

# An Innovative Approach to Employer-Provided Benefits for Obesity Care: A Case Report on H-E-B's Healthier Lifestyle Choices Program

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September 19, 2022

## The Clinical and Economic Impact of Obesity

Obesity presents a formidable challenge to health care financing systems. According to the 2017-2018 National Health and Nutrition Survey (NHANES), rates of obesity among U.S. adults have now climbed to 42.8% (Hales et al., 2020). The problem of this high prevalence of obesity has been particularly highlighted during the COVID-19 pandemic, when individuals with obesity were shown to have increased risk for adverse outcomes of COVID-19, including hospitalization, admission to the intensive care unit, mechanical ventilation, or death (Kompaniyets et al., 2021). In addition, the increase in obesity rates has also led to an increase in the burden of other obesity-driven chronic diseases, such as heart disease, cancer, chronic lung disease, stroke, diabetes, Alzheimer's disease, and chronic kidney disease. According to the Centers for Disease Control and Prevention (CDC), six in ten American adults have at least one chronic disease and four in ten have two or more (NCCDPHP, 2022).

Given this connection between obesity and chronic disease, the impact of obesity on medical care costs is alarming. According to a recent study, aggregate medical costs in 2016 due to obesity among U.S. adults were \$260.6 billion (Cawley et al., 2021). Adults with obesity (BMI >30 kg/m<sup>2</sup>) incurred \$2,505 more in annual medical costs, double the medical expenditures of those with BMI between 18.5 and 25 kg/m<sup>2</sup> (Cawley et al., 2021). Patients with obesity had higher costs in every category of care, including inpatient and outpatient expenses, as well as prescription drug expenses. Further, costs were shown to increase significantly with class of obesity, with class 1 (BMI 30<35 kg/m<sup>2</sup>), class 2 (BMI 35<40 kg/m<sup>2</sup>), and class 3 (BMI >40 kg/m<sup>2</sup>) categories demonstrating ascending costs. For those whose insurance was funded by public programs, annual medical expenditures were more (\$2,868) as compared to those with privately funded health insurance (\$2,058) (Cawley et al., 2021).

Obesity also has economic implications beyond direct health care costs, including productivity costs (absenteeism, presenteeism, disability, premature mortality), transportation costs, and human capital costs (Hammond and Levine, 2010). This commentary explores a case study of one large employer, H-E-B, LP, that developed and implemented an employer-provided benefits program as an attempt to tackle the clinical and economic impacts of obesity among their workforce.

## The Problem: Lack of Health Care Provider Engagement and Financial Disincentives

Given the adverse clinical and economic impacts of obesity, prevention and remediation of obesity and its health complications are of great importance for public health. Medical and surgical approaches to obesity treatment have made distinct progress in producing safe and sustainable weight loss with resultant health benefits, but low rates of obesity diagnoses hinder this progress (Bray et al., 2016). A 2019 U.S.-based study of primary care providers (PCPs) in 15 health systems found that obesity was diagnosed in only 45% of patients with obesity and only 70% of patients with severe obesity (Ciemins et al., 2020). When obesity was diagnosed, however, 17% of patients lost more than 5% of body weight and 6% of patients lost more than 10% (Ciemins et al., 2020). Still, even successful diagnoses are difficult to follow through on: for example, follow-up appointments are scheduled less than 25% of the time (Kaplan et al., 2018). There is a disconnect between what health professionals know can be done to produce clinically meaningful weight loss and what they are able to implement on a broad scale.

The barriers to successful obesity intervention in real-world medicine are numerous (Hite et al., 2019). One such barrier, highlighted in the development of obesity Standards of Care and Obesity Competencies, is the lack of a trained workforce (Dietz and Gallagher, 2019; Kushner et

al., 2019). Another commonly cited barrier is the lack of reimbursement: more than 50% of PCPs have indicated that improvements in the reimbursement process “would improve their ability to counsel patients with obesity” (Petrin et al., 2017). In 2016-2017, only 21 state Medicaid programs reimbursed providers for nutritional counseling, 16 programs covered pharmacotherapy, and 49 programs covered bariatric surgery (Jannah et al., 2018). It is clear that providers cannot provide obesity care without financial support.

### Businesses as Part of the Solution: The Importance of Employer-Based Obesity Benefit Plans

There are many health benefits of reducing body weight in persons with obesity. The benefits begin with weight loss of about 5% over one or two years, and expand with greater weight loss (Ryan and Yockey, 2017). Thus, weight reduction should be associated with direct medical cost savings and, if intervention costs can be minimized, even a return on investment. The economic case for bariatric surgery is especially strong. Bariatric surgery produces sustainable, clinically significant weight loss; reduction in cardiovascular events and mortality; and reduction in health care costs (Lopes et al., 2015). When combined with clinical interventions, lifestyle intervention counseling has also shown improved treatment engagement and economic benefits (Wadden et al., 2020). For example, when provided to more than 52,000 employees as a wellness benefit, an online digital weight loss program administered over one year demonstrated 2.8% average body weight loss, with 23% of this population achieving 5% or more weight loss at one year (Horstman et al., 2018). In a sub study of that benefit, the 4,790 participants studied had \$3,693,090 of total medical costs savings in the three years following the intervention (with total program costs of \$1,639,961), a 2.3:1 return on investment (Horstman et al., 2021). The Diabetes Prevention Program also successfully reduced medical costs compared to the control group (Diabetes Prevention Program Research Group, 2012). While there is some emerging evidence from integration of large electronic health record data sets of the cost savings of non-surgical weight loss, more real-world studies of the costs are needed, as well as the cost effectiveness of such treatments, including medications (Ding et al., 2021). Clearly, both payers and providers must have a shared understanding that obesity is a chronic disease for which treatments can produce sustained weight reduction, remediation of obesity complications, and even reduction in health care costs.

Businesses can also play a valuable role in supporting their employees with obesity and providing benefits that reach at-risk populations. Just as there has been a change

in scientific knowledge about the biologic basis of obesity – an understanding that obesity is not caused by a lack of willpower and is indeed a disease – there is an emerging change in attitudes among human resource managers, who are beginning to see that it is appropriate to include medical and surgical management of obesity in employee health benefits. Understanding the biologic basis of obesity means that medical management is essential and education in nutrition and physical activity is not sufficient as a health benefit. Incorporating medications into the benefit plan, which is compatible with a medical approach to chronic disease management, is included in the case study below.

### Case Study: H-E-B, LP

H-E-B, LP (H-E-B) is a family-owned grocery retailer, manufacturer, and transportation company, operating for 117 years with a footprint in Texas and Mexico and powered by more than 130,000 employees, referred to as “Partners.” H-E-B views its culture as a source of pride and attributes that culture and the reputation of the company to its Partners.

H-E-B’s commitment to its Partners includes providing opportunities for Partners to make healthier lifestyle choices through a robust, value-based benefits plan design. More than 10 years ago, H-E-B began tracking a cohort of Partners’ biometric results as part of a corporate health and wellness program (Partners in this cohort were screened every year from 2010-2019, excluding 2017). Over the past 10 years, H-E-B’s incentive program has rewarded participants with a reduced Partner premium contribution. Partners who improve upon their biometric results earn a larger reduction on their weekly premium. The most prevalent risk factor within the H-E-B Partner population is overweight and obesity, as defined by body mass index (BMI). Recognizing that Partners have a need for weight reduction, H-E-B implemented value-based benefits that support Partners seeking reduction in body weight and BMI through a variety of treatment options which can be selected by Partners with the advice of health care providers.

The value-based plan design components of the H-E-B benefits include:

- Digital therapeutics to help Partners monitor important health metrics and consult with telehealth providers when needed;
- Near-worksites employee primary care clinics;
- Three free Registered Dietitian (RD) consultations annually, and, once exhausted, RD visits that are covered by a low Partner co-pay;
- Network of Employee Assistance Program counselors that are trained in behavior change and motivational interviewing (an approach to behavior change that includes a guiding style of communica-

tion, patient empowerment, and respect for patient autonomy) (Miller and Rollnick, 2013);

- Coverage of obesity medications with a custom prior authorization process managed by H-E-B pharmacists; and
- Coverage for bariatric surgery (all Partners must engage with the H-E-B BlueCross BlueShield of Texas [BCBSTX] Partner Care Team prior to surgery).

In 2019, one year after implementing an outcomes-based incentive requirement and supporting Partners with new benefit offerings, H-E-B recognized measured improvement in the prevalence of overweight and obesity (via BMI measurements) of the cohort population, which it has screened every year since 2010.

### Learnings and Best Practices

H-E-B's approach to population health has evolved over time. Each evolution occurred after a thorough analysis of the data and consideration of how a change might impact company culture. Obesity medication coverage, for example, relied on a strategy to educate company leaders and overcome stigma about obesity medication to garner support. Company leaders were briefed to ensure they understood the data and recognized the need for coverage. The company built a financial model around medications, considering co-pays and use of generic medications. While progress is incremental, going forward, H-E-B's leaders will consider other plan designs marketed as incentives, taking into consideration overall plan costs. Options under discussion include changes in bariatric surgery plan coverage, other preventive health improvement program options, such as those noted above, and the use of telehealth services and devices.

### Can the H-E-B Experience Inform National Efforts?

H-E-B is proud to have included obesity care in its benefits package and has made it accessible for all its Partners. The decision to cover obesity medications is particularly noteworthy. What makes the H-E-B model especially innovative is the care with which the company approached the design of benefits and the way it used its own data for decision making. Other companies might consider gathering data describing their employees' health from their insurance carriers, interviewing companies providing health promotion interventions, and surveying their employees to identify health care priorities and needs. These measures might support the adoption of core components of obesity care (meaningful lifestyle intervention programs, and medical and surgical management provision). These surveys and

above-mentioned data gathering efforts would help define the scope and severity of the problem and the types of obesity treatment services which ought to be covered. Employers, in partnership with scientists, doctors, point solution companies, and insurance carriers, have an opportunity to identify evidence-based obesity treatment modalities that can support clinically significant weight loss among persons with obesity, define the economic consequences of those treatment approaches, and determine the best ways for employees to access the defined solutions.

Among government programs, comprehensive obesity benefits are becoming more common: as of 2023, federal employees, active-duty military, and veterans will all have access to the full continuum of care. Under current law, Medicare does not cover anti-obesity medications (Bodenheimer, 2022). In Congress, bipartisan and bicameral efforts are underway to provide Medicare beneficiaries access to the full continuum of coverage for weight management (117th Congress, 2021). While a modern approach to weight management in the nation's largest insurance program would be a critical step forward, obesity coverage is required in order to achieve a meaningful reduction in obesity prevalence and its concomitant chronic disease burden. The H-E-B case study provided above is one approach. Other employers will also need to understand the financial, social, and personal benefits of including obesity care in their benefits packages to begin to make significant progress in caring for people who are overweight or have obesity.

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## DOI

<https://doi.org/10.31478/202209a>

## Suggested Citation

Ammerman, A. and D. H. Ryan. 2022. An Innovative Approach to Employer-Provider Benefits for Obesity Care: A Case Report on H-E-B's Healthier Lifestyle Choices Program. *NAM Perspectives*. Commentary, National Academy of Medicine, Washington, DC. <https://doi.org/10.31478/202209a>

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## Acknowledgments

The authors would like to acknowledge **Cypress Lynx, MPH**, of the National Academies of Science, Engineering, and Medicine for her valuable contributions to this paper.

## Conflict-of-Interest Disclosures

**Abigail Ammerman** is a full-time employee of H-E-B, LP and is president of the San Antonio Business Group on Health. **Donna H. Ryan** is a scientific advisor to Novo Nordisk, Wondr Health, Calibrate, Gila Therapeutics, Real Appeal, Epitomee, Xeno Bioscience, Roman, Lilly, Zealand, Amgen, Altimmune and Ysopia; receives honoraria for lectures from Novo Nordisk, and IFA Celtic. She serves on a Data Safety Monitoring Board for Rhythm and a study Steering Committee for Novo Nordisk and is a stock option holder in Epitomee, Calibrate, Roman, and Scientific Intake.

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