What Obesity's Designation as a Disease Means for Health Plan Sponsors

By Dr. Sadhna Paralkar and Edward A. Kaplan

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. 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.

In June 2013, the American Medical Association (AMA) voted in favor of recognizing obesity as a disease that requires medical treatment. 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, or 35.7 percent of those older than 18, and 12 million children, or 16.9 percent of youngsters (see the sidebar for details on who is considered obese).

Calling obesity a disease is not without controversy. 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. Some doctors, though, 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. Other opponents of the AMA position also 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.

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

Current Coverage

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.

The Internal Revenue Service (IRS), though, 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 IRS Code. Moreover, obesity screening and counseling is a preventive benefit under the Affordable Care Act (ACA), and nongrandfathered plans must cover such noninterventional care with no patient cost-sharing.

Medicare, which insures an estimated 13 million obese Americans who are 65 or older or disabled, already covers the costs of "intensive behavioral therapy" for obese patients, as well as bariatric surgery for those with additional health conditions, such as diabetes. However, Medicare Part D, the prescription drug benefit, does not currently require coverage of weight-loss drugs.

Changing Coverage

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 nonclinical counseling with group or personal support services:** Covered enrollment in Jenny Craig and Weight Watchers has been available for years to help overweight and obese workers lose weight. More recently, weight-loss tools such as activity-monitoring wristbands (e.g., Fitbit) have become eligible

for reimbursement. A growing body of expertise around behavior modification is helping clinicians improve the efficacy of weight-loss programs. However, studies suggest that although a very high number of participants can lose weight, most have trouble keeping the weight off.

- **Prescription drug therapy:** Two relatively new drugs, Qsymia and Belviq, are approved by the U.S. Food and Drug Administration (FDA) to treat obesity. Qsymia was viewed as a potential first-line obesity drug for many patients, but limited coverage through drug plans coverage has prevented widespread adoption. Although the drugs are expensive at around $200 per monthly prescription, the duration of drug therapy varies by patient.
- **Surgical intervention:** As more providers perform gastric bypass procedures, the efficacy increases and risks for complications decline. Bariatric surgery, which costs, on average, $20,000 to $25,000, has perhaps the best data supporting positive outcomes far beyond weight loss. The science behind some of these unexpected favorable results, such as eliminating diabetes, lowering a patient's set point for bodyweight and limiting the production of so-called "hunger hormones" is not clear, but the benefits are. Given that surgery has risks, plan sponsors should help patients compare 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 a potentially lower risk of surgical complications. Lap bands, though, may be losing some of their attraction because of the degree of postsurgical care required.

For the public marketplaces created under the ACA for individuals to purchase health insurance, 23 states chose benchmark plans that cover bariatric surgery. More insurance plans are expected to start covering the cost of obesity treatments, including counseling on diet and exercise, surgery and medications approved by the FDA and prescribed by a physician. The U.S. Preventive Services Task Force recommends that qualified health care providers offer a patient with a body mass index (BMI) of at least 30 intensive, multicomponent behavioral interventions. The group also urges referrals for such interventions, which it defines as participation in a weight-loss program that features 12 to 26 sessions in a year and provides a variety of activities and strategies for losing weight. The federal agencies responsible for implementing the ACA 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. This should be monitored for future developments.

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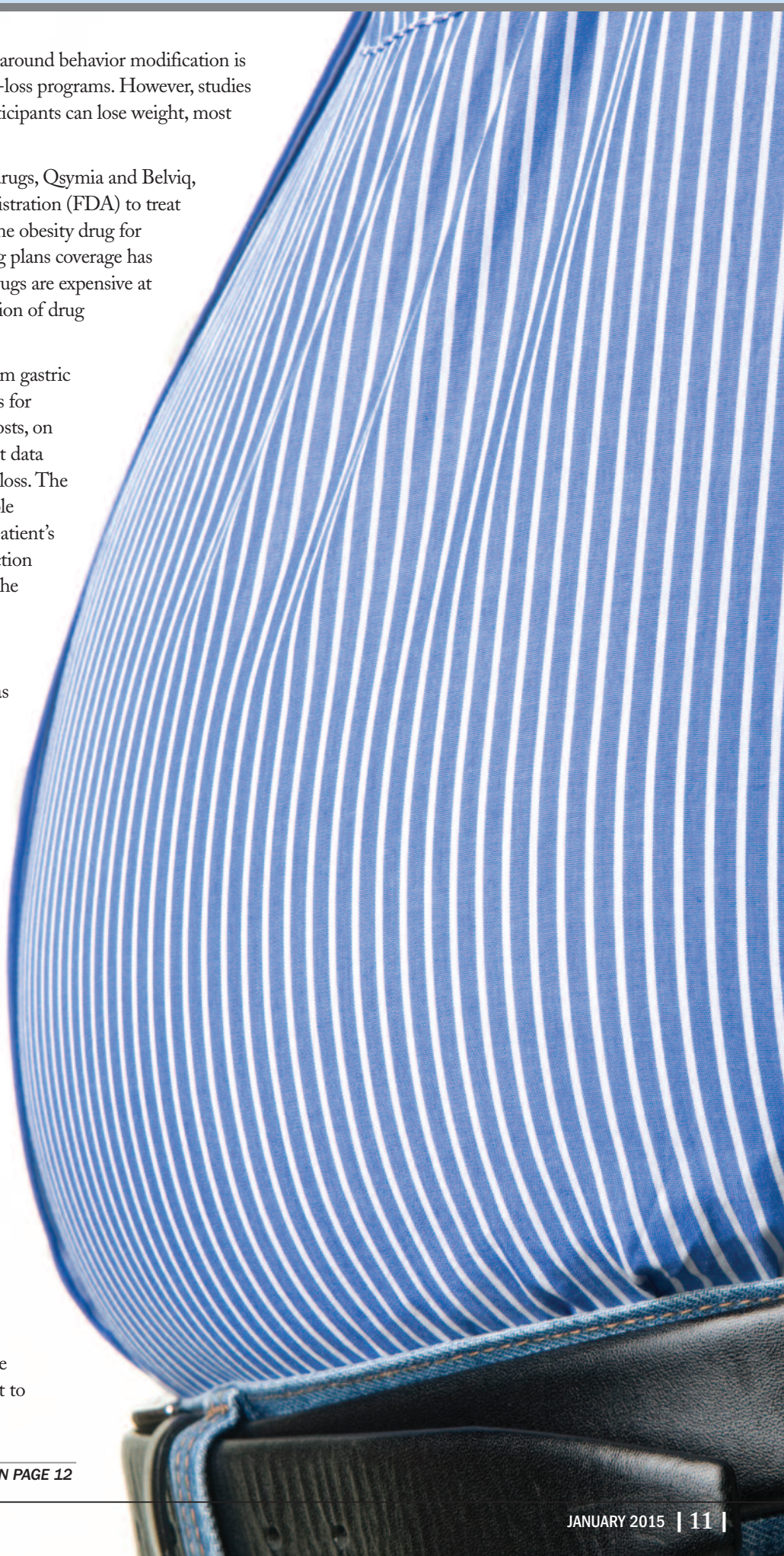

Obesity

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The ACA 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 targets, such as a percentage of weight loss or reduction in BMI, before earning a reward.

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 preventing 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 the 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 they were for non-obese employees and dependents.

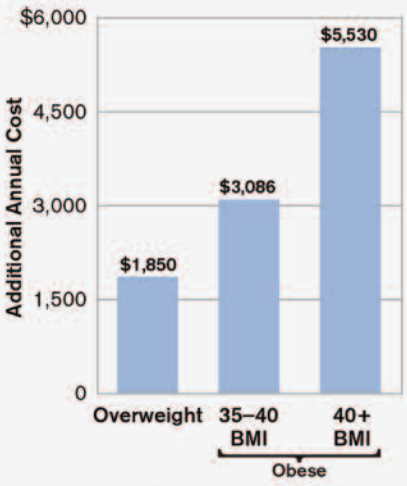
Graph 2 shows how the monthly per-participant costs break down by participants' waist size for one of the clients of Segal Consulting.

Cost Management

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. These include doing the following:

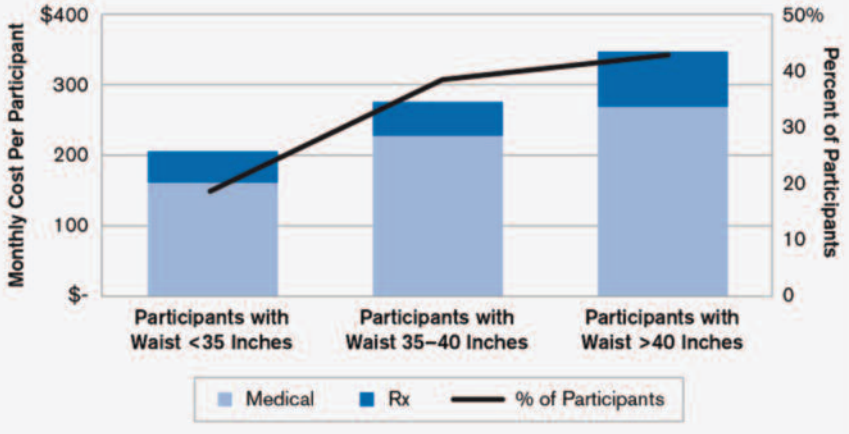
- **Institute step therapy for obesity treatment.** This approach might start with nutrition and exercise counseling. If that proves insufficient, the plan might cover one or both of the FDA-approved prescription drugs. Surgery can be the last resort if earlier treatments fail.

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



Source: Moriarty, James P. MSc; Branda, Megan E. MS; Olsen, Kerry D. MD; Shah, Nilay D. PhD; Borah, Bijan J. PhD; Wagie, 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.

Graph 2: A Segal Client's Monthly Health Costs by Participants' Waist Measurements and Percent of Participants in Each Measurement Group



Source: Segal Consulting

- **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 surgical Centers of Excellence for complex cases.** Highly experienced providers typically produce the best outcomes from both clinical and cost perspectives.
- **Introduce reference-based pricing.** This approach sets maximum reimbursement payment amounts 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 drugmakers.

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.

While many diseases can be defeated with a pill or vaccine, tackling obesity is considerably more complex because losing weight and keeping it off requires people to change the ways they eat and live. Plan communications can play an important role in helping participants understand the serious health risks associated with obesity and to modify their behavior.

Nevertheless, the effort and additional short-term costs are worthwhile because the long-term health benefits and 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 cost savings and healthier workers now and down the road.

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Biography:
Neil Reichenberg is the Executive Director of the International Public Management Association for Human Resources. He has worked for IPMA-HR for 34 years, the last 18 as the executive director, where he is responsible for the overall management of the association.

Prior to joining the association, he worked for a law firm specializing in labor and employment law. —N