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National Alliance of Healthcare Purchaser Coalitions
Driving Innovation, Health and Value

Action Brief

OBESITY

Confronting a Misunderstood and Undermanaged Workforce Disease

The importance of enhancing benefits to support needed medical care

ACTION STEPS FOR EMPLOYERS

1. Know the science. The processes that regulate appetite and energy become dysfunctional in obesity, which makes losing weight and keeping it off more difficult.
2. Prevent when possible. Many who are overweight do not progress to obesity when identified as being at-risk and given access to proper preventive care. Work with health plans and other vendors to ensure prevention is embedded in your benefits.
3. Get the data. Getting a true picture of your population risk will require health plan, PBM, and wellness vendors to work together and share data. Does your plan know how many of your employees have obesity? Are they educating physicians about treating and coding for the disease?
4. Know your coverage. Work with your PBM and health plan to ensure that coverage for evidence-based behavioral, pharmacological and surgical interventions are adequate and prudent.
5. Fight stigma. Treating obesity as a disease in communications and benefit plan design reduces stigma and encourages employees to get the care they need.

Obesity is common, serious and costly, affecting nearly 40% of the U.S. adult population at an estimated annual cost of $147 billion...and rising. It's clear that tactical attempts to address overweight and obesity — discounts to health clubs, occasional "lunch and learns," improved cafeteria offerings — aren't working for those at risk. This *Action Brief* highlights the barriers to effectively addressing obesity and suggests solutions. It's time to move past the stigma, look at the challenge objectively, and treat obesity as a disease.

WHY EMPLOYERS SHOULD CARE

- **Healthcare Costs are high.** The estimated annual health care costs of obesity-related illness are staggering at nearly 21% of annual medical spending in the U.S.[1] Further, healthcare costs are up to 46% higher and prescription drugs costs are 80% higher for individuals with obesity than for those who do not have obesity.[2]
- **Lost productivity costs are worrisome.** Compared to employees of healthy weight, employees with obesity have diminished productivity in the form of absenteeism (up to 57% more likely to be absent); presenteeism (up to 22 more days of presenteeism); and disability (76% increased risk of short-term disability).[3]
- **It's not getting better.** No progress has been made in stemming what is now being called a pandemic. The CDC reports that rates of obesity increased about 15% — to nearly 40% of the US adult population — over the most recent eight years of data.

- **The future work force is at risk.** The largest increase in severe obesity is among 18– to 29–year-olds. Because longer exposure to obesity is likely to be correlated with increased obesity-related conditions (e.g., hypertension, stroke, coronary heart disease, type 2 diabetes, dyslipidemia, osteoarthritis, depression, sleep apnea, asthma, and certain cancers) and disability, it is likely to have a greater effect on work limitations and employment in the future.[4]

A FAR-REACHING ISSUE AFFECTING MULTIPLE STAKEHOLDERS

Like most diseases, there are a number of stakeholders involved.

- **Doctors.** Research shows that patients are more likely to engage in weight management if their doctor brings it up, **but only 55% of people with obesity reported being diagnosed with within the past five years.** Because less than one-third of physicians have confidence treating obesity, many face significant barriers.[5] They may not be trained to open these sensitive conversations, know how to code and be paid for the work, or understand treatment options or where to refer patients who are ready to take action.
- **Health plans.** Many health plans offer access to evidence-based weight management programs, **but many identify only about 5% to 8% of their members as obese.** With plans able to enroll less than 30% of identified members into available programs, very few members actually enroll. Additionally, health plans often do not communicate with network physicians about talking to patients, treating or referring for treatment, and coding for reimbursement.
- **Healthcare purchasers.** Purchasers have the buying power to influence the entire system, however many continue to address obesity as a personal lifestyle issue. Accordingly, they apply the same strategies that haven't worked for the past 30 years. While walking trails, improved cafeteria offerings, and discounts to health clubs are attractive benefits, they do not alter obesity levels. **While 72% of purchasers provide some support, only 17% of employees with obesity perceive it as useful.**[6]

THE MEDICAL SIDE: OBESITY IS A DISEASE

Research has revealed complex physiological underpinnings to obesity. Adipose tissue (fat) actively impacts processes and substances in the body related to hunger, diabetes, blood pressure, and more. People with obesity have more trouble losing weight because of these changes. The American Medical Association, National Institutes of Health, Centers for Medicare and Medicaid Services, Obesity Society, Institute of Medicine, and American Association for Clinical Endocrinology have all declared obesity to be a disease.

- **Causes of obesity.** Obesity is caused by many factors. In today's environment, food contains more calories, and the environment has led to a decrease in physical activity. Although diet and exercise play a role, an individual's biology—which includes genetic predisposition and hormonal regulation—personal economics, psychology, and even maternal status play more a part than previously thought.
- **Diagnosis of Obesity.** Body Mass Index (BMI) is used as the screening tool for overweight or obesity. Just as there are numeric cut-off measures for conditions such as diabetes, blood pressure, and cholesterol, obesity is defined as a body mass index (BMI) ≥ 30. Crossing this diagnostic level has a serious impact on health and costs.

THE CONTINUUM OF OBESITY TREATMENT OPTIONS

Lifestyle/Diet/Exercise	Pharmacotherapy	Bariatric Surgery
Indicated for all, across all spectrums[1]	Indicated for BMI ≥30 or BMI ≥27 with risk factors[1]	Indicated for BMI ≥40 or BMI ≥35 with risk factors[1]
Low invasiveness	Medium invasiveness	High invasiveness
~3–4% mean weight loss[2]	~3–9% mean weight loss[3]	~23% mean weight loss at 2 years[4] ~15% mean weight loss at 15 years[4]

1. Jensen MD, et al. J Am Coll Cardiol. 2014;63(25 pt B):2985-3023. 2. Dunkley AJ, et al. Diabetes Care. 2014;37 (4):922-933. 3. Yanovski SZ, et al. JAMA. 2014;311(1)74-86. 4. Sjostrom L. J Intern Med. 2013;273(3):219-34.

FOR PURCHASERS: A NEW APPROACH TO OBESITY

THE USUAL APPROACH: JUDGMENTAL AND INCONSISTENT

Purchasers have typically treated obesity as something caused by insufficient willpower, lack of discipline, and bad choices, only recognizing it as a medical issue and providing access to bariatric surgery in extreme cases. Support has been inconsistent and informal, with no strategic plan to address the issue. Although obesity has been recognized as a disease for several years, it is not typically addressed as such by either purchasers or the healthcare system, while co-occurring conditions (listed on page 1) are treated and covered.

THE NEW APPROACH: SCIENTIFIC AND STRATEGIC

Purchasers need to address obesity in the same way they address the conditions associated with it. Examples include actively identifying and engaging the affected population; providing adequate behavioral, pharmacological, and surgical benefits; and expecting that disease management, wellness, pharmacy, and medical vendors exchange data related to obesity. It's never been more important to lay to rest the stigma that obesity is a lifestyle choice.

COMPREHENSIVE OBESITY TREATMENT COVERAGE

Behavioral. Choose evidence-based obesity programs, such as the National Diabetes Prevention Program (see sidebar), and tie coverage to success. Include improved access to healthy foods and physical activity.

Pharmacological. Pharmacological treatments have been shown to have a significant impact on weight management. Purchasers can implement co-pays and prior authorizations that manage financial risk, adjusting them as they gain comfort (see sidebar).

Surgical. As with pharmacological and behavioral support, purchasers

established guidelines are readily available. Centers of Excellence are best able to support patients before and after surgical procedures.

Pharmacotherapy Options

According to FDA labeling, medications should be used as an adjunct to a reduced-calorie diet and increased physical activity. A recent Action Brief from the Greater Philadelphia Business Coalition on Health points out that research shows those who couple lifestyle therapy with a pharmacotherapy weight loss program lose between 3% and 9% more on average than those strictly focused on a lifestyle plan (see Resources). Medications should be for adult patients with a BMI of ≥30 (obese) or ≥27 (overweight) with at least one weight-related comorbid condition. If patients have not achieved at least 4% to 5% weight loss within 12-16 weeks (depending on medication), the medication should be discontinued. Typically, anti-obesity medication coverage will also include prior authorization (PA) language to ensure appropriate utilization.

"Lack of coverage for weight-loss treatments including medical visits for overweight treatment, behavioral health intervention, anti-obesity medications, and bariatric surgery is the single biggest obstacle to dealing effectively with overweight and obesity at the employer level. Employers can play an important role by changing their messaging, increasing access to treatments, and exerting their leverage with the delivery system to align with evidence that obesity needs to be treated as a medical disorder."

— Louis J. Aronne, M.D.
Director of the Comprehensive Weight Control Program at Weil Cornell Medicine
Chairman, American Board of Obesity Medicine

Preventing Type 2 Diabetes

The National Diabetes Prevention Program (DPP) lifestyle change program is a year-long intervention that is delivered in person, online, through distance learning, or through a combination approach in group settings. The program includes a 16-segment curriculum spread over 12 months and must meet stringent CDC requirements. Research shows that people with prediabetes who take part in this structured lifestyle change program can cut their risk of developing type 2 diabetes by 58% (71% for people over age 60 years).[8] Losing just 5% to 10% of body weight also results in a reduction in cardiovascular risk factors and improvements in blood pressure and blood lipid profile.

Widespread Bias

Bias against people with obesity is common and serious. Studies indicate that weight-based discrimination increased by 66% from 2000 to 2010, with prevalence rates comparable to race-based prejudice. Bias within the health care profession is similar to or worse than the general public. Even professionals attending an obesity conference reported significant weight stigma.[7]

Measuring Up: eValue8 and its related PBM assessment measure processes used by health plans and PBMs to achieve cost-effective member health

Even though the primary means of gathering data for action is through physician ICD coding, eValue8™ shows that:

- 67% of plans DO NOT **promote** use of obesity ICD Codes
- 60% of plans DO NOT **reimburse** for obesity ICD Codes

Studies show that patients who are advised by their physicians are far more likely to take action on health risks.

- 80% of plans DO NOT provide incentives for physicians to **screen** for obesity
- All but two of the responding PBMs have LESS THAN 1% of members taking AOMs.

RESOURCES

- National Alliance Obesity Portal (podcasts, templates and articles offer new research about obesity as a disease)
- Greater Philadelphia Business Coalition on Health Action Brief: Covering Prescription Weight Loss Therapies to Address Obesity
- Novo Nordisk WORKS™ helps employers understand the value of chronic weight management and provides resources to help organizations improve, maintain and monitor employee health and wellness.
- National Diabetes Prevention Program (National DPP)
- NDPP Economic Assessment Tool developed by researchers from the University of Colorado School of Medicine under contract with the Colorado Business Group on Health.
- Weight Control and the Workplace: Northeast Business Group on Health

ENDNOTES

1. Fast Facts: The Cost of Obesity
2. The Epidemiology of Obesity: A Big Picture
3. Productivity Loss due to Overweight and Obesity: A systematic Review of Indirect Costs
4. Long-term Effects of Obesity on Employment and Work Limitations
5. A Cross-cultural Analysis of Physician Management of Obesity
6. Anti-fat Prejudice Reduction: A Review of Published Studies
7. Perceptions of Barriers to Effective Obesity Care: Results from the National ACTION Study
8. The National Diabetes Prevention Program

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