>15</sup> Since the DHP, is designed to minimize or eliminate co-payments, this type of value-based benefit feature combined with an automatic enrollment approach could potentially increase use of both diabetes-specific services (eg, routine A1C checks and retinal exams) as well as general preventive services (eg, mammograms).

The strongest determinant of enrollment rates within both voluntary and automatic enrollment groups was the employer. We believe that these differences may be driven by variation in marketing the plan to employees, use of financial incentives for participation at the employee level, and implementation of compliance criteria. Although the study team did not collect this information in a standardized manner, communications with the health plan design team indicate that employers with the highest voluntary enrollment rates tend to be those that offer multiple wellness programs or incentives, and have designated wellness champions or wellness committees who take an active role in decisions about health programs.

Our analysis has 2 notable limitations. First, no small or medium-sized employers (<1000 employees) purchased the DHP so the analysis is limited to large employers. We are therefore unable to generalize these results to smaller companies. However, because of this, the results are unlikely to be affected by changes caused by the Affordable Care Act, as these individuals eligible for the DHP were with larger companies already offering insurance. Secondly, potential ceiling effects may limit the ability of our analyses to detect differences in enrollment rates with the automatic enrollment strategy.

The first and arguably most important barrier to access for any health plan or health program is enrollment of eligible individuals. Our findings of increased enrollment of blacks and higher-income individuals with voluntary enrollment, as well as a higher probability of remaining enrolled for Hispanics and covered dependents with automatic enrollment, may help inform future policies that involve employer health programs. It is important to note that employees who are automatically enrolled may be less likely to fully engage with the benefits and features available, which may diminish the overall effectiveness of the program. The administrative burden of including these less engaged individuals in a health program may present an excessive burden in certain cases. Conversely, programs that use a voluntary enrollment approach are likely to have more engagement among participants but will likely need to make a large upfront investment in time and financial resources to drive enrollment.

Forthcoming analyses will evaluate the effectiveness of the DHP in terms of key outcomes such as control of cardiovascular risk factors, utilization of care, and total costs. However, based on previous research, we expect that lower cost-sharing applied across entire populations will enhance medication adherence and may also drive these more distal outcomes.<sup>17-18</sup> In a quickly evolving health policy environment, innovative ideas and a strong push

in the direction of wellness and population management will likely result in millions of dollars being spent on new health promotion programs. If these programs enroll only small and unrepresentative proportions of targeted individuals, it will be very difficult not only to evaluate the likely impact on the larger population, but also to disseminate effective programs to a broad spectrum of eligible individuals. An automatic enrollment approach may prove critical in overcoming entrance barriers that hinder participation in health promotion programs that may ultimately decrease costs and lead to better health outcomes.<sup>4-6,19</sup>

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