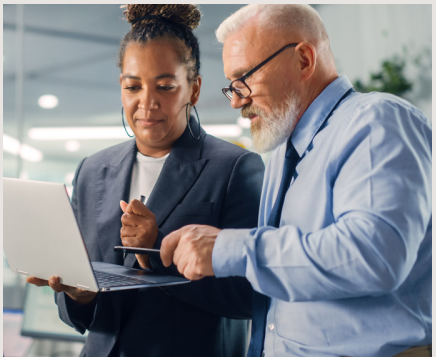
Addressing health disparities in commercial health plans for individuals with overweight and obesity

Funded by and developed in collaboration with Novo Nordisk.



Specific health and healthcare disparities exist among people living with overweight and obesity.[1] They can adversely affect employee productivity and raise absenteeism rates, depending on the clinical risk profiles.[2] Further, these barriers to care can ultimately lead to additional health complications.[1]

A retrospective data analysis was conducted by Novo Nordisk and Optum Life Sciences to uncover potential opportunities for enhancements to employer-sponsored health plans that would address unmet needs. It examined social determinant of health (SDoH) risks and access barriers to obesity care.[3,a]

These barriers hinder effective obesity management, offering opportunities to improve healthcare access and outcomes in employer-sponsored plans.

Disparities in people with obesity

- Racial and ethnic differences[1]
- Age[4]
- Gender[5]
- Financial situation[1]

SDoH[6]

- Healthcare access
- Housing security
- Social isolation
- Financial stress
- Education access

Link between obesity and comorbidities

- Obesity-related comorbidities (ORCs) can have far-reaching consequences, impacting physical health and daily life while complicating both short- and long-term treatment[7]

Select examples of ORCs[7-9]

Short-term ORCs[b]

- Type 2 diabetes
- Hypertension
- Dyslipidemia
- Obstructive sleep apnea (OSA)
- Prediabetes
- Gastroesophageal reflux disease (GERD)
- Heart failure with preserved ejection fraction (HFpEF)

Long-term ORCs

- Cardiovascular disease (CVD)
- Atherosclerotic CVD (ASCVD)
- Metabolic dysfunction-associated steatotic liver disease (MASLD)[c]
- Metabolic dysfunction-associated steatohepatitis (MASH)[c]
- Chronic kidney disease (CKD)

[a]Based on a retrospective data analysis conducted from January 1, 2021, to December 31, 2022, using the Optum Research Database (ORD) to examine 1,140,753 commercial health plan members with overweight or obesity. The analysis explored the relationship between SDoH risks and barriers to accessing obesity care. Members were categorized into body mass index (BMI) cohorts, and SDoH risk indices were assessed to highlight unmet social needs and obesity-related complications.[3]

[b]The short-term ORCs were defined as occurring and able to impact in 3 years or less.

[c]MASLD was formerly known as nonalcoholic fatty liver disease (NAFLD) and MASH was formerly known as nonalcoholic steatohepatitis (NASH).[10]

Key findings

Employees

- ~50% of the study's 1.14 million members had at least 1 obesity-related comorbidity, with dyslipidemia, hypertension, and type 2 diabetes most prevalent[3,a]
- 13% of employees with coverage were aware of available weight-management solutions[11,b]
- 51.3% of members had low health self-management[3,a]

Employer-sponsored health plans

- 32% of employers offered a weight-management program, but program features varied by employer[12,c]
- <10% of members participated in employer programs, underscoring the need for better accessibility[13,d]
- Despite comprehensive health plans, many members faced barriers to care, with racial/ethnic minorities and those with low to moderate incomes particularly affected[14]

SDoH and BMI influence

- 12.9% of members had at least 1 SDoH risk measure that was very high risk, such as food insecurity and housing instability, which is higher than the expected 10%[3,a]
- For the 5 SDoH risks analyzed, risk increased as BMI obesity class increased[3,a]
- Individuals with higher BMI tended to face more significant social determinant risks, complicating their ability to manage their weight and associated health conditions[15]

Proposed actions to improve access to obesity care[3]

- Provide comprehensive solutions that treat obesity as a primary condition, giving members better control over both obesity and its related complications
- Account for the increased SDoH risks in individuals with overweight and obesity to create more equitable access to care
- Provide accessible, tailored obesity care to increase employee engagement in managing their weight

[a]Based on a retrospective analysis of data collected between January 1, 2021, and December 31, 2022.[3]

[b]Data were collected through online surveys conducted from October 29 to November 12, 2015.[11]

[c]Derived from the 2022 Employee Benefits Survey.[12]

[d]Based on self-reported data from the Workplace Health in America Survey conducted between November 2016 and September 2017.[13]

Scan the QR code to read the full paper and explore these findings in greater detail.

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