Obesity in (Corporate) America:
Large Employer Concerns and Strategies of Response

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The epidemic of obesity in America has been likened to "a massive tsunami heading towards the shoreline".[1] Employers understand very well that they and their employees finance healthcare in the United States, either directly through the purchase of employer-sponsored healthcare or indirectly as corporate and individual taxpayers for publicly provided care. If the obesity tsunami strikes with the gale force predicted, employers will see financial and human capital effects even greater than those they now face. An expected proliferation of new treatment options will further challenge cost and quality management efforts.

A Familiar Problem

Compared to five years ago, employees are paying 64% more in healthcare costs today and employers are paying 78% more.[2] As health costs dramatically outpace economic growth, both private and public resources are reallocated to cover this burgeoning expense. The high cost of healthcare limits job growth and wage increases, leads to higher numbers of uninsured Americans, and diverts resources from other social needs, such as education, which, along with healthcare, is critical to ensuring a competitive workforce in years to come.

Employers, as purchasers of healthcare, try to (1) stem the growth in spending on healthcare and (2) ensure they are paying for quality. It is a terrible truth that while United States healthcare expenditures are out of control, we are still not receiving care commensurate with established quality standards more than about half the time.[3] Of the multitude of strategies deployed by employers over the years for dealing with these quality of care issues, some of the more enduring include: disease management and health improvement programs, employee cost-sharing and plan design changes to limit or restrict coverage, information and incentives for employees to manage their own health, and strong support for the National Committee for Quality Assurance's HEDIS (Health Plan Employer Data and Information Set) performance measures and other quality purchasing initiatives. Newer pay-for-performance incentives also appear promising.[4]

Current Game Plan: Health Improvement

Increasingly large self-insured employers, especially those with high employee retention, see their challenge as *population health management*. The argument that trends in health spending can be managed by improving employee (and dependent) health status appears to hold. Employers therefore are focused on reducing the number of health risks (e.g., high blood pressure, unhealthy weight gain, high cholesterol, sedentary lifestyle, poor diet, high stress, etc.) across their population in an effort to flatten the cost trend. Such health improvement/risk reduction efforts often co-exist with "disease management" programs targeting individuals with diabetes, back pain, heart disease, etc.

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Employers work with health plans, consultants, and vendors to develop and execute their own population health strategy. Typically an analysis of medical claims data and health risk appraisal (HRA) biometric information sets the stage. Sometimes employees are surveyed to determine their priorities. Specific programs are purchased from health plans or other companies to address priority areas; program cost and intensity are tied to an expected financial return. Financial incentives for employees/dependents are commonly used to encourage participation.

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Evidence that this may be working comes from published literature on return-on-investment from well designed health promotion programs.[5] In addition, employee benefits consultants have shown that companies identified as "best performers" (i.e., experiencing the lowest medical cost trend) are disproportionately found to be early adopters of aggressive health improvement programs.[6]

Ultimately, however, these efforts to improve population health may be swamped by the increasing numbers of obese individuals and the corresponding, exponentially increasing, healthcare costs. Unless employers can "turn the tide," costs are more likely to escalate than flatten.

Senior Leadership Response

The bigger the bite healthcare takes out of corporate profits, the higher healthcare falls on the CEO and CFO priority list. The magnitude of expense affects global competitiveness (for example, think of the $1,500 added to the price of every GM car to cover healthcare). It also can directly impact earnings per share (EPS), as in the Fortune 500 company whose CEO reported a drop of $0.19 in EPS due to an overage in health-care expenses (i.e., the amount actual expenses exceeded the healthcare budget in a year).

More and more companies, with top leadership support, are intensifying their efforts to:
- Define a strategy based on company data and consistent with corporate culture to improve employee health, establishing appropriate goals and measures.
- Communicate with employees and dependents about why healthy weight and healthy lifestyle improvements are a win-win opportunity, using corporate branding and messages tied to business goals.
- Provide tools and incentives to help employees and dependents understand their own health risk profile and start to improve their personal health risks.
- Create a supportive work environment, including healthy on-site dining, vending and catering for employees as well as opportunities for physical activity at work and on the employee's own time.
- Develop a benefit plan that, consistent with company resources, reflects the importance of a non-sedentary, non-smoking, healthy-weight workforce.

Companies who are engaged in these activities may apply for the National Business Group on Health's *Best Employers for Healthy Lifestyles* awards. Platinum, Gold and Silver award levels recognize large employers who have implemented robust health and wellness programs at the worksite; 57 awards have been made in the first two years of the program. Examples of Platinum winners include: Aetna, Florida Power & Light, IBM, Johnson and Johnson, Pitney Bowes, and Union Pacific Railroad.

Overweight and Obesity Compound the Problem

It is well documented that overweight and obesity are important drivers of healthcare costs both today *and* tomorrow. Physicians provide (and employers finance) care for more cases of diabetes, hip, knee and back problems, cancer, heart disease, high-risk pregnancy and many other conditions due to the prevalence of obesity, especially severe obesity, and its complications. One study attributed 27% of private insurance spending increases between 1987 and 2001 to obesity.[7]

In addition, obesity itself is beginning to be treated as a disease with drugs, surgery, and behavior therapy in various combinations. We have seen only the tip of the proverbial iceberg to date. *Treated prevalence* is growing rapidly, and along with this growth in treated prevalence, significant cost increases are expected (similar to the increase in costs for treated hyperlipidemia when widespread use of cholesterol-lowering medications became the standard of care). Although per case costs are high, it is the treated prevalence that drives the total cost, according to Thorpe's work in the privately insured market.[8]

For example, a large employer (35,000 employees) in the northeast discovered that 85% of its employees are overweight or obese, with only 15% currently at a healthy weight. It is not a stretch to assume that half of the 85% (14,875 employees) might qualify for a new weight loss drug expected to receive FDA approval in late 2006. Imagine the economic impact of putting even 14,875 employees on a new prescription drug at an estimated $1,800 per person—nearly *$27,000,000 per year*, for a drug that is prescribed indefinitely.

The provider community views the epidemic of obesity as a tremendous opportunity; from this perspective, the "unmet need" is pressing. Because fewer than five percent of obese Americans are now receiving surgery, drugs and/or behavioral therapy for obesity, the remaining 95% of the obese patient population—some 58 million people—can be seen to represent "unmet need." If even a fraction of those millions begin receiving obesity care, the costs can be staggering, given the high cost of treatment per patient (for new drugs in the pipeline, surgeries such as the lap band and gastric bypass, and others still in development) and, especially, the vast number of potentially eligible patients.

Arguments will be made that obesity surgery cures diabetes, and that the return on investment is such that the treatments achieve breakeven in a few years' time. It's likely that some treatments will prove cost-effective for *some* patients, but in many cases coverage is requested without standardized treatments or patient selection protocols.

The Challenge

Increasingly, employers recognize that *everyone* needs weight management. Those (often younger) employees with healthy BMI levels (<25) need to be encouraged and supported to maintain their health. Those in the overweight-to-obese category (BMI 25-35) are candidates for various types of weight loss

programs (group support, individual coaching, medically supervised, etc.). And those in the over-35 BMI category need individualized plans and are, potentially, candidates for surgical treatment.

Historically very little insurance coverage has been provided until patients reach a BMI of 35 or greater and present with co-morbidities. Today, however, employers are asked to cover everything from Weight Watchers at Work to gastric bypass surgery with subsequent excess skin removal. Given the importance of weight management at lower and moderate BMI levels, as well as in the pediatric population, employers are reevaluating their benefit plans and coverage policies.

Evidence-based benefit design is the goal, and offers the best answer to the question: Which obesity treatments should be covered? Even partial coverage would help assure quality standards and allow employees to benefit from network pricing in every category (outpatient pharmaceuticals, behavioral therapy/ lifestyle management, bariatric surgery). But how can the already-burdened employer-sponsored health plan take on a new category of expense that, given the prevalence of the problem, is likely to increase medical spending so significantly? In any case, employees will need to brace for even more cost-sharing and the likelihood of much higher cost-sharing, or no coverage, for high-cost services related to health problems associated with individual lifestyle choices. **NCMedJ**

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