Employers and targeted obesity care: Exploring the concept of an obesity center of excellence

Assessing benefits, financial structures, and operational considerations

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A targeted obesity care model combined with a risk-sharing financial component may align provider and employer incentives for treatment of obesity.

Introduction

Obesity has become a significant public health concern in the United States (U.S.), with its prevalence increasing dramatically over the past few decades. According to the Centers for Disease Control and Prevention (CDC), the rate of obesity among adults in the U.S. is 41.9% as of 2020, an increase from 30.5% in 2000.[1] The pathology of obesity is complex, involving a combination of genetic, behavioral, metabolic, and environmental factors.[2] Individuals with obesity have a higher rate of certain comorbidities, including type 2 diabetes (T2D), cardiovascular diseases, metabolic syndrome, chronic kidney disease, depression, and others.[3] The impact of obesity in the workplace has resulted in less overall productivity and increased absenteeism, relative to employees who do not have obesity.[4,5] Moreover, individuals with obesity have a greater risk of all-cause mortality and cardiovascular-related mortality.[6]

Studies have shown weight loss for individuals with obesity leads to decreased health risks and therapeutic benefits for comorbidities.[7,8,9] However, in the current landscape of obesity treatment and management, several challenges exist. Stigma and negative stereotypes regarding obesity can influence the judgment and behavior of providers toward affected patients, potentially affecting the quality of care provided.[10] This stigma can lead to patients with obesity experiencing stress, avoiding care, mistrusting doctors, and having poor adherence to treatments.[10] Additionally, treatment approaches for obesity often lack coordination among providers, with patients having inadequate short- and long-term support. From a group health insurance point of view, employers have inconsistent coverage of obesity-related treatments, such as bariatric procedures and glucagon-like peptide-1 (GLP-1) agonist medications. According to recent studies of large employers, it is estimated that 45% of employers currently provide coverage for bariatric surgery,[11] and an anticipated 43%[12] to 49%[13] of employers will provide coverage in 2024 for GLP-1 medications indicated for chronic weight management. Comparatively, 92% of large employers currently cover GLP-1s for T2D.[13] More than half of the employers surveyed were “very concerned” about the long-term cost implications of GLP-1s.[13]

Currently, there exist a variety of programs and businesses targeted at the treatment of obesity. Employer wellness programs are aimed at promoting healthy behaviors and frequently include weight management components, but studies reveal mixed reviews on the ability of wellness programs to significantly impact health and economic outcomes for patients and employers.[14] Alternately, obesity telehealth programs have emerged as a way of offering targeted and individualized obesity care for employees. These programs typically include a virtual care model, diet and activity planning, metric tracking, and health coaching. The most popular obesity telehealth platforms have monthly per-subscriber fees, but the cost of medical services (e.g., labs) and prescription drugs are often not included in the fees.[15,16,17]

Given the current challenges related to the treatment of obesity and management of related costs, this white paper explores financial and operational considerations for creating a best-in-class treatment center for obesity, in the form of a center of excellence (CoE). The CoE would incorporate financially at-risk components associated with obesity treatment and outcomes, with a goal of consistent and appropriate care, sustainable patient outcomes, and long-term reductions in overall healthcare costs. By exploring the dynamics of an obesity CoE, this white paper aims to provide a conceptual solution for employers that aligns incentives among stakeholders in the treatment and management of obesity.

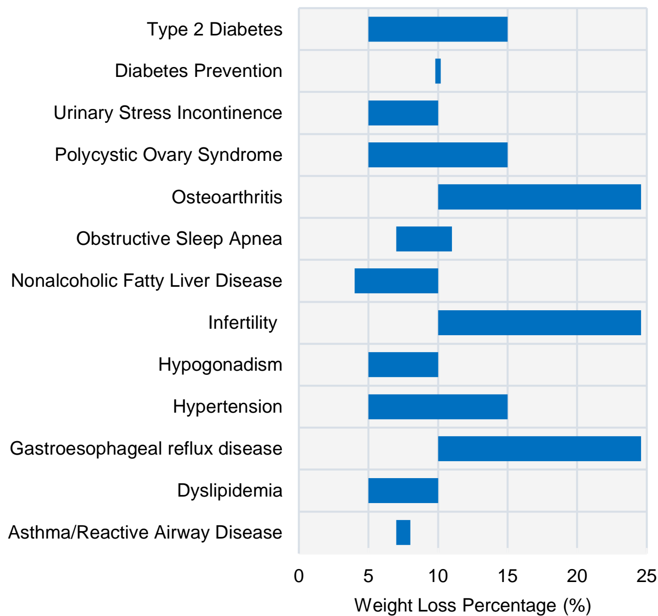
Note that the framework discussed herein is oriented toward an obesity CoE model for self-insured employers and their

employees; however, the model may be applicable to other types of payers and insurers as well.

Benefits of weight loss and obesity management

The American Association of Clinical Endocrinology (AACE) and the American College of Endocrinology (ACE) published obesity clinical practice guidelines in 2016. According to the guidelines, for most obesity-related conditions a loss of 5% to 10% of body weight can result in therapeutic benefits. Figure 1 summarizes the weight loss required for therapeutic benefits of 13 comorbidities related to obesity, as noted in the AACE/ACE guidelines.[18] Note that improvements due to weight loss for congestive heart failure and cardiovascular disease were ongoing or in the planning phase at the time of the AACE/ACE guidelines, and thus these diseases are not included in Figure 1.

FIGURE 1: WEIGHT LOSS (%) REQUIRED FOR THERAPEUTIC BENEFIT OF COMORBIDITIES (SUMMARIZED FROM AACE/ACE GUIDELINES[18])



Note: Additional therapeutic benefits may be seen at weight loss levels higher than what is displayed in this figure; the percentages in Figure 1 are supported by studies included in the AACE/ACE guidelines.

Therapeutic benefits of weight loss are numerous, including decreased blood pressure, decreased hemoglobin A1c levels, and improvements in inflammation, joint stress mechanics, and ovulation.[9] In one study, individuals with a body mass index (BMI) of 40 kg/m^2 who lost weight (median of 13% weight loss) had risk reductions for T2D of 41%, sleep apnea of 40%, hypertension of 22%, dyslipidemia of 19%, and asthma of 18%.[8]

The AACE/ACE guidelines[2] recommend lifestyle modifications as a first line of treatment for obesity, which includes diet, physical activity, and behavioral modifications. Under certain circumstances, the guidelines also recommend medication-assisted weight loss in conjunction with lifestyle therapy, or bariatric procedures to help meet goals for clinical outcomes. Figure 2 summarizes recommended treatment guidelines across increasing BMI classes.

FIGURE 2: RECOMMENDEDED TREATMENTS BY BMI (SUMMARIZED FROM TREATMENT GUIDELINES[18,19])

	BMI 25-26.9 kg/m^2	BMI 27-29.9 kg/m^2	BMI 30-34.9 kg/m^2	BMI 35-39.9 kg/m^2	BMI 40+ kg/m^2
Lifestyle Modification	✓	✓	✓	✓	✓
Pharmacotherapy/ Medications & Lifestyle Modification		with comorbidity	✓	✓	✓
Bariatric Procedures			certain procedures with comorbidity	certain procedures with comorbidity	✓

CONSIDERATIONS FOR EMPLOYERS

From an employer's healthcare cost perspective, the financial implications of obesity can be significant. Adults ages 20 to 65 with obesity are estimated to incur annual medical expenses that are twice as high as those of adults with a normal weight. Additionally, average expenditures increase as BMI increases. Compared to a normal-weight cohort, annual medical expenditures are 1.7 times higher for class 1 obesity (BMI 30.0-34.9), 2.2 times higher for class 2 obesity (BMI 35.0-39.9), and 3.3 times higher for class 3 obesity (BMI ≥ 40.0).[20] Over 30 units of BMI, each one-unit BMI increase is associated with an additional cost of $253 per person per year (in 2019 dollars).[21]

Weight loss can lead to potential healthcare savings for employers. According to a publication that estimated weight-loss-associated decreases in medical care expenditures in a commercially insured population, individuals with obesity and chronic conditions can have estimated reductions in total medical expenditures ranging from $238 to $752 in annual savings for each one-point decrease in BMI unit.[22] Note that these savings estimates do not include the incremental cost of the care plan and/or treatment to achieve the BMI decreases.

In the workplace, weight loss can result in reduced job absenteeism, as individuals with obesity are estimated to miss three more days of work annually due to injury or illness compared to individuals with normal weight (5.3 days missed versus 2.3 days missed, respectively).[5] Presenteeism may also be improved with weight loss, given employees with a BMI ≥ 35 experience greater health-related work limitations—such as needing additional time to complete tasks and lower ability to perform physical job

demands—than the average worker.[23] More generally, employers who provide comprehensive healthcare coverage and offer wellness programs to their employees have been shown to increase employee job satisfaction levels and productivity, and decrease their likelihood of seeking other employment opportunities.[24,25]

Exploration of an obesity CoE model

A CoE is a dedicated facility or team within a healthcare organization that provides exceptional care and leadership in a specific area of medicine. It is characterized by a high concentration of specialized skills and resources, coupled with a commitment to research, education, and quality. A CoE typically aims to provide high-quality patient outcomes, advance medical knowledge, and reduce healthcare costs in its area of focus.

The concept of a CoE model is familiar to U.S. payers. CoEs have been implemented to improve value in multiple conditions and medical episodes from cancer to knee replacement.[26,27] The CoEs where providers are willing to take on risk for outcomes are typically targeted at conditions that are acute in nature or have a defined treatment period (e.g., oncology, kidney, musculoskeletal).[17,26,28] The CoEs that treat chronic conditions (e.g., diabetes or chronic obstructive pulmonary disease)[29,30] are often structured around a fee-for-service (FFS) payment model. Additionally, CoEs typically treat conditions prevalent in older populations, where Medicare may be able to benefit from longer-term clinical improvements due to the lower rate of member turnover or churn compared to commercial insurance. Lastly, CoEs typically have a physical facility where they see patients and may add telehealth services as additional support. For obesity treatment and management, a CoE provides best-in-class care through a specific provider network. An obesity CoE has a few key differences from typical CoE models in place today:

- Obesity is a chronic, long-term condition that requires ongoing support, even after weight-loss goals are achieved.
- A longer time horizon may be needed to realize cost savings associated with weight loss and other therapeutic benefits.
- Obesity and weight-related outcomes are generally easy to self-measure. Thus, an obesity CoE could provide treatment and support primarily through a telehealth platform, with referrals to in-person specialists, as needed.
- Individuals with obesity often have other conditions that are already being managed by a primary care provider or specialist. Thus, continuity of care and coordination among providers both within and outside of the CoE are essential.
- Obesity affects individuals of all ages, with the highest prevalence in older age groups.[1] However, Medicare is currently prohibited from covering weight-loss medications[31] and only covers bariatric surgery in certain circumstances related to severe obesity.[32] Thus, an obesity CoE would likely target care for employee populations and commercially insured individuals.

FEATURES OF AN OBESITY COE

Comprehensive obesity care. Conceptually, an obesity CoE provides comprehensive care with a holistic approach that incorporates obesity treatment protocols (such as those described within the AACE/ACE guidelines) to provide the most effective care for patients. The goals are to develop a personalized treatment plan that is tailored to a patient's risk, provide support for short-term and long-term weight management success, and align incentives for all stakeholders. This approach would result in a patient receiving the most appropriate and beneficial treatment for their specific situation, while, ideally, the employer benefits from shared financial accountability. Elements of this holistic approach are already being implemented in some healthcare settings. These existing organizations are paving the way for a more integrated and comprehensive approach to obesity treatment, demonstrating the feasibility and effectiveness of such a model.

Lifestyle support. One of the key components of obesity comprehensive care is lifestyle support. This includes dietary and exercise guidance, as well as psychological support to help patients make and maintain healthy lifestyle changes. It could even provide financial counseling to help patients plan for or manage the costs associated with purchasing healthier food options or enrolling in wellness classes. The CoE could also interact with existing wellness benefits such as lifestyle management and fitness programs that employers are offering. This allows for a more holistic approach to obesity treatment, addressing not just the physical aspects of the condition, but also the behavioral factors that contribute to it.

Pharmaceutical and procedural interventions. In addition to lifestyle support, the CoE may also prescribe anti-obesity medications (AOMs) or recommend bariatric procedures, depending on the patient's individual needs and circumstances. Independent studies suggest pairing AOMs with an obesity-centric care program can lead to more patient engagement, greater weight loss, and better adherence to the medication than average.[33,34]

From an employer's perspective, AOM prescription coverage and bariatric procedures could be limited to the CoE provider network through medical network and pharmacy coverage policies. Therefore, only patients who are participating in the program and have been evaluated as appropriate would be able to receive pharmaceutical treatments for obesity. This strategy safeguards against misuse or off-label use of AOM interventions by

restricting treatment to patients who meet the clinical obesity indication requirements. Simultaneously, it combines AOM usage with continuous care from the CoE to promote lifestyle changes that contribute to greater adherence and longer-term success.

Breadth of care. A CoE for obesity requires expertise in all areas of obesity—professionals ranging from bariatricians to dieticians to sleep experts who are well-versed in the complexities of obesity and are equipped to provide comprehensive care to patients. Access to these professionals would be made easier through the CoE, given its foundation in telehealth. Patients could access expert care and ongoing support without needing to travel to a healthcare facility. This would make treatment more convenient and accessible, even for employees living in rural areas and other areas with limited access to healthcare professionals. However, recognizing that the journey to a healthier lifestyle is a long-term commitment that requires continuous encouragement and guidance, there can and should still be coordinated, in-person engagement opportunities, likely through community or patient support groups.

Integration with primary care and other specialists. Given the overlap between obesity and other conditions, coordination among providers both within and outside of the CoE is important. A CoE model should provide continuity of care with the patient's current primary and specialty providers. A coordinated care model may facilitate collaboration among healthcare providers, resulting in more efficient healthcare spend—such as not duplicating labs across multiple providers—and personalized treatment plans that consider a patient's underlying conditions (e.g., mental health). Furthermore, it enables the patient's primary care provider to be engaged in the patient's care plan, which provides additional accountability and support to the patient outside the CoE.

POTENTIAL DRAWBACKS OF AN OBESITY COE

There are potential drawbacks to consider when evaluating an obesity CoE as well. The capacity to support all acuities of obesity, including the ability to engage with patients long-term, may be a challenge. It is particularly important to ensure that certain populations, especially those without access to telehealth or technology, are not disadvantaged. To address this, an additional fee could be included to offset this disparity, such as an employer paying for necessary equipment like scales or other remote monitoring devices or providing access to computers or tablets for virtual visits. Finally, depending on the financial model and incentives associated with treatment at the CoE, it may be prudent for employers to structure their benefit designs to drive utilization to the CoE through reduced member cost sharing or other incentives. However, this could result in limiting patient choice and access to providers outside the CoE.

Operationalization of an obesity CoE

ESTABLISHING AN OBESITY COE

The formation of an obesity CoE requires defining the scope of services and care plans that will be offered, identifying clinical characteristics of patients eligible to be treated within the CoE, setting up the provider network and ensuring proper credentialing, and development of a platform tailored to the CoE.

Scope of services. One of the first steps to setting up an obesity CoE is determining the scope of services provided under the network. Ideally, the CoE network would provide comprehensive obesity care, including medical services (e.g., healthcare provider visits, bariatric procedures), prescription drugs (e.g., AOMs), coordination of care (e.g., connecting patients to specialists for comorbidities), and non-billable service (e.g., support groups). Measures for sustainable weight loss should be agreed upon and incorporated into the care plans so they can be adequately monitored and tracked over the performance period. This includes defining care pathways that outline the patient's journey from initial diagnosis and treatment to long-term maintenance. It also involves prescribing AOMs or bariatric procedures as part of a comprehensive treatment plan, when appropriate. These elements together ensure that the CoE provides a well-rounded, effective approach to obesity care.

Patient eligibility. The next step is establishing the clinical characteristics—such as BMI, body fat percentage, and presence of comorbidities—that would be necessary for an individual to qualify for care through the CoE. Treatment guidelines, such as the ACE/AACE guidelines,[18] may be considered when defining the criteria for the CoE-eligible population. The CoE should assess stratification of members based on the severity of obesity and the presence of any comorbidities, as well as consider how to manage long-term member alignment for ongoing weight maintenance support.

CoE credentialing and provider network. Once the scope of services and patient eligibility criteria has been determined, the CoE can initiate creating the provider network and ensuring proper credentialing. Providers must have or obtain state licensure to ensure they meet the necessary qualifications and standards to treat patients in each state, particularly given the nationwide telehealth-based platform of the CoE. The CoE may include providers that are employed by the CoE as well as third-party providers that are contracted to provide specific services under the CoE network, such as bariatric surgeons.

Platform development. Lastly, the CoE can develop or acquire a patient engagement telehealth platform that enables seamless patient interaction, data collection, and care coordination across the various professionals and services offered within the CoE. This could be built in-house by the CoE development team, outsourced to an external development team, or purchased from a large telehealth provider and customized to the CoE's needs. The platform should automate the specific care model for the CoE, with the care pathways integrated into the website and app.

COE AND EMPLOYER CONTRACTING

CoEs may offer various options for financial structures, member attribution methods, tracking and monitoring, and ongoing reassessments. The CoE and employers may negotiate and contract on terms for each population of interest (e.g., newly treated versus maintenance individuals). The employer could contract directly with the CoE, or the contracting could be through an insurance company, pharmacy benefit manager (PBM), or the employer's third-party administrator (TPA). The contract would reflect the agreed-upon financial model, as well as the terms for any risk-sharing or quality metrics. At a minimum, the employer would include the CoE as an in-network provider to enable patient access to the specialized provider network.

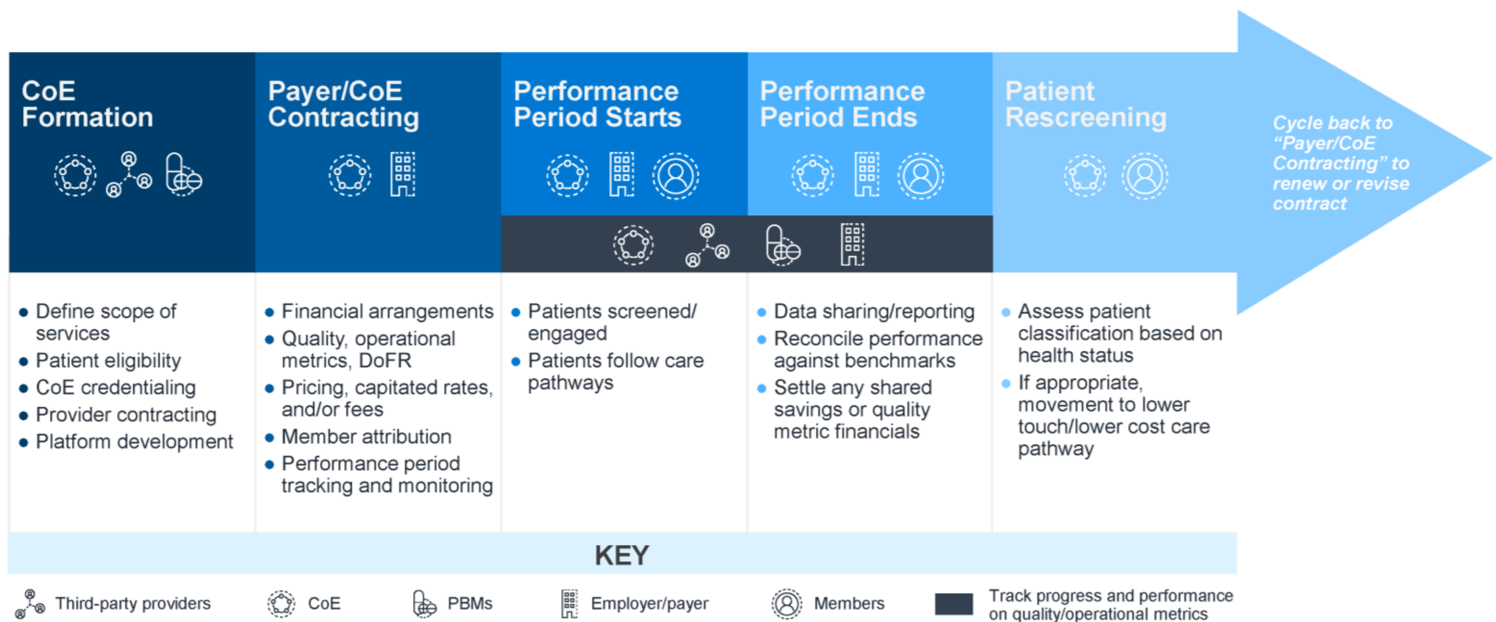
Figure 3 summarizes the timeline, key activities, and stakeholders associated with the development and operationalization of a CoE.

Financial structures and contracting. Financial structures and pricing for the CoE's services can take different forms based on the CoE's capacity for risk sharing and the employer's preferences for partnering with the CoE. The goal is to achieve a balanced and fair payment system that considers the quality, quantity, and cost of the care provided, including care and management that is not reimbursable through typical provider contracts. It is practical for the CoE to offer different financial models that align their incentives with the employers' needs to ensure both parties benefit from the partnership. Depending on the features of the chosen financial model, the CoE and employer may need to align on a division of financial responsibility (DoFR) and/or outcomes and quality metrics to ensure transparency and accountability among the contracting parties. Pricing, such as fee-for-service rates, capitated payments, bundled payments, and other fees, should also be included in the contract terms.

Setting up data-sharing pipelines and business associate agreements (BAAs) with employers, TPAs, providers, and PBMs is a key step to facilitate the efficient and secure exchange of information, promoting collaboration and coordination among all parties involved in the patients' care. Additionally, cooperation with PBMs or pharmaceutical manufacturers is crucial to ensure the appropriate management of, and access to, AOMs.

Member attribution. Attributing qualified members to the obesity CoE should be a systematic process based on objective criteria and analytics. Attribution can be performed either prospectively or retrospectively. Under a prospective approach, potential members undergo a screening process to assess their health status and determine their suitability for the program. The screening process could be triggered upon an overweight or obesity diagnosis being identified in claims data, or if an individual has diagnosed comorbidities that are typically associated with obesity, even if obesity has not directly been identified in claims data. Individuals may also choose to self-elect or may be referred by their healthcare provider to participate in the screening process. Following the screening, the eligibility of the members is determined based on specific criteria set by the CoE or employer. Once deemed eligible, members can elect to be enrolled in the CoE treatment program.

FIGURE 3: TIMELINE AND STAKEHOLDERS ASSOCIATED WITH OPERATIONALIZATION OF A COE



Under a retrospective approach, there may not be an up-front screening process for individuals who are deemed eligible to receive treatment through the CoE. Rather, any employee can choose to seek care through the obesity CoE. At the end of the performance period, the CoE-treated employee population would be assessed to identify the individuals who met certain criteria or received certain types of service. Only those individuals would be included in the attributed population for the financial modeling and outcomes or quality payment calculations.

Tracking and monitoring. Tracking progress and monitoring outcomes is a crucial aspect if quality/outcome payments or financial risk-sharing is involved. This involves the use of measurable operational and quality metrics to assess the effectiveness of the care provided, such as prevalence and incidence of obesity-related complications, percentage weight change, and overall health costs and outcomes.

There is also the potential for the CoE to collect patient-reported measures, such as patient experience, self-esteem, absenteeism, mobility, and impact on quality of life, to provide insight into indirect outcomes associated with obesity treatment. These metrics provide tangible data on the performance of the CoE, allowing for continuous improvement, refinement of the care model, and execution of outcomes contracting. They also provide valuable insights into the patients' progress, helping to guide future treatment decisions.

A recent study on measurable metrics in obesity assessed multiple obesity-related measures within 10 healthcare organizations and found that there were certain operational and quality performance measures that were useful for obesity tracking and outcomes. These measures included prevalence of overweight/obesity in the organization and within the targeted clinics, diagnosis and assessment of obesity-related complications, documentation of obesity diagnosis, percentage weight change in a 15-month period, and prescriptions for AOMs.[35]

The CDC has also published guidance on employer evaluation measures for planning of obesity prevention and control programs, which includes measurement categories such as worker productivity, healthcare costs, health outcomes, and organization changes (e.g., workplace programming).[36] It should be noted that tracking and measuring clinical outcomes over time should be normalized for the continual flux of new versus maintenance patients to limit the potential skew in overall outcomes that may result from new patients being added.

FIGURE 4: ASSESSMENT OF POTENTIAL FINANCIAL MODELS FOR AN OBESITY COE

	FFS	FFS + Quality	Shared Savings	Specialty Capitation	Full Capitation
Financial model definition	Each service has an associated payment to the provider with no link to quality or value	Each service has an associated payment and bonuses are issued to the provider for achieving quality metric goals	Total cost is compared to a benchmark and a portion of savings or losses are shared with the provider	An amount is paid to the provider to cover all services within a specialty category, shifting the risk of these services to the provider	An amount is paid to the provider to cover all services, shifting the risk of all services to the provider
Key aspects of the financial model as it applies to an obesity CoE	• FFS rate structure for obesity-related services and drugs (e.g., medical/ pharmacy claims, nutritional coaching, coordinated care) • Employers who send their members to the CoE providers pay a negotiated rate for services	• FFS rate structure for obesity-related services and drugs, supplemented with payouts associated with meeting particular quality measures, such as weight loss, patient engagement, and adherence to medication • Potentially lower FFS negotiated rates for obesity drugs and services versus FFS-only model	• CoE providers share in profit (or losses) based on total cost of care (i.e., not limited to obesity-related incurred costs) compared to benchmarks. • Shared savings measurements should be on total cost of care for there to be an opportunity for savings. The obesity CoE would take risk on total cost of care but only be responsible for managing obesity	• Capitated rate covers certain medical and drug expenditures specifically identified as being related to obesity. Incentivizes providers to not overutilize or overprescribe • Capitated rate is set in advance, potentially with premium rates varying by treatment protocol	• Capitated rate covers all medical and drug expenditures, not just those specifically identified as being related to obesity. The CoE must have large network to take risk on total cost of care • Capitated rate is set in advance, potentially with premium rates varying by treatment protocol
Assessment of financial models for an obesity CoE	**Does not mitigate volume or cost risk:** There are no outcomes-oriented risk components, nor cost containment **Easy model to implement today:** All drugs and services are paid on a fee-for-service basis	**Aligns incentives:** Provider network is oriented to obesity management and provider payments are contingent upon positive outcomes **Fairly easy model to implement today:** Requires clear outcomes/quality measures. Good precedence for this model among other condition-specific CoEs	**Accounts for total cost of care:** Shared savings/loss is possible if the CoE is willing to take risk on total cost of care, even without having a direct relationship with the provider networks managing other comorbidities **Difficult model to implement today:** Requires a clear member attribution method, multi-year tracking, and access to all medical and pharmacy claims	**Offers predictability, for a premium:** This model works for obesity CoE, but only if the PMPM rate is high enough to mitigate treatment disincentives and employers are willing to pay the higher premiums **Difficult model to implement today:** Requires a clear member attribution method, agreement on the division of financial responsibilities and premium rates	**Requires robust network of specialties and providers:** A full capitation model requires a large provider network and may limit patient choice **Difficult model to implement today:** Requires a clear member attribution method, a wide provider network, and access to all medical and pharmacy claims

Ongoing reassessments. Lastly, in a typical CoE, patients "graduate" from the CoE when they have successfully completed their treatment plan and no longer require the intensive support of the CoE. For obesity care, studies have shown that individuals with continued clinical support are more successful at maintaining their initial weight loss.[37] For this reason, an obesity CoE may elect to use an acuity-based care model that enables ongoing engagement with individuals who have met their weight loss goals and encourages continued adherence to lifestyle changes and medications (if applicable). Therefore, payments and quality measures that are tailored to short-term and long-term treatment of obesity are important for sustainability of the program. For example, the employer should not be overpaying for maintenance services, nor should the CoE be subject to quality measures that are not applicable for a treated population in the maintenance phase of treatment. The financial and quality measures must ensure that patients who require long-term care continue to receive the support they need, while also preserving the financial sustainability of the CoE.

Financial models for an obesity CoE

CoEs perform many services that replace those performed by other healthcare providers, while also performing additional services that may not be submitted or captured within the healthcare claims process. Payment contracts can be set up on a financial risk spectrum from FFS (i.e., no financial risk is shifted from the employer to the CoE) to full capitation (i.e., financial risk for total cost of care of enrolled patients is shifted to the CoE). Figure 4 describes each financial model, as well as the benefits and drawbacks for employers and providers focused on managing obesity. Of these five financial models, "FFS + Quality" and "Specialty Capitation" will be explored further in the next section, given the shared financial risk between employers and CoEs, feasibility, and likely interest of employers in such models for treatment and management of obesity.

DEEPER DIVE: "FFS + QUALITY" MODEL

Figure 5 presents the role of the employer, the CoE, and other providers as it relates to the "FFS + Quality" model.

The key benefits of a "FFS + Quality" financial model are that it offers a network of physicians who are accountable for outcomes associated with obesity care and weight loss management and may also provide reduced FFS rates for obesity care services and drugs. The key drawback of this model is that employer costs increase as the volume of services, prescriptions, or adherence to AOMs increase.

The CoE and employers executing a "FFS + Quality" model must align on the fee schedule and quality payments. For instance, the obesity CoE may offer lower fees for obesity services compared to other providers, with additional quality/outcome payments made contingent on successfully meeting agreed-upon measures. Thus, providers are incentivized to meet quality/outcome goals to receive the contingent payment(s). Quality measures and outcome goals should vary depending on the population being measured, such as a newly treated population versus a maintenance population. Under the "FFS + Quality" model, the employer or its TPA will also be responsible for the monitoring and auditing of healthcare utilization. This offers another layer of oversight for the employer to confirm the CoE is not overutilizing treatment.

FIGURE 5: "FFS + QUALITY" STAKEHOLDER ROLES

Role	Responsibilities
Role of Employer	• Pays for all medical and pharmacy claims. • Potentially, pays PMPM management fee to CoE for obesity management services (non-billable services) for a specific attributed population. • Makes quality improvement payments to CoE/providers for a specific attributed population, contingent upon quality measures being met.
Role of CoE	• CoE acts as obesity program administrator. • Offers assessments, counseling, plan of action, patient interactions, etc. • Has networks of high performing specialists. • Offers discounts for services performed through the CoE network. • Administers quality metric performance tracking.
Role of Other Providers	• Network of providers engaged through the third party for services not available/rendered under CoE. • Other providers file FFS claims.

DEEPER DIVE: "SPECIALTY CAPITATION" MODEL

Figure 6 presents the roles of the employer, the CoE, and other providers as they relate to the "Specialty Capitated" model.

Key benefits of a "Specialty Capitation" financial model are that it provides per-individual cost stability to the employer for the year related to obesity treatment and incentivizes providers to provide efficient care at lower costs to retain revenue from the per member per month (PMPM) capitation rate.

A drawback of this model is that the CoE providers are financially at-risk for all obesity-related care. The provider is responsible for balancing the management of healthcare costs with providing appropriate care and maintaining quality outcomes. Additionally, because direct healthcare savings from weight loss are usually linked to improvements in obesity-related comorbidities, a provider in an obesity CoE may have limited opportunities for cost savings because the healthcare cost offsets would occur outside the CoE's remit. A capitated payment model stabilizes an employer's cost exposure for an individual member, but it does not necessarily incentivize providers to drive toward particular outcomes or quality care. Therefore, it may be necessary to incorporate quality metrics into the "Specialty Capitation" model to offset the potential disincentives for providing more expensive care (when appropriate).

Furthermore, the capitation amount may be difficult to set without accounting for the mix of obesity severity levels within the employer population. Depending on the size of the employer,

experience may not be sufficient to set a credible capitation rate without using a market benchmark. Patients with more severe obesity may have a care plan that includes higher-cost AOMs and/or bariatric procedures, while patients with less severe obesity may have a care plan focused on lifestyle and nutrition management. For these reasons, the capitation rate will need to be set high enough so there is not a disincentive for providing care. However, this may make it less attractive to employers if the rate is higher compared to what is spent on obesity care today. The CoE may need to work with actuaries and other pricing experts to help determine appropriate capitation rates for each employer contract.

The attribution of patients and determination of appropriate capitation rates are critical in the "Specialty Capitation" model. There may be different capitation rate cells given a patient's characteristics, which would be assessed during the screening process. Furthermore, the employer and CoE must agree upon the DoFR to align on the services for which the CoE is responsible under the capitation.

Under the "Specialty Capitated" model, the employer is incentivized to drive all obesity care through the CoE. For example, if the obesity CoE is responsible for the costs of AOMs within the capitation, but an individual receives an AOM outside of the CoE, then the employer would likely be responsible for those costs. A benefit of this restriction is that the employer has confidence that obesity treatments, like AOMs, are being prescribed appropriately (i.e., no off-label use). However, this restriction may limit patient access and treatment choice. For example, if a patient with T2D was being treated with a GLP-1 drug outside of the CoE and wanted to begin treatment for obesity through the CoE, an employer might prefer that the individual switch to a GLP-1 medication indicated for obesity because the AOM costs would be included within the capitated rate. Thus, the "Specialty Capitated" model may unintentionally prefer certain GLP-1 medications.

The capitation rate needs to be high enough to ensure providers can appropriately and adequately treat each patient, but low enough that employers are willing to pay to direct all obesity care to the CoE. The employer or its TPA will be responsible for the monitoring and auditing of healthcare utilization, with the goal of verifying the CoE is appropriately using its options according to the treatment guidelines and the contracting terms to ensure the providers are not underutilizing certain treatments, such as bariatric procedures or AOMs.

Bundled payments, also known as episode-based payments, are another form of specialty capitation. A bundled payment is a fixed-price agreement for a predefined episode of care, commonly consisting of a procedure and all related services or all care for a medical condition. Bundled payments eliminate the risk to the CoE that an attributed member will receive higher-cost services early in the capitation period and then leave the program or the employer.

FIGURE 6: "SPECIALTY CAPITATION" STAKEHOLDER ROLES

Role of Employer	• Pays PMPM capitation payment to the CoE for select obesity-related medical services, pharmaceuticals, and other management services (non-billable services) for a specific attributed population. • Pays for all medical and pharmacy claims outside of the CoE's responsibility.
Role of CoE	• CoE acts as obesity program administrator. • Offers assessments, counseling, plan of action, patient interactions, etc. • Has networks of high performing specialists. • Accepts full financial responsibility for specific service categories.
Role of Other Providers	• Network of providers engaged through the third party for services not available/rendered under CoE. • File FFS claims or encounters (if sub-capitated) with the CoE.

Conclusion

The current landscape of obesity treatment presents several challenges, including lack of care coordination, inadequate patient support, and inconsistent coverage of treatments. This paper explored and presented key considerations for operationalizing a CoE for obesity treatment. The program should provide comprehensive, coordinated care with a goal of appropriate, efficient, and effective care. The implementation of an obesity CoE would require careful planning, including defining the scope of care, setting up data-sharing pipelines, and tracking progress and outcomes. Financially, the CoE may offer a variety of models that can shift or share the financial risk between the CoE providers and the employer. Employers that want to drive toward positive obesity outcomes may favor a financial model with payments contingent on quality or outcomes, while employers that desire predictable costs may favor a capitated pricing model. In summary, a CoE for obesity could potentially align financial and treatment incentives for obesity care, benefiting employees, employers, and healthcare providers.

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References

1. CDC. Adult Obesity Facts. Retrieved December 15, 2023, from https://www.cdc.gov/obesity/data/adult.html.
2. Lin, X. & Li, H. (2021). Obesity: Epidemiology, pathophysiology, and therapeutics. *Front Endocrinol (Lausanne)*;12. doi: 10.3389/fendo.2021.706978.
3. Swinburn, B.A., Sacks, G., Hall, K.D. et al. (2011). The global obesity pandemic: Shaped by global drivers and local environments. *Lancet*;378(9793):804-814. doi: 10.1016/S0140-6736(11)60813-1.
4. Bustillos, A., Vargas, K.G. III, & Gomero-Cuadra, R. (2014). Work productivity among adults with varied body mass index: Results from a Canadian population-based survey. *J Epidemiol Glob Health.* 201;5(2):191-199. doi: 10.1016/j.jegh.2014.08.001.
5. Cawley, J., Biener, A., Meyerhoefer, C. et al. (2021). Job absenteeism costs of obesity in the United States: National and state-level estimates. *J Occup Environ Med*;63(7):565-573. doi: 10.1097/JOM.0000000000002198.
6. Kuk, J.L., Ardern, C.I., Church, T.S. et al. (2011). Edmonton obesity staging system: Association with weight history and mortality risk. *Appl Physiol Nutr Metab*;36(4):570-576. doi: 10.1139/h11-058.
7. Bailey-Davis, L., Wood, G.C., Benotti, P. et al. Impact of sustained weight loss on cardiometabolic outcomes. *Am J Cardiol*. 2022;162:66-72. doi: 10.1016/j.amjcard.2021.09.018.
8. Haase, C.L., Lopes, S., Olsen, A.H., Satylganova, A., Schnecke, V., & McEwan, P. (2021). Weight loss and risk reduction of obesity-related outcomes in 0.5 million people: Evidence from a UK primary care database. *Int J Obes (Lond)*;45(6):1249-1258. doi: 10.1038/s41366-021-00788-4.
9. Cefalu, W.T., Bray, G.A., Home, P.D. et al. (2015). Advances in the science, treatment, and prevention of the disease of obesity: Reflections from a diabetes care editors' expert forum. *Diabetes Care*;38(8):1567-1582. doi: 10.2337/dc15-1081.
10. Phelan, S.M., Burgess, D.J., Yeazel, M.W., Hellerstedt, W.L., Griffin, J.M., & van Ryn, M. (2015). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obes Rev*;16(4):319-326. doi: 10.1111/obr.12266.
11. International Foundation of Employee Benefit Plans. Employee Benefits Survey: 2022 Results. Retrieved December 15, 2023, from https://www.ifebp.org/store/employee-benefits-survey/Pages/default.aspx.
12. Nasdaq (October 9, 2023). GLP-1 Coverage in Employer Plans Could Nearly Double in 2024. Retrieved December 15, 2023, from https://www.nasdaq.com/press-release/glp-1-coverage-in-employer-plans-could-nearly-double-in-2024-2023-10-09.
13. Khemlani, A. (August 22, 2023). Large employers split on covering GLP-1 drugs for weight loss: Survey. Yahoo Finance. Retrieved December 15, 2023, from https://finance.yahoo.com/news/large-employers-split-on-covering-glp-1-drugs-for-weight-loss-survey-140004887.html.
14. Patel, M.S., Asch, D.A., Troxel, A.B. et al. (2016). Premium-based financial incentives did not promote workplace weight loss in a 2013-15 study. *Health Aff (Millwood)*;35(1):71-79. doi:10.1377/hlthaff.2015.0945.
15. Ro. Get prescription weight loss medication online. Retrieved December 15, 2023, from https://ro.co/weight-loss/.
16. Lopatto E. (October 2, 2023). Who wins when telehealth companies push weight loss drugs? The Verge. Retrieved December 15, 2023, from https://www.theverge.com/23878992/ro-ozempic-subway-ads-telehealth-weight-loss-drugs.
17. University of Michigan Health Frankel Cardiovascular Center. Comprehensive Complex Coronary Disease. Retrieved December 15, 2023, from https://www.umcvc.org/conditions-treatments/comprehensive-complex-coronary-disease.
18. Garvey, W.T., Mechanick, J.I., Brett, E.M. et al. (July 2016). American Association of Clinical Endocrinologists & American College of Endocrinology Comprehensive Clinical Practice Guidelines for Medical Care of Patients With Obesity. *Endocr Pract.*;22(3). Retrieved December 15, 2023, from https://pro.aace.com/files/obesity/final-appendix.pdf.
19. Mechanick, J.I., Apovian, C., Brethauer, S. et al. (2019). Clinical practice guidelines for the perioperative nutrition, metabolic, and nonsurgical support of patients undergoing bariatric procedures – 2019 update: Cosponsored by the American Association of Clinical Endocrinologists/American College of Endocrinology, the Obesity Society, American Society for Metabolic and Bariatric Surgery, Obesity Medicine Association, and American Society of Anesthesiologists. *Endocr Pract*;25(12). doi: 10.4158/GL-2019-0406.
20. Cawley, J., Biener, A., Meyerhoefer, C. et al. (2021). Direct medical costs of obesity in the United States and the most populous states. *J Manag Care Spec Pharm*;27(3):354-366. doi: 10.18553/jmcp.2021.20410.
21. Ward, Z.J., Bleich, S.N., Long, M.W., & Gortmaker, S.L. (2021). Association of body mass index with healthcare expenditures in the United States by age and sex. *PLoS One*;16(3). doi: 10.1371/journal.pone.0247307.
22. Thorpe, K., Toles, A., Shah, B., Schneider, J., & Bravata, D.M. (2021). Weight loss-associated decreases in medical care expenditures for commercially insured patients with chronic conditions. *J Occup Environ Med*;63(10):847-851. doi: 10.1097/JOM.0000000000002296.
23. Gates, D.M., Succop, P., Brehm, B.J., Gillespie, G.L., & Sommers, B.D. (2008). Obesity and presenteeism: The impact of body mass index on workplace productivity. *J Occup Environ Med*;50(1):39-45. doi: 10.1097/JOM.0b013e31815d8db2.

24. AHIP (May 24, 2023). New survey: Consumers say comprehensive employer-provided coverage vital to their financial peace of mind. Retrieved December 15, 2023, from https://www.ahip.org/news/press-releases/new-survey-consumers-say-comprehensive-employer-provided-coverage-vital-to-their-financial-peace-of-mind.
25. Marshall, C. (2020). Analysis of a comprehensive wellness program's impact on job satisfaction in the workplace. *IHR*;34(2):221-241. doi: 10.1108/IHR-05-2020-0014.
26. Memorial Sloan Kettering Cancer Center. For Health Plans. Retrieved December 15, 2023, from https://www.mskcc.org/mskdirect/health-plans.
27. Virgina Mason Medical Center (March 22, 2016). State picks Virgina Mason as center of excellence for total joint replacement. News Wise. Retrieved December 15, 2023, from https://www.newswise.com/articles/state-picks-virginia-mason-as-center-of-excellence-for-total-joint-replacement.
28. Panoramic Health. Treatment with a 360° view of your health. Retrieved December 15, 2023, from https://panoramichealth.com/patients/.
29. UMass Memorial Health. Diabetes. Retrieved December 15, 2023, from https://www.ummhealth.org/umass-memorial-medical-center/diabetes.
30. Johns Hopkins Medicine. The Johns Hopkins Precision Medicine Center of Excellence for Chronic Obstructive Pulmonary Disease (COPD). Retrieved December 15, 2023, from https://www.hopkinsmedicine.org/inhealth/copd.
31. Centers for Medicare and Medicaid Services (April 19, 2006). Part D drugs/Part D excluded drugs. Retrieved December 15, 2023, from https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/partddrugspartdexcludeddrugs.pdf.
32. Medicare. Bariatric surgery. Retrieved December 15, 2023, from https://www.medicare.gov/coverage/bariatric-surgery.
33. Pantalone, K.M., Smolarz, B.G., Ramasamy, A. et al. (2021). Effectiveness of combining anti-obesity medication with an employer-based weight management program for treatment of obesity: A randomized clinical trial. *JAMA Netw Open*;4(7). doi: 10.1001/jamanetworkopen.2021.16595.
34. Leach, J., Chodroff, M., Qiu, Y. et al. (July 11, 2023). Real-world analysis of glucagon-like peptide-1 agonist (GLP-1a) obesity treatment one year cost-effectiveness and therapy adherence. Prime Therapeutics. Retrieved December 15, 2023, from https://www.primetherapeutics.com/wp-content/uploads/2023/07/GLP-1a-obesity-treatment-1st-year-cost-effectiveness-study-abstract-FINAL-7-11.pdf.
35. Ciemins, E., Joshi, V., Horn, D., Nadglowski, J., Ramasamy, A., & Cuddeback, J. (2021). Measuring what matters: Beyond quality performance measures in caring for adults with obesity. *Popul Health Manag*;24(4):482-491. doi: 10.1089/pop.2020.0109.
36. CDC. Obesity evaluation measures. Retrieved December 15, 2023, from https://www.cdc.gov/workplacehealthpromotion/health-strategies/obesity/evaluation-measures/index.html.
37. Lenoir, L., Maillot, M., Guilbot, A., & Ritz P. (2015). Primary care weight loss maintenance with behavioral nutrition: An observational study. *Obesity (Silver Spring)*;23(9):1771–1777. doi: 10.1002/oby.21157.

Limitations

Milliman was engaged by Eli Lilly to support exploring the concept of an obesity CoE. This paper was supported by research and Milliman subject matter experts familiar with disease management programs, CoEs, and risk-sharing models. This white paper outlines typical and/or the most relevant types of programs that may be applicable to an obesity CoE; it is not intended to be a comprehensive study of every type of program or model available.

While this report provides a guide for operationalizing a center of excellence, entities interested in creating a CoE model for obesity should engage with the appropriate professionals to address specific financial and operational nuances. The comprehensive obesity CoE model described in this white paper, to our knowledge, is not yet in existence. Therefore, the process and financial models outlined here are intended to provide thought leadership as a conceptual solution for obesity treatment. Actual experience for operationalizing an obesity CoE may vary from what has been described herein.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Austin Barrington and Jessica Naber are members of the American Academy of Actuaries and meet the qualification standards for authoring this report.

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