Implications for Plan Sponsors of Obesity’s Designation as a Disease

Obesity is a major risk factor for serious chronic diseases and conditions including, but not limited to, type 2 diabetes, hypertension, sleep apnea, gallstones, infertility, varicose veins, gout, osteoarthritis and deep vein thrombosis (DVT). The financial impact of obesity related diseases and treatments on medical plan budgets can be significant. Medical care costs associated with obesity were about $147 billion in 2008, according to a study cited by the Centers for Disease Control and Prevention.1

In June 2013, the American Medical Association (AMA) voted in favor of recognizing obesity as a disease that requires medical treatment.2 According to the AMA, recognizing obesity as a disease will help change the way the medical community tackles this complex issue that affects more than 78 million American adults (35.7 percent of adults) and 12 million children (16.9 percent of children).3 (The text box below discusses how obesity is defined.)

The supporters of the move claim that it makes diagnosis and treatment of obesity a physician’s professional obligation. More than half of obese patients have never been told by a medical professional they need to lose weight.4 Some doctors are reluctant to offend their patients by telling them that they are obese and/or are unwilling to open a discussion that will result in a lengthy consultation for which they might not be reimbursed.

Calling obesity a disease is not without controversy. Opponents of this AMA vote believe it will shift the nation’s focus too much toward expensive drug and surgical treatments and away from measures to encourage healthy diets and regular exercise.


Who Is Considered Obese?

According to the Centers for Disease Control and Prevention, an adult is obese if his or her body mass index (BMI) is 30 or higher. For comparison purposes, a person with a BMI between 18.5 and 24.9 is considered to have a healthy weight, while a person with a BMI between 25 and 29.9 is overweight.

BMI for adults is calculated by taking weight (measured in kilograms) and dividing it by the square of the person’s height (measured in meters). For those who prefer standard measurements, measure weight in pounds, divide it by the square of height measured in inches, and multiply the result by 703.

It should be noted that these government-set BMI measurements have limitations. For example, the BMI definition of obesity is not useful for those who are athletic (because they typically have more muscle mass/weight and low body fat). Consequently, some medical professionals prefer measuring waist circumference as a measure of obesity. However, the BMI metric is an adequate starting point for most patients and doctors.

The Internal Revenue Service (IRS) has long recognized obesity as a disease. Consequently, a weight-loss program prescribed by a physician to treat obesity is considered a medical expense under Section 213(d) of the Internal Revenue Code. Moreover, obesity screening and counseling is a preventive benefit under the Affordable Care Act, and non-grandfathered plans must cover such care with no patient cost-sharing requirement.

After noting how obesity treatments typically are covered today, this Newsletter discusses the implications for plan sponsors of the AMA’s designation of obesity as a disease.

**Coverage for Obesity Treatments Today**

Today, coverage of obesity-related treatments is inconsistent. Most plans either do not cover the treatment or provide spotty coverage. Sources vary on the exact percentage of group plans that cover weight-loss coverage with or without covering bariatric surgery.

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### How Coverage for Obesity Treatment Is Likely to Change Based on Obesity’s Designation as a Disease

In response to the AMA’s designation of obesity as a disease, coverage for obesity treatment is likely to change. Like most other diseases, there are three potential treatments for obesity:

- **Clinical or Non-Clinical Counseling with Group or Personal Support Services** Jenny Craig and Weight Watchers have been available to workers for years to help overweight and obese members lose weight and keep it off. More recent weight-loss tools, like FitBit, use technology to help people track their progress. A growing body of expertise around behavior modification is helping clinicians to improve the efficacy of weight-loss programs. However, studies suggest that although very high number of participants can lose weight, most have trouble keeping the weight off.

- **Prescription Drug Therapy** There are two relatively new drugs approved by the Food and Drug Administration (FDA) for treating obesity: Qsymia® and Belviq®. Qsymia was viewed as potentially a first-line obesity drug for many patients, but the current lack of or restricted mail-order-only coverage has prevented its widespread adoption. Although these drugs are expensive (around $200 per prescription per month) the duration of the drug therapy will vary by patient.

- **Surgical Intervention** As more and more providers perform gastro-bypass procedures, the efficacy strengthens and the risks of surgical complications decline. Bariatric surgery, which costs, on average, $20,000 to $25,000, has perhaps the best data supporting positive outcomes. The science behind some of these unexpected favorable outcomes (e.g., eliminating diabetes in diabetics) is not clear, but there are changes that go well beyond the direct effects of the surgery, and seem to impact hormonal balance and change the “setpoint” that often works against traditional weight-loss approaches. Given that surgery has risks, plan sponsors should help patients study quality results by provider and facility. Other surgical approaches, such as the gastric sleeve, while not as efficacious as bariatric surgery, could gain favor because of the convenience of performing the procedures, and potentially lower risk of surgical complications. Lap bands may be losing some of their attraction because of the degree of post-surgical care required.

For the public Marketplaces created by the Affordable Care Act for individuals to purchase coverage, 23 states chose benchmark plans that cover bariatric surgery. Under the Affordable Care Act, more insurance plans are expected to start covering the cost of obesity treatments, including counseling on diet and exercise, surgery and medication, as long as they are approved by the

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9 For information about these drugs, refer to an online supplement to this Newsletter: [http://www.segalo.com/publications/newsletters/714update.pdf](http://www.segalo.com/publications/newsletters/714update.pdf)

10 This data is from the National Institute of Diabetes and Digestive and Kidney Diseases, which is part of the National Institutes of Health: [http://www.nlm.nih.gov/pubs/policymb/forall/8009.html](http://www.nlm.nih.gov/pubs/policymb/forall/8009.html)

FDA and the treatment is prescribed by a physician. The U.S. Preventive Services Task Force recommends that health care providers offer or refer patients with a BMI of at least 30 to intensive, multi-component behavioral interventions, which would include weight-loss programs that have 12 to 26 sessions in a year and that include a variety of activities and strategies to help them lose weight. The federal agencies responsible for implementing the Affordable Care Act have not yet directed plan sponsors to pay for 12 to 26 sessions per year, but the preventive services coverage requirements are subject to change, and should be monitored for future developments.

The Affordable Care Act also addressed wellness programs. The final rule implementing those provisions increased the amount of a reward that may be provided through a wellness program and tightened requirements for “health-contingent wellness programs” that require individuals to achieve specific health targets, such as weight loss, before they are eligible for a reward.

**Should Plan Sponsors Be Worried About the Additional Costs of Coverage?**

To some extent, the designation of obesity as a disease will increase plans’ immediate costs. However, over the long term, covering obesity treatments is likely to save plans money by avoiding serious and costly chronic diseases and conditions for which obesity is a major risk factor.

Designating obesity a disease will reduce the stigma that stems from the widespread perception that it is simply the result of eating too much or exercising too little, when in reality some people do not have full control over their weight. Recognizing this, more people will seek treatment under the diagnosis of obesity, as opposed to waiting to receive treatment until they develop one of the obesity-related conditions.

Ultimately, prudent plan sponsors will get ahead of this issue and structure benefit coverage to support effective weight reduction and management programs in a manner that reduces wasteful spending and holds providers and patients accountable for taking action to best manage this disease. When significant weight loss occurs, by any means, the result is highly observable to co-workers. The risk of regaining weight is real. An organizational culture that supports health improvement, empathy and respect toward others will go a long way toward helping individuals develop and maintain new positive health habits.

The potential savings are substantial. As shown in Graph 1, the Mayo clinic found that annual medical costs for its obese employees and adult dependents were thousands of dollars more than for non-obese employees and dependents. Graph 2 on the next page shows how a Segal client’s monthly per-participant costs break down by participants’ waist size.

**Cost-Management Strategies**

Plan design can be used to ration spending in a prudent fashion (e.g., reference-based pricing of surgery linked to target provider costs, prior-authorization for approval of prescription drug therapy). There are several strategies for dealing with the short-term cost increase associated with obesity’s designation as a disease:

> **Institute “step-therapy” for obesity treatment.** This approach might start with nutrition and exercise counseling. If that proves insufficient, the plan might cover one or both of the FDA-approved prescription drugs. Surgeries can be the last resort if everything else fails.

**Graph 1: Amount by Which Annual Medical Costs for Overweight and Obese Employees and their Adult Dependents Exceed the Costs for Healthy Weight Employees and their Adult Dependents**

<table>
<thead>
<tr>
<th>Waist Size</th>
<th>Additional Annual Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight</td>
<td>$1,850</td>
</tr>
<tr>
<td>35–40 BMI</td>
<td>$3,086</td>
</tr>
<tr>
<td>40+ BMI</td>
<td>$5,530</td>
</tr>
</tbody>
</table>

Source: Moriarty, James P. MSc; Branda, Megan E. MS; Olsen, Kerry D. MD; Shah, Nilay D. PhD; Borah, Bipan J. PhD; Wagle, Amy E. BS; Egginton, Jason S. MPH; Naessens, James M. ScD. “The Effects of Incremental Costs of Smoking and Obesity on Health Care Costs Among Adults: A 7-Year Longitudinal Study.” *Journal of Occupational & Environmental Medicine* – 54.3 (2012): 286–291.

Over the long term, covering obesity treatments is likely to save plans money by avoiding serious and costly chronic diseases and conditions for which obesity is a major risk factor.”
Require prior authorization for covering obesity treatments. Under this approach, physicians must report information to the plan on a patient’s biometrics and prior efforts, in order to seek approval of a treatment plan.

Choose narrow networks or Centers of Excellence for complex surgeries, such as bariatric surgery. These highly experienced providers typically yield the best outcomes from both a clinical and cost perspective.

Introduce reference-based pricing. This approach sets maximum payment amounts to be reimbursed based on reference provider(s) or drug(s), meaning individuals pay the cost above the reference price. Reference-based pricing creates market controls to mitigate excessive pricing set by some providers or drug makers.

Plan sponsors may want to enlist the support and expertise of specialty wellness vendors to help lead the process to design, implement and monitor an effective weight management program that best fits their needs. Segal can help clients review current popular design strategies and help clients find the right specialty vendors to administer the program.

“Obesity [is] harder to treat than other diseases.”

**CONCLUSION**

While many diseases can be defeated with a pill or vaccine, tackling obesity is considerably more complex because it requires people to change the way they eat and live. That makes obesity harder to treat than other diseases. Changing patient behavior plays a pivotal role in conquering obesity. Plan communications can play an important role in helping participants to understand the serious health risks associated with obesity and to modify their behavior.

Nevertheless, the effort and the additional short-term costs are worthwhile because the long-term health benefits and the associated savings can be substantial. For plan sponsors with long-term employment relationships, reducing the prevalence and severity of obesity among a plan’s population should result in both plan cost savings and healthier workers a few years down the road.

Segal Consulting can help plan sponsors to design coverage for treating obesity that best meets their objectives and to identify the right vendors to provide effective participant support and counseling for weight loss. For more information about or assistance with these services, contact your Segal consultant, Andrew Sherman, National Multiemployer Health Practice Leader, at 617.424.7337 or asherman@segalco.com or one of the authors:

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