Obesity And The Workplace: Current Programs And Attitudes Among Employers And Employees

Large employers have accepted a role in addressing obesity in the workplace, but they don't believe they should act alone.

by Jon R. Gabel, Heidi Whitmore, Jeremy Pickreign, Christine C. Ferguson, Anjali Jain, Shova KC, and Hilary Scherer

ABSTRACT: This paper presents findings about weight management programs at the workplace, and employers' and employees' views about these programs. Data are from a survey of 505 randomly selected public and private employers with fifty or more employees, and a survey of 1,352 households with employer-based insurance. The majority of employers with 5,000 or more workers offer programs such as on-site exercise facilities, nutritional counseling, and health risk appraisals, whereas sizable minorities of smaller employers offer them. Employers and employees view weight management programs as appropriate and effective. Employers want programs to pay for themselves, whereas employees are willing to pay higher premiums for them. [*Health Affairs* 28, no. 1 (2009): 46–56; 10.1377/hlthaff.28.1.46]

Since 1980, the percentage of Americans designated as obese has grown from 15 percent to 34 percent of the adult population, with serious consequences for many segments of American society.[1] About two of every three adults today are either overweight or obese.[2] It is predicted that by 2015, 40 percent of the U.S. adult population will be obese.[3]

Nearly 80 percent of obese adults have diabetes, coronary artery disease, high cholesterol levels, high blood pressure, gallbladder disease, or osteoarthritis. About 40 percent of obese Americans have two or more of these conditions.[4] Obesity is linked to 400,000 deaths per year and has roughly the same effect on the

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presence of chronic conditions as twenty years of aging.[5]

For employers, the cost of obesity entails higher medical claims expenses for obesity and its accompanying chronic conditions, increases in short- and long-term disability expenses, increased absenteeism, and lower productivity. Kenneth Thorpe and colleagues report that 27 percent of the increase in real per capita health care spending from 1987 to 2001 is attributable to the increased prevalence of obesity and its higher treatment costs.[6] Obese people ages 18–65 incur medical spending that is 37 percent higher than spending for people of normal weight.[7] Absenteeism among severely obese women (body mass index, or BMI, greater than or equal to 40 kg/m^2) is more than double that for women of normal weight.[8]

From a societal perspective, as obesity adds to the growing cost of health insurance and rising costs render health insurance less affordable to employers and employees, obesity also is linked to the problems of un- and underinsurance. Since obesity is more prevalent in low-income populations than in high-income populations, firms employing many low-income workers might pay a heavier economic price for obesity, and these firms are the ones least able to afford higher premiums.

Research on obesity is extensive and fast-growing. There is, however, limited research on what employers are doing to address obesity in the workplace, what their viewpoints are about the causes of obesity, and what responsibility they take to address the problem. We are unaware of any national survey of public and private employers, where the sample was randomly selected, that has examined these issues in detail.

One national survey of 1,139 employees examined employees' attitudes about employer-based weight management programs.[9] Employees identified "lack of willpower" and the "cost of healthy food" most frequently as the causes of obesity. Large majorities supported favorable tax treatment for employers that provide exercise facilities (85 percent), requiring health insurers to provide obesity treatment and prevention (73 percent), and providing discounts to people who maintain or lose weight (72 percent). Obese people generally held the same viewpoints as nonobese people, except that obese people were significantly more likely to favor discounts for weight-challenged people who maintain or lose weight.

This paper presents findings from two recent and related surveys, one of employers and the other of employees. The first survey examined programs employers offer to their workforce to counter obesity as well as employers' attitudes about obesity.[10] The second survey explored employees' views on weight management programs in the workplace.

Study Data And Methods

■ **Survey of employers.** From October to December 2007, using computer-assisted telephone interviews, National Research LLC completed interviews with employee benefit managers from 505 randomly selected public and private employers. The sample was drawn from a Dun and Bradstreet listing of U.S. public and pri-

vate firms with fifty or more workers, and all surveyed firms offered health benefits to their workers. The sample was stratified by firm size, with controls for industry and geographic location. The questionnaire asked about characteristics of the firm, its workforce, and the types of health plans offered. It also asked about weight management programs offered, perceived responsibilities of employers, attitudes toward obesity, and efforts to address it in the workplace.

All analyses used statistical weights that were calculated as follows: first, the basic employer weight was set equal to the inverse of the firm's probability of selection into the sample. This basic employer weight was then adjusted to correct for nonresponse bias, and overly influential weight values were identified and trimmed. Finally, the weights were poststratified based on the Statistics of U.S. Businesses compiled by the U.S. Census Bureau. In the analysis, all statistics from the survey of employers are employer-based weights, as opposed to employee-based weights.

When calculating standard errors, we used the statistical program SUDAAN to account for design effects. Differences presented in the text are statistically significant at the 0.05 confidence level unless otherwise noted.

■ **Survey of employees.** From January to February 2008, as part of the EXCEL Omnibus Survey, International Communications Research (ICR) conducted a survey of U.S. households. The questions on obesity were a special supplement for a subsample from the larger survey. The sample design was a fully replicated, stratified, single-stage, random-digit-dial sample of telephone households. Using computer-assisted telephone interviews, ICR interviewed one randomly selected adult from each household. ICR completed 1,352 interviews with people who satisfied the following criteria: (1) 18–64 years of age; (2) employed either full or part time; (3) employed by a company with fifty or more employees; and (4) enrolled in either employer- or union-sponsored health insurance. ICR developed statistical weights that adjusted for the probability of selection of the respondent, with further adjustments for nonresponse bias.

In the special supplement, employees were asked to provide information on their height and weight, which allowed us to calculate the BMI for each respondent. Other researchers have found that when respondents self-report their height and weight, they overestimate their height and underestimate their weight. We did not make adjustments in these self-reported figures, and we used these unadjusted BMI figures as covariates to understand employees' responses.

Study Findings

■ **Appropriateness and perceived effectiveness of weight management programs.** Both employers and employees view weight management programs at the workplace as appropriate and effective. Seventy-one percent of employers and 92 percent of jumbo employers (with 5,000 or more workers) agreed that "it is an appropriate role for an employer to include a range of obesity-related services and

benefits for employees" (data not shown). Employers connected the appropriateness of weight management programs with their concern about medical claims expenses, sickness and disability expenses, and lost productivity. Sixty-seven percent of employers indicated concern about the effect of obesity on medical claims expenses, with 26 percent saying that they were "very concerned" (not shown). Among jumbo employers, 50 percent responded that the firm was "very concerned," and 39 percent said that the firm was "somewhat concerned."

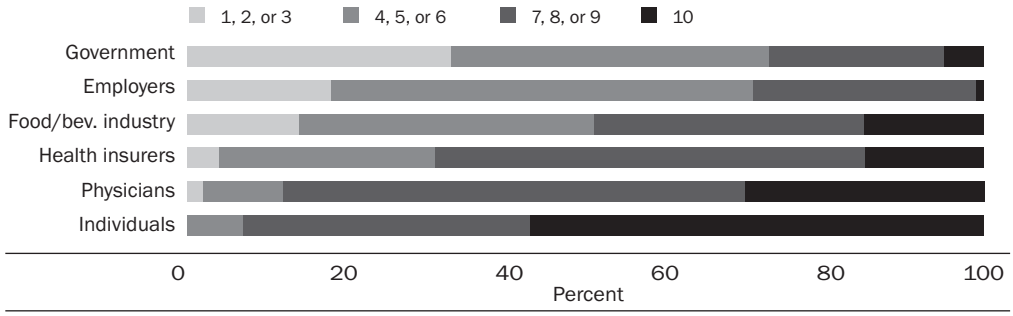
Eighty percent of surveyed employees concur that "programs related to weight management or healthy lifestyles belong in the workplace" (data not shown). Workers earning less than $25,000 per year were less likely than others to agree with the appropriateness of weight management programs. More affluent, better-educated, and female employees were more likely than others to agree that these programs belonged in the workplace. Only 10 percent of employees strongly agreed (not shown) that "workplace programs related to weight and healthy lifestyle issues interfere with an employee's privacy." Another 28 percent "somewhat agreed." Low-income employees were more likely than high-income employees to agree that these programs interfere with privacy. Employees were less inclined than employers were to link obesity with higher medical claims expenses. Fifty-five percent of employees agreed that "seriously overweight or obese employees raise premiums for everyone," and only 12 percent agreed "a lot" with the statement (not shown). Men, people in good health, and higher-income workers were more likely than others to agree with the assertion.

Although employers viewed anti-obesity-related workplace programs as appropriate, they also were likely to identify other stakeholders as having a major role in addressing obesity (Exhibit 1). When asked to identify on a scale from 1 to 10 the extent to which various entities "should have a significant role to play in terms of addressing obesity," with 1 being "completely disagree" and 10 being "completely agree," 57 percent of firms gave the employee a 10, and 31 percent gave physicians a 10. Sixty-nine percent of employers scored health insurers at 7 or higher, and 49 percent of employers scored the food and beverage industry at 7 or higher. In contrast, 28 percent of employers scored employers at 7 or higher, and 26 percent ranked the government at 7 or higher.

Employers generally agreed that offering obesity-related services and benefits was effective in lowering the rate of obesity.[11] Seventy-three percent of employers and 86 percent of jumbo employers saw these programs as effective (data not shown). Among employers who felt that these services were effective, 45 percent strongly agreed that it was because offering these services showed employees that obesity is serious and important, while 51 percent somewhat agreed. Forty-eight percent strongly agreed that they were effective because there is evidence that they work, while 43 percent somewhat agreed.

■ **Employers' views on the causes of obesity.** Employers were far more likely to view obesity as a "result of poor lifestyle choices" (93 percent) or "preventable"

EXHIBIT 1
Percentage Of Firms Reporting That Various Entities Have A Major Role To Play In Addressing Obesity, On A Scale Of 1 To 10, 2007



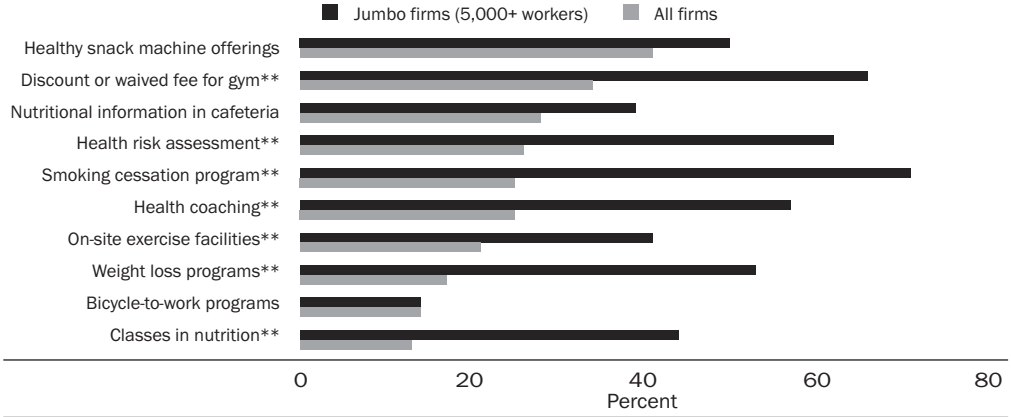
SOURCE: NORC/George Washington University Survey on Employer and Employee Views of Obesity, 2007–2008.
NOTE: 1 represents "completely disagree"; 10, "completely agree."

(87 percent) than "out of one's control" (41 percent) or "futile to treat" (18 percent; data not shown). At the same time, 81 percent of employers saw obesity as having a genetic component, but only 11 percent "strongly agreed" with that description.

■ **Programs offered.** Employers are providing a range of weight-related "programs," from the relatively simple worksite changes such as healthy snacks in vending machines and on-site exercise programs to those using the health care system. Many programs are oriented to general wellness as well as weight-related problems. Examples of the latter include disease management (DM) programs and services targeting obesity in their health plan offerings. Employers may offer weight management programs either through their health plans or independent of them. When programs are offered independently, the most prevalent feature offered by firms is healthy snack machine options, 41 percent (Exhibit 2). The next most common were discounts or waived fees for gym memberships, nutritional information in employee cafeterias, health risk assessments, health coaching programs, and on-site exercise facilities. In comparison, 25 percent of firms offer a smoking-cessation program, a wellness program that clinical trials have found to be effective.[12] The largest firms, with 5,000 or more workers, were significantly more likely than smaller firms to offer most of these programs. For example, 53 percent of the largest firms offered weight-loss programs such as Weight Watchers versus 16 percent of small firms, and 57 percent of the largest firms offered health coaching versus 24 percent of small firms (not shown). Firms with a high retention rate (95 percent or greater in the past year) were no more likely to offer such services/features than were firms with lower retention rates.

Similarly, for the health plan with the largest enrollment offered by the employer, 72 percent of firms reported that the plan covered prescription drugs for physician-supervised weight loss (not shown). Sixty-two percent covered nutritional counseling with a physician order (not shown), and 53 percent covered weight-loss surgery with a physician order and included a DM program targeting

EXHIBIT 2
Percentage Of Firms Offering At Least Some Employees Various Obesity-Related Services Or Benefits, Excluding Any That Health Plans Might Offer, By Firm Size, 2007



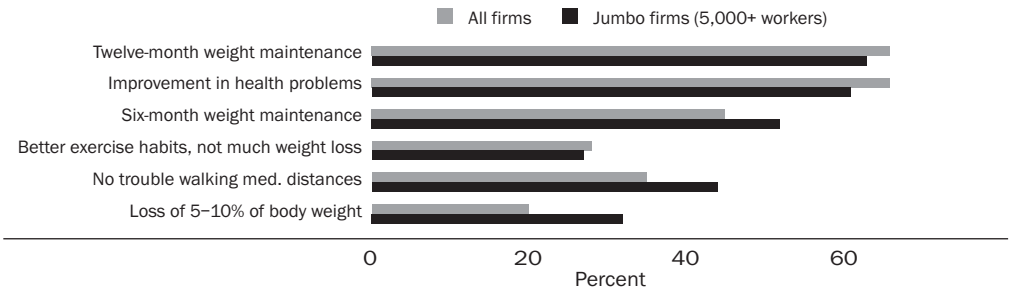
SOURCE: NORC/George Washington University Survey on Employer and Employee Views of Obesity, 2007–2008.
NOTE: Statistical significance denotes that jumbo firm estimate is significantly different from all firms.
** $p < 0.05$

obesity.[13] In most plans, these treatments require specific conditions to be met to qualify for treatment. Jumbo firms were significantly more likely (70 percent) than smaller firms to report that the most popular plan included a DM plan targeting obesity (not shown). Firms with 50–199 workers were least likely to do so. Again, firms with the highest retention rates were no more likely to have these services covered in the most popular health plan than were firms with lower retention rates.

■ **Employees' assessments of weight management programs.** Employees generally viewed workplace programs to address obesity and promote wellness as effective.[14] On-site exercise facilities and subsidizing healthy foods in the cafeteria were viewed most highly, with 89 percent and 88 percent of workers, respectively, saying that the programs "frequently helped" or "sometimes helped" people reach or maintain a healthier weight. Overall approval ratings were statistically equivalent for health coaching, health risk appraisals, and discounted gym memberships, but the percentage of employees who said that these programs "frequently help" was statistically lower.

■ **Defining success.** Overall, employers have varying ideas about what constitutes success in addressing the health risks of obesity.[15] Two-thirds of employers strongly agreed that maintenance of one's new weight for twelve months defined success in terms of addressing the health risks of obesity (Exhibit 3). The same percentage strongly agreed that improvement in other related health problems, such as better blood pressure control or decreased joint pain, defined success. Just 45 percent of employers strongly agreed that maintenance of one's new weight for six months defined success, followed by no longer having trouble walking medium dis-

EXHIBIT 3
Percentage Of Firms That Strongly Agree That Various Achievements Constituted "Success" In Addressing The Health Risks Of Obesity, By Firm Size, 2007



SOURCE: NORC/George Washington University Survey on Employer and Employee Views of Obesity, 2007–2008.
NOTE: Tests found no significant difference between jumbo firms and all firms.

tances (35 percent). Only 20 percent strongly agreed that the loss of 5–10 percent of weight constituted success. It is not possible to determine from the question whether employers thought that this standard was too stringent or too lax. It may also be attributable to the lack of employers' awareness about the important health benefits that can result from losing 5–10 percent of one's weight. Differences by firm size generally were not statistically significant.

■ **Views on financial incentives.** Both employers and employees favor positive financial incentives for participating in weight management programs and oppose financial penalties. Seven percent of employers strongly agreed and another 18 percent somewhat agreed that "obese employees should pay a larger share of premiums" (not shown). In contrast, 29 percent of employers strongly agreed that smokers should pay a larger share of the premium, and another 23 percent somewhat agreed. When it comes to positive incentives, 39 percent of employers (and 63 percent of jumbo firms) strongly agreed that firms should offer discounts/incentives for participating in obesity management programs. Another 38 percent somewhat agreed.

Incentives versus penalties. Employees strongly support positive financial incentives and vehemently oppose financial penalties for participating or not participating in various workplace programs to address obesity and promote wellness.[16] Seventy percent of workers support discounts on health insurance or other monetary incentives for participation in weight management programs, 77 percent for participating in health risk appraisals, and 66 percent for participating in health coaching. Obese employees are more likely to support discounts and other monetary incentives than employees with BMI of normal weight or overweight. In contrast, about 6 percent of employees support higher premium contributions for people who decline to participate in weight management programs. Comparable figures are 2 percent for not participating in health risk appraisals and 6 percent for not participating in health coaching.

Tax breaks. When employers were asked, "To the best of your knowledge, would

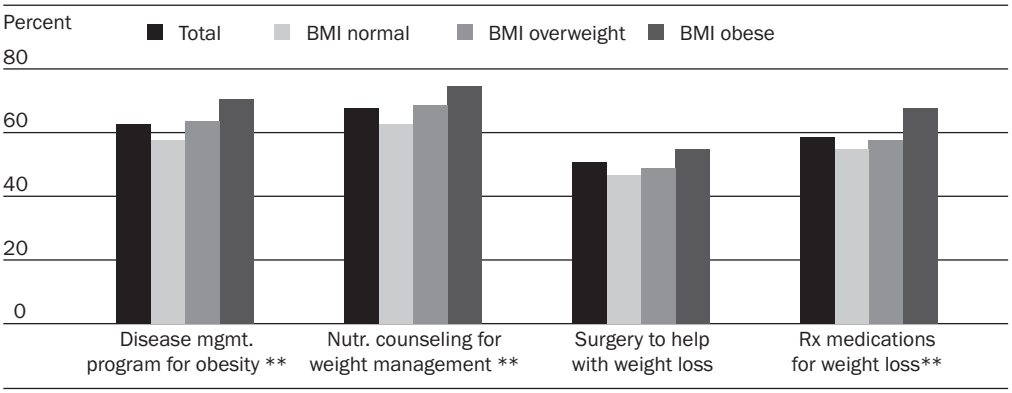
a tax break for employers that provide worksite health and wellness programs make your firm more likely to provide these programs?" 28 percent indicated "very likely" and 43 percent, "somewhat likely" (not shown). Smaller employers were more likely than larger ones to indicate that the tax break would influence their behavior.

■ **Financing weight management and wellness.** Only a minority of firms are willing to pay higher premiums for more obesity prevention or treatment benefits. Employees, in contrast, are willing to contribute more for their premiums to pay for these programs. For example, only 2 percent of employers strongly supported paying higher health insurance premiums for more obesity prevention benefits, while 31 percent somewhat supported doing so.[17] Similarly, just 3 percent strongly supported and 34 percent somewhat supported paying higher health insurance premiums for more obesity treatment benefits. The largest firms (5,000 or more workers) were no more likely than smaller firms to do so. The reluctance to pay more likely stems from the perceived length of time it would take for employers to "recoup their investment" in the form of lower premiums—the time horizon. Employers most commonly saw obesity management programs as needing to pay for themselves within a three-year period (not shown). About one-quarter of employers were unable to designate the time necessary for obesity efforts to pay for themselves.

Majorities of employees were willing to contribute slightly more for premiums so that various services would be covered for every person in the firm (Exhibit 4). This varies from 68 percent for nutritional counseling to 51 percent for surgery to help with weight loss. Employees with BMI obesity scores were statistically more likely to support paying more in premiums than were employees not so desig-

EXHIBIT 4

Percentage Of Workers Who Think That Various Services Should Be Covered For Everyone In Firm, Even If The Amount They Have To Pay For Health Insurance Increases Slightly, By Body Mass Index (BMI), 2008



SOURCE: NORC/George Washington University Survey on Employer and Employee Views of Obesity, 2007–2008.
NOTE: Statistical significance denotes that obese is significantly different from normal.
** $p < 0.05$

nated. African Americans were more willing than whites to pay more for the services by an average of fifteen percentage points (not shown).

When asked if employees would rather have their employer spend money in other ways instead of paying for workplace programs related to weight and healthy lifestyles, 12 percent of employees strongly agreed (not shown) and an additional 30 percent somewhat agreed. Sixty-five percent of lower-income employees (less than $25,000 per year) agreed with this statement. African Americans were less likely than whites to agree, but people of normal weight were no more likely to agree with the statement than were obese people.

Discussion

Two surveys, one of employers and one of employees, depict how U.S. society views the national epidemic of overweight and obesity. On the one hand, both employers and employees believe that overweight and obesity result from poor lifestyle choices or poor willpower and, as such, are preventable conditions. On the other hand, both employers and employees believe that overweight and obesity cause health problems that may require a health care intervention. Further, regardless of their perception about personal responsibility, many large employers seem to accept the workplace as an appropriate venue for addressing these problems. This appears to be attributable largely to employers' overriding concerns about rising health care costs and lower productivity. Employers, particularly the largest, have made the leap connecting concerns about productivity, absenteeism, and rising health costs with managing their employees' weight.

Employers appear to have accepted a role in addressing overweight and obesity in the workplace, but they clearly do not believe that they should act alone. In fact, employers see individuals, their physicians, and health insurers as the primary combatants in this fight, with the food and beverage industry close behind. Interestingly, both employers and employees support positive financial incentives over punitive or negative incentives for employees to address their weight. Again, this reflects what seems to be acceptance that although personal responsibility is an aspect of addressing weight management, it cannot be the sole strategy.

Some employers articulated realistic definitions of individual success in managing overweight and obesity. For example, they cited maintaining a reduced weight for twelve months, reducing blood pressure, and improving related health problems, but many have not gotten the message that a 5–10 percent weight loss can lead to major health improvement.

■ **Study limitations.** We note a few limitations of the study. First, the sample of employers did not include firms with fewer than fifty employees, and these small firms account for about 25 percent of the workforce. Second, the discussion on the effectiveness of weight management and wellness initiatives pertains to "perceived" effectiveness, rather than actual effectiveness. Third, the survey of employees does not include as much detail on employees' attitudes toward obesity as does the sur-

vey of employers. Fourth, the surveys did not ask employers or employees to identify actual current health plan or workplace spending to reduce overweight or obesity, nor did they ask for an estimate on how much they believe should be spent.

■ **Relevance of findings to health reform.** The United States is again on the threshold of a debate about reforming the health care system. This debate should address more than coverage expansion and entail a comprehensive review of our health care system and what changes can make it more efficient. This review should consider what constitutes a successful intervention, what services are underused and overused, and what reform can do to encourage more underused and fewer overused services. The case of overweight and obesity illustrates the problems of continuing the traditional fee-for-service model designed to pay for medical services for acute illnesses.

In a nation where the average waist size for a white male is 39 inches and for females, 36.5 inches, according to the National Center for Health Statistics, and where 27 percent of the increase in health spending from 1987 to 2001 is attributable to obesity, designing a system that would encourage providers to address obesity is paramount.[18] Many of the services necessary to address obesity, such as weight and disease management programs, do not lend themselves to the fee-for-service, acute care medical model. A partial or full capitation system would provide the proper incentives for such services. A reformed system should also financially reward providers for outstanding clinical outcomes, not simply the quantity of services delivered. The treatment of obesity would require an agreed-upon standard of appropriate weight loss—such as the loss of 5–10 percent of body weight over a year—with a financial bonus to providers who achieve such success.

The current reform debate divides into two schools of thought: should the United States strengthen its eroding employer-based system, or move to a system built on individuals' purchasing insurance directly from insurers? Obesity is now such a major health problem that policymakers should take it into consideration when determining which path to take. Would employers be willing to invest as many resources in controlling obesity if they did not have the responsibility for providing health insurance? On the other hand, would there be less plan switching in a system based on individual coverage, since plan choice would no longer be dependent on where one works? Would insurers invest more in weight management programs if they knew that beneficiaries were likely to remain in the same plan for many years? At this time, there is little evidence to address these issues.

WE NEED TO RECOGNIZE THAT OUR APPROACHES to overweight and obesity may begin but must not end with personal responsibility. Few diseases require a more holistic approach than the effort to contain and reduce the levels of overweight and obesity, and in few places are the stakes higher. Large employers seem to have recognized this and are trying to develop programs to address it. If policymakers take a similar approach in the coming de-

bate, using the impact of possible reforms on both the prevalence and cost of obesity, it may greatly determine how effective and affordable any health reform proposal will be in the long run.

The authors thank the Strategies to Overcome and Prevent (STOP) Obesity Alliance for the financial support that made this study possible. The views expressed in the paper are those of the authors and not necessarily the views of the STOP Obesity Alliance and its member organizations.

NOTES

1. People with a body mass index (BMI) greater than 30 kg/m^2 are classified as obese. Someone with a BMI between 25 and 30 is regarded as overweight. Institute on the Costs and Health Effects of Obesity, "Addressing Obesity and Enhancing Productivity," Issue Brief 3, no. 3 (Washington: National Business Group on Health, 2005), 1–2.
2. C.L. Ogden et al., "Prevalence of Overweight and Obesity in the United States, 1999–2004," *Journal of the American Medical Association* 295, no. 13 (2006): 1549–1555.
3. Y. Wang and M.A. Beydoun, "The Obesity Epidemic in the United States—Gender, Age, Socioeconomic, Racial/Ethnic, and Geographic Characteristics: A Systematic Review and Meta-Regression Analysis," *Epidemiologic Reviews* 29 (2007): 6–28.
4. A. Must et al., "The Disease Burden Associated with Overweight and Obesity in the United States," *Journal of the American Medical Association* 282, no. 16 (1999): 1523–1529.
5. R. Sturm, "The Effects of Obesity, Smoking, and Drinking on Medical Problems and Costs," *Health Affairs* 21, no. 2 (2002): 245–253.
6. K. Thorpe et al., "The Impact of Obesity on Rising Medical Spending," *Health Affairs* 23 (2004): w480–w486 (published online 20 October 2004; 10.1377/hlthaff.w4.480).
7. Sturm, "The Effects of Obesity."
8. E. Finkelstein, C. Fiebelkorn, and G. Wang, "The Costs of Obesity among Full-Time Employees," *American Journal of Health Promotion* 20, no. 1 (2005): 45–51.
9. B. Fuemmeler et al., "Employer and Healthcare Policy Interventions Aimed at Adult Obesity," *American Journal of Preventive Medicine* 32, no. 1 (2007): 44–51.
10. The alliance entails a diverse group of organizations including employers, health insurers, unions, health care providers, and consumer groups.
11. Questions asked of employees pertained to specific programs offered by employers, such as health coaching, on-site exercise facilities, and subsidizing health foods in the employee cafeterias. A subsequent section will present these findings.
12. U.S. Department of Health and Human Services, "NHBLI Study Shows Smoking Cessation Programs Improve Survival," *NIH News*, 14 February 2005, http://www.nhlbi.nih.gov/new/press/05-02-14.htm (accessed 7 August 2008); and R. Boyle et al., "Does Insurance Coverage for Drug Therapy Affect Smoking Cessation?" *Health Affairs* 21, no. 6 (2002): 162–168.
13. The survey did not provide a definition of a disease management program directed at obesity.
14. See Appendix Exhibit 1, online at http://content.healthaffairs.org/cgi/content/full/28/1/46/DC1.
15. Employees were not asked about what constitutes success.
16. See Appendix Exhibit 2 online, as in Note 14.
17. See Appendix Exhibit 3 online; ibid.
18. Cited in N. Onishi, "Japan, Seeking Trim Waists, Measures Millions," *New York Times*, 13 June 2008; and Thorpe et al., "The Impact of Obesity on Rising Medical Spending."