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Weight Management

A Guide for Employers

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Executive Summary

It seems every website, magazine, and media outlet is publishing article after article about new weight loss drugs like Ozempic and Mounjaro. This new generation of weight loss medication belongs to a class of drugs called GLP-1 receptor agonists. It's no surprise that alongside media attention, employers and health plans are evaluating whether to include GLP-1s in their formularies. There are two competing priorities: the undeniable need for effective obesity treatment and the need to contain costs.

Weight management and metabolic health are important for individual health and have a significant financial impact on employers, who bear many of the costs related to obesity. There are also many old conceptions about obesity that are outdated or flat-out wrong.

Employers can reduce healthcare spend through the downstream health benefits of weight loss, yet traditional health plans and providers treat obesity as a willpower issue and not as a complex, chronic condition. The science behind new obesity medications signal a shift away from characterizing obesity as a personal failing to a chronic medical condition. These new therapies represent a promising sign of progress in the understanding of obesity. However, fixating on GLP-1s as a magic bullet misses the complex nature of obesity, especially for sustained weight loss and overall health.

Effective, lasting treatment for obesity should leverage a comprehensive, whole-person approach. In this guide, we'll share what employers should know about the costs of excess weight, myths and realities about weight, and the quickly evolving landscape of obesity medicine.

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01. Employers' cost of obesity

Weight management and metabolic health are important for individual health *and* have a significant financial impact on employers, who shoulder many of the costs related to obesity. The Centers for Disease Control (CDC) estimates the annual medical cost of obesity in the U.S. was $173 billion in 2019.[1]

In total, **almost half of working-age Americans have obesity** and their annual medical costs are on average 50% higher, driving up health plan costs. Normal-weight employees cost an average of $3,830 per year in covered medical, sick day, short-term disability and workers' compensation claims, while morbidly obese employees cost more than twice that amount, or $8,067.[2]

There are also significant soft costs correlated with obesity to take into account. For example, it significantly impacts absenteeism. An in-depth study in 2016 found that an employee with obesity, relative to one with a healthy weight, raises job absenteeism due to injury or illness by three days per year with national productivity losses ranging from $13 to nearly $27 billion.[3] The CDC estimates that five chronic diseases and risk factors—high blood pressure, diabetes, smoking, physical inactivity, and obesity—directly reduce worker productivity and cost US employers $36.4 billion a year from employees missing days of work.[4]

There's presenteeism and a broad impact to productivity related to obesity as well. Workers with moderate or extreme obesity (classified as having a BMI higher than 35) experienced the greatest health-related work limitations, specifically regarding time needed to complete tasks and ability to perform physical job demands. These workers experienced a 4.2% health-related loss in productivity, 1.18% more than all other employees, which equates to an additional $506 annually in lost productivity per worker.[5]

Even after controlling for other variables, a recent study found a significant effect of obesity on receiving disability insurance. For men in the study, obesity raises the probability of receiving disability income by nearly 7% and for women by almost 6%.[6]

The bottom line is that, between direct costs from increased healthcare spend and indirect costs like work absence and productivity challenges, obesity has a significant impact on employers' health spend.

Section Summary

- Obesity is widespread and rising in the U.S.
- Obesity is expensive—for individuals and for payers
- There are significant indirect costs associated with obesity for employers including absenteeism, presenteeism, and increased disability costs

Weight by the numbers

41.9%

of U.S. adults have obesity[7]

19 states

have an adult obesity prevalence > 35%[8]

$260.6B

Annual medical costs related to obesity in the U.S.[9]

3 days

increase in the average number of missed days per year due to obesity[10]

02. Weight and chronic conditions

Obesity itself is a chronic condition, and is linked to over 200 related health conditions. For the full picture on obesity and its related costs, understanding the way it is intertwined with overall health is key–it's not about the number on a scale alone. People with overweight or obesity, compared to those with healthy weight, are at increased risk for many serious diseases and health conditions including:

- All causes of death
- High blood pressure
- High cholesterol
- Type 2 diabetes
- Gallbladder disease
- Stroke
- Osteoarthritis
- Some types of cancer
- Sleep apnea
- Asthma
- Depression
- Anxiety

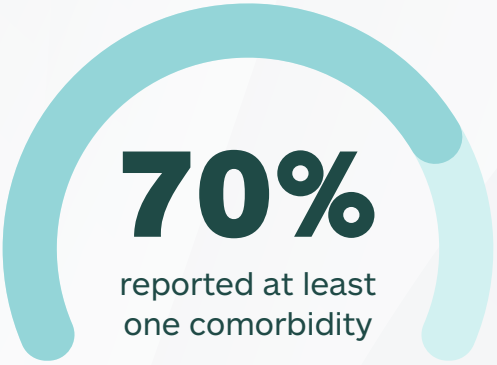
Obesity is thought to be co-occur with these conditions because:[11]

- Excess weight can put physical stress on the joints, leading to problems like osteoarthritis.
- Excess weight can push on the chest and diaphragm and cause the soft tissues of the throat to collapse, leading to sleep apnea.
- An increase in hormones and other substances secreted by adipose (fat) tissue impacts the endocrine (hormone) system, resulting in diabetes and other metabolic conditions.
- Physical and metabolic problems can harm the body's organs, such as the heart and kidneys.

Not everyone who has obesity has these conditions, and likewise not everyone who has these conditions has obesity. The risk rises if there's a family history or environmental factors for one of these conditions.

The Data

Our own data reinforces the link between excess weight and other chronic conditions. Hello Alpha analyzed more than 10,000 patients who completed an initial weight loss visit in 2023, and found:



- 27% reported a mental health comorbidity—approximately two thirds with anxiety and the rest with depression
- 19% reported diabetes or pre-diabetes
- 18% reported high blood pressure
- 13% reported PCOS

The Obesity Medicine Association defines obesity as “a chronic, relapsing, multi-factorial, neurobehavioral disease, wherein an increase in body fat promotes adipose tissue dysfunction and abnormal fat mass physical forces, resulting in adverse metabolic, biomechanical, and psychosocial health consequences.” Effective, lasting treatment for obesity must be holistic. A siloed approach to weight management means that a patient is less likely to be screened for a chronic condition, which further drives up healthcare costs for individuals and employers.

It's important to recognize and understand comorbidities for several reasons, including disease prevention and issues with diagnosis and treatment. If a patient has a diagnosis that can lead to comorbidities, they may be able to take steps to prevent those other conditions from developing. For example, if someone has been diagnosed with prediabtes, it’s likely a healthcare provider will suggest improvements to diet and fitness, and potentially take medicine, to lower the risk of comorbidities such as heart attack and stroke.[12]

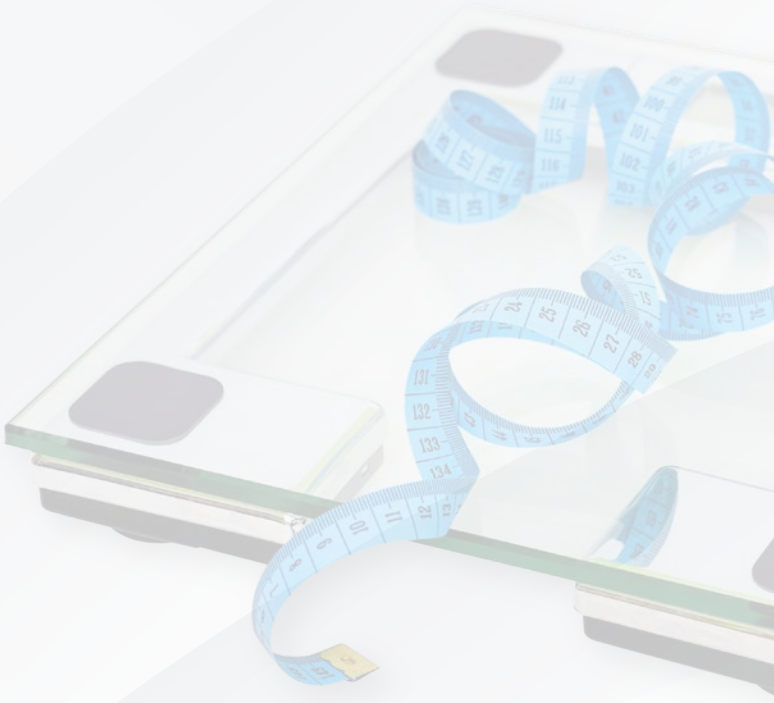
Understanding comorbidities can also help with the diagnostic process by giving a healthcare provider a place to start. If someone has excess weight and joint pain, it may make more sense for the healthcare provider to first screen for non-autoimmune diseases like osteoarthritis and gout instead of considering autoimmune pain conditions such as lupus or rheumatoid arthritis.

Recognizing comorbidities can also help a healthcare provider properly diagnose and treat all of a patient's conditions, which gives them a better chance of feeling and functioning well overall.

Typically losing even a small amount of weight has health benefits and has been shown to lower the risk of diseases linked to obesity.

Section Summary

- Obesity is associated with an increased risk of many common medical conditions including high blood pressure, high cholesterol, type 2 diabetes, and more
- A healthy eating plan, weight loss, and improved aerobic fitness can reduce health risks
- Understanding comorbidities is important for a patient's overall health



03. Obesity myths

Myths and misconceptions about obesity are pervasive in the media, popular culture, and older scientific literature. These unsupported beliefs can yield poorly informed clinical decisions from healthcare providers and unproductive resources from employers. Let's address some of the most widespread myths:[13]

Myths	Facts
BMI is the only measure needed to understand a person's health	BMI, or body mass index, is a measure of weight relative to height that is used to screen for weight-related health problems. However, BMI has some problems such as: • It does not account for body fat and muscle mass, which can vary with age, sex, and ethnicity • It may overestimate or underestimate the health risks of people with different body shapes and sizes • It may not capture the full impact of obesity on health and mortality In the summer of 2023, the American Medical Association (AMA) voted to adopt a new policy that encourages providers to de-emphasize their reliance on BMI when assessing individual patients' weight and health.
GLP-1s and weight loss medications are the easy way out	GLP-1 drugs and other prescription weight loss medication are one of several tools to help someone lose weight, under the supervision of a licensed provider. They are not the "easy way out," and are used alongside dietary and lifestyle changes. There are many health and physiologic reasons why weight loss medication may be suitable for someone.

Anyone can lose weight if they just use some will power	Obesity isn’t a choice. Losing weight isn't just about willpower or following a one-size-fits-all program. People's responses to weight loss efforts vary greatly, even with the same intervention and compliance. Some might not see additional weight loss due to compensatory changes in the body, genetics, or an underlying health condition.
Obese people are unhealthy and thin people are healthy	Weight is only one aspect of overall health, and outward appearances are not reliable. Many health conditions are “invisible” or affect both people with obesity and people in a healthy weight range.
Diets work long-term	Dieting alone doesn’t lead to sustainable weight loss. Successful long-term weight loss requires dietary adjustments, regular exercise, self-monitoring, and environmental changes. It is an on-going journey that looks different for each person.
Losing weight is a linear process	Weight loss is rarely, if ever, a straight line from starting to goal weight. It’s normal for weight to fluctuate, and even more common for this to happen to women due to hormonal cycles or changes. Other ways to track progress include measuring waist circumference and taking photos.
Cutting carbs cures obesity	Not all carbs are equal. Whole, unprocessed carbs (oatmeal, leafy vegetables, lentils) are rich in fiber and nutrients that our bodies use as a main source for energy. Refined, processed carbs with added sugars, on the other hand, should be limited. Low-carb diets can be effective for weight loss in some people. However, these restrictive diets are rarely sustainable long term and it’s easy for someone to gain the weight back.
Eating fats makes you fat	Just like carbs, not all fats are equal. In balanced amounts, unsaturated fats help give the body energy, protects organs, keeps the brain healthy, supports cell growth, keeps cholesterol and blood pressure under control, and helps the body absorb vital nutrients. Saturated fat consumption should be limited, and trans fats avoided completely.

Exercise is better than dieting for weight loss	Exercise offers many health benefits, but when it comes to weight loss, its impact is relatively modest. This might be because exercise can lead to increased sedentary activities and appetite, countering the extra calories burned. However, regular exercise can still reduce harmful belly fat, even without significant weight loss. Including exercise as part of a weight-loss plan improves overall health and helps maintain weight in the long run.
"Number of pounds lost" is the only metric to measure a successful weight management program	Research shows that solely focusing on weight loss may not lead to healthier bodies and can even be harmful, causing food and body preoccupation, weight cycling, low self-esteem, eating disorders, and discrimination. Instead, a more effective approach is to shift the focus to overall health and wellness. It's important to guide patients in making behavior changes, without just fixating on the number on the scale.

Section Summary

- Weight is a topic that is subject to many misconceptions that still persist, even in healthcare settings
- Common, seemingly harmless advice we hear today is based on an outdated understanding of obesity and weight
- Just as every body is different, an approach to obesity treatment must be tailored to an individual's needs

04. Prescription weight loss medications

Weight management studies have shown that pharmacotherapy along with lifestyle changes result in more weight loss for patients with obesity than medicine or lifestyle changes alone.

There are different categories of prescription medications to support weight loss. Every body is different, so providers may prescribe medication depending on the desired results, side effects, and health conditions.

GLP-1 Receptor Agonists

This class of drugs is the most commonly prescribed. They have made headlines for their impressive results in controlled clinical studies. GLP-1 medications mimic the action of a hormone called glucagon-like peptide-1. This medication acts on several systems to decrease appetite by producing feelings of fullness. It affects the appetite centers of the brain and slows down how quickly the stomach empties, which leaves people feeling full for longer.

- **Semaglutide,** known by the brand names Wegovy, Rybelsus, or Ozempic. Semaglutide also acts on the pancreas to increase insulin secretion and decrease glucagon. (This reduces blood sugar levels, after eating.) Another way semaglutide works is converting white fat-storing cells into brown fat, which increases energy expenditure. Semaglutide medications are typically taken once weekly via injection although there is a pill form. In the drug manufacturer's clinical study, participants had a mean weight loss of 14.9%.

- **Tirzepatide,** known by the brand name Mounjaro. Like semaglutide, tirzepatide mimics GLP-1 but also includes GIP (glucose-dependent insulinotropic polypeptide). Tirezepatide works similarly to semaglutide medications to reduce appetite and increase feelings of fullness. It is also taken once weekly via injection. In the drug manufacturer's clinical study, participants had a mean weight loss of 21.1%.

- **Liraglutide,** known by the brand names Saxenda and Victoza. Like both semaglutide and tirzepatide, it mimics the GLP-1 hormone to slow down the process of stomach emptying. This medication is taken via a daily injection. In the drug manufacturer's clinical study, participants had a mean weight loss of 9.2%.

Other weight loss medications

- **Metformin,** known by the brand name Glucophage. Doctors typically prescribe metformin for people with diabetes or prediabetes to help manage their blood sugars, but people who take the medication can often experience modest weight loss.
- **Orlistat,** known by the prescription name Zenical or the over-the-counter in a lower dose under the brand name Alli. As a gastric and pancreatic lipase inhibitor, this medicine reduces the amount of fat the body absorbs
- **Phentermine** is similar to an amphetamine. It stimulates the central nervous system (nerves and brain), which increases heart rate and blood pressure and decreases appetite. This medicine is for short-term use only.
- **Phentermine/Topiramate,** known by the brand name Qysmia. This is a combination drug that can help increase feelings of satiety, make foods taste less appealing, and help the body burn more calories.
- **Naltrexone/Bupropion,** known by the brand name Contrave. Naltrexone, typically used to reduce cravings for people with substance use disorder, can also curb hunger and food cravings. Bupropion is an antidepressant medicine that can also decrease appetite.
- **Gelesis-100,** known by the brand name Plenity. This pill (considered a medical device) is composed of cellulose and citric acid to absorb water and expand in the stomach and small intestine. This creates a feeling of fullness and increased satiety.

While these are the weight loss medications already on the market, there are several promising treatments currently in clinical trials and this area of medicine is evolving quickly.

The most significant drawbacks of prescription weight loss medications are the potential side effects. Often, side effects are short-term and improve as the body adjusts to the medication. Not everyone will experience side effects. It's important to check with a provider for guidance on how to manage any side effects that are experienced.

Another drawback of prescription weight loss medications is that weight loss may stop if medication use stops, and there is also a strong possibility of regaining weight in that case, potentially leading to weight cycling. Weight cycling refers to repeatedly losing and regaining weight. Studies have linked weight cycling to a greater risk of diabetes, hypertension, and gallbladder stones.

Not everyone is a good candidate for every medication. The following people should avoid prescription weight loss medications:

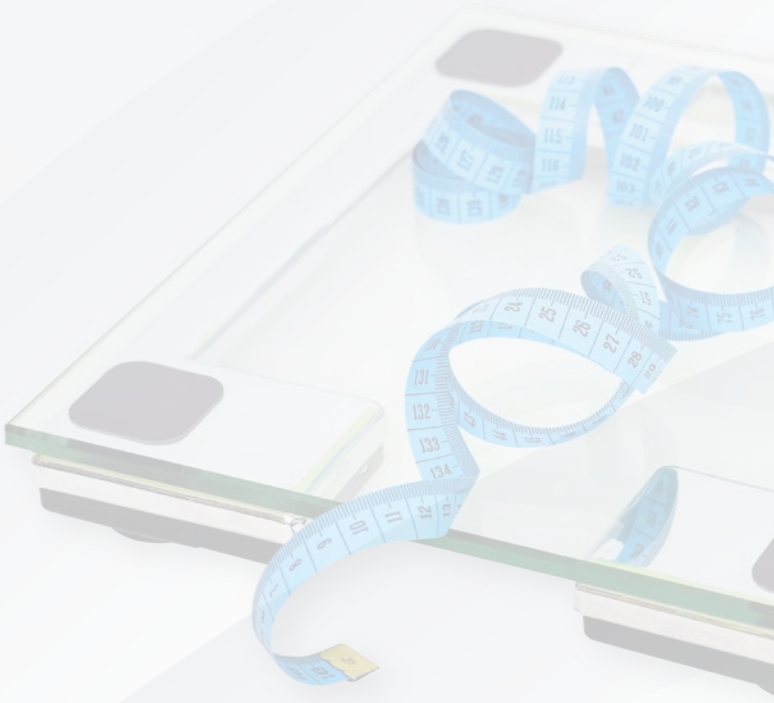
- Individuals for whom weight loss would be contraindicated, such as patients with a history of anorexia or bulimia, patients who are a healthy weight, or patients who are healthy and overweight (BMI between 27–29.9).
- Patients with a personal or family history of medullary thyroid cancer or of MEN2 Syndrome should not take injectable medications like Mounjaro, Wegovy, Ozempic, Saxenda, and Victoza. (MEN2 Syndrome is a rare genetic disorder that affects the endocrine glands and can cause tumors in the thyroid gland, parathyroid glands, and adrenal glands.)
- Patients with a history of blood-pressure related stroke, “ischemic” (clogged artery) heart attack or narrow angle glaucoma should not take phentermine, phendimetrazine or diethylpropion.
- Clinical guidelines restrict the use to certain medications for children whose BMI are above the 95th percentile for their age and gender.

It’s important to note that clinical trials on the GLP-1s and tirzepatide excluded people with certain mental health issues. Researchers hypothesize that GLP-1s may improve depressive symptoms, but in contrast, a few small studies show an association with unhealthy weight and risk of suicide and worsening depression. The impact of GLP-1s on people with certain mental health symptoms can’t be predicted.

We encourage everyone to keep in mind that a fixation on medications, even highly effective new medications like GLP-1s, misses the complex nature of obesity, especially for sustained weight loss and overall health. Consuming healthy foods, along with getting regular physical exercise, help patients reach and maintain a healthy weight and can ultimately lower risk of comorbidities. Maintaining a healthy weight, getting adequate sleep, and managing stress also help reduce risk and are vital parts of any comprehensive weight management approach.

Section Summary

- There are a wide variety of prescription medications available today to support weight loss, and this area of pharmacology is evolving quickly
- Medication alone is not adequate for sustained weight management. A holistic approach is necessary
- There are side effects and risks that come with weight loss medication
- Not everyone is a good candidate for every medication



05. Weight is more than “just diet and exercise”

“So many things go into the weight a body carries,” Dr. Mary Jacobson, Chief Medical Officer of Hello Alpha says. Genes, ethnicity, age, pre-existing health conditions, prescription interactions, where a patient lives, what their income is, and how someone sleeps all play a role, even if some medical providers focus only on calories. There are a lot of factors—internal and external—that explain why the body isn’t just a machine that runs on calories in, calories out.

Weight is so complex that even longtime researchers don’t yet understand all the variables involved—and the science is quickly evolving. It’s important to note again that obesity or excess body weight is a chronic condition, not a lifestyle choice or a weakness of willpower. Researchers haven’t reached a consensus on the cause of obesity, but all agreed it isn’t a personal failing.[14]

Obesity is commonly linked to excessive eating and lack of physical activity, but it's essential to consider other factors too. Insufficient sleep, stress, medications, and more can contribute to weight gain. Simply telling people to "eat less and move more" is not effective. There may also be underlying conditions causing weight gain. Moving beyond the oversimplified approach will lead to more effective and individualized strategies for weight management.

Obesity remains a common chronic disease that can often relapse. It’s unclear exactly why and how certain individuals will respond to certain treatments. Some experts are studying anti-obesity medications based on specific obesity "phenotypes" or characteristics to enhance weight loss.

A team at the Mayo Clinic recently identified four obesity phenotypes:[15]

“ Hungry Brain”

People that can’t seem to feel full despite how much theyve eaten

“Emotional Hunger”

Linking eating to coping with emotions

“Hungry Gut”

People that eat typical amounts but feel hungry again sooner than others

“Slow Burn”

Relating to a decreased metabolic rate

Knowing a person’s phenotype means being able to target weight loss efforts more effectively. The researchers found that a phenotype-guided approach to medication resulted in 1.75 times greater weight loss after one year compared to non-phenotype-guided treatment. Moreover, 79% of patients in the phenotype-guided group lost more than 10% of their weight, whereas only 34% did so in the non-guided group.

Identifying phenotypes helps explain differences in food intake and energy expenditure among patients, allowing for personalized obesity therapy. The research aims to develop a precision medicine approach to optimize obesity treatment, using individualized medication to enhance weight loss while minimizing side effects. The quickly evolving science of obesity medicine is working towards better understanding obesity, reducing treatment inconsistencies, and developing safer and more effective medications for personalized obesity management.

Section Summary

- Obesity or excess body fat is a chronic medical condition, not a lifestyle choice or a willpower deficit
- Weight is complex, and it’s not as simple as “calories in vs calories out”
- The science of obesity is evolving quickly

06. Next steps for employers

People leaders want to offer the best benefits to their employees, but must make difficult tradeoffs regarding cost. There are also considerations around inclusion—benefit programs were originally developed for a fairly homogenous male population of dominant ethnicities within a certain age range, underserving groups with different needs and circumstances. In this section, we'll cover DEI considerations to help guide your decision-making around weight management benefits.

Weight bias in the workplace

In today's corporate culture, companies are placing welcome emphasis on diversity, equity, inclusion, and belonging. A particular element of DEI that to-date has flown under the radar is weight bias. This discrimination can take many forms in the workplace:

- Studies show that higher weight people may be passed over for promotions or not hired in the first place[16]
- About 50% of people managers say they tend to favor interacting with healthy-weight employees[17]
- Nearly 72% of workers who have experienced unfair treatment at work due to their weight say it made them feel like quitting their job[17]
- While unconscious bias against race and sexual orientation fell over a 14-year period, implicit bias against high-weight people remained steady[18]
- More than 5 in 10 employees in the U.S. who identify as being overweight say they've experienced weight discrimination in the workplace[19]

This can be compounded for women: women who were considered overweight made less money and were more likely to work in lower-paying and physically demanding jobs than female colleagues who were considered average weight and male colleagues of any weight.[20]

Weight bias in healthcare

Weight bias manifests in healthcare settings in various ways, such as providers making assumptions about an individual's health solely based on their weight or size, using judgmental language, and making assumptions with treatment plans. These biases can occur in routine check-ups, diagnostic procedures, and even in conversations about lifestyle choices. Weight bias (negative perceptions about someone based on their weight) leads to weight stigma (the discriminatory acts that people with higher weights experience).

Most people with high body weight have a story about how their doctors judged or blamed them or didn't listen—and this is unfortunately true with all types of providers, even ones who specialize in weight management. It can lead to a vicious cycle in which people avoid going to the doctor because they don't want to be fat-shamed, then miss out on crucial treatment or early detection. In other cases, health complaints that have nothing to do with weight are inaccurately blamed on a person's size, so patients miss out on the correct treatment.

Chronic illnesses like diabetes and heart disease, which are associated with excess weight, are especially important to identify early. Early detection and treatment are easier and more cost effective. When healthcare professionals put too much emphasis on body weight, however, they may miss the signs and symptoms of these conditions.

Some researchers believe that weight stigma can trigger changes in the body, such as increased cortisol levels, that lead to poor metabolic health and increased weight gain. In addition, those with higher body weight may cope with weight stigma by increasing alcohol and substance use, overeating to deal with negative emotions, and avoiding health care settings or social encounters. The subsequent negative health outcomes are a result of what they call chronic social stress, and studies have found the harmful effects of weight discrimination resulted in a 60% increased risk of death, even when BMI was controlled for.[21]

Again: health can't be measured in just one metric. The whole person must be treated, an approach that helps patients adhere to their weight care plans and reinforces that health is not just a number on a scale. This is important for employers as well; by narrowly focusing on weight through specialized point solutions or one-off wellness incentives, your healthcare approach is fragmented. With the high propensity of comorbidities alongside obesity, to truly contain cost, patients need to be treated holistically.

Combatting weight discrimination

Much of weight bias and stigma is rooted in the belief that body weight is controllable or that people could manage and maintain a healthy weight if they simply "eat less and move more." Being heavy, then, could be considered a personal failure and attributed to a lack of willpower.

As demonstrated in this guide, this is simply not true. Obesity is a complicated, whole-body chronic illness that must be treated medically. Therefore the inclusion of an evidence-based, holistic weight management benefit in your benefits portfolio will go a long way towards serving a diverse employee population.

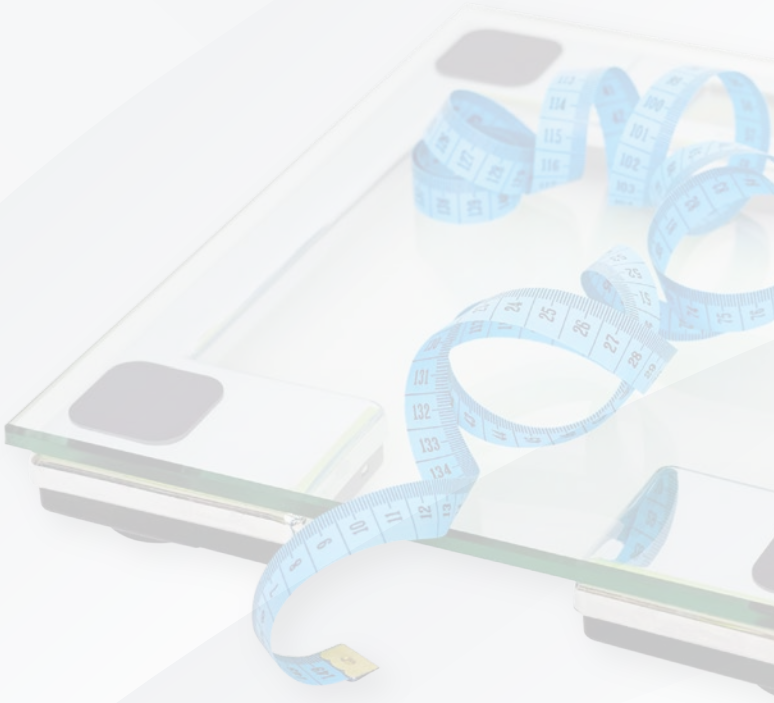
There are a wide variety of other tactics you can implement to fight against weight bias:

- Create a zero-tolerance policy on weight discrimination
- Include weight discrimination in HR training
- Examine workplace policies around hiring and promotion to ensure that people of all sizes are treated equitably in the process
- Avoid informal wellness practices such as weight loss competitions
- Ensure adequate seating and spaces to accommodate people with larger body sizes

With the health and wellbeing of employees as the ultimate goal, recognizing obesity as a disease will help change the way medical and professional communities tackle this complex issue.

Section Summary

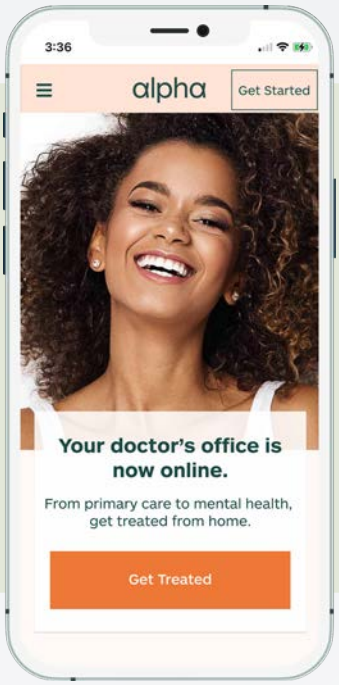
- Weight-based discrimination is a pervasive problem in the workplace
- Weight bias and weight stigma are unfortunately common in healthcare
- These discriminatory practices have an impact on individuals' health, independent from their weight
- There are clear opportunities to combat weight discrimination



07. About Hello Alpha

Hello Alpha is a virtual primary care platform that specializes in inclusive, expert care for all by bridging the gaps in women's health. Through technology and a specially-trained team of PCPs, we deliver whole-person care and expand healthcare accessibility.

Our weight management program, **Ahead with Alpha™**, combines primary care and preventive services with evidence-based weight loss treatment for an engaging, cost-saving solution that reduces overall healthcare spend. It supports sustainable weight loss for employees with whole-person primary care, balancing behavioral coaching and traditional weight management tactics with new medication where appropriate.



In a nutshell, **Ahead with Alpha™** offers:

- **Weight care is primary care.** Every patient partners with a dedicated PCP who provides personalized, preventive care and evidence-based treatment at every visit. Our platform eliminates the most common barriers to healthcare with asynchronous telehealth visits that empower patients to get care at any time without appointments, travel, or waiting rooms.
- **Sustainable, real-world results.** The program has treated over 50,000 patients with a sustained 15% reduction in BMI through medication and lifestyle coaching.
- **High-value care.** The right treatments to the right people, at the right time. We migrate patients who have successfully lost weight to a lower-cost maintenance program.

Hello Alpha's virtual primary care model, which has proven population health results in both clinical outcomes and cost trend reduction, provides a map for how to effectively incorporate weight management into a benefits portfolio. Reach out to **sales@helloalpha.com** today to learn more.

Sources

1. "Obesity Is a Common, Serious, and Costly Disease." Centers for Disease Control and Prevention, 20 July 2022, www.cdc.gov/obesity/data/adult.html.
2. "Obese Employees Cost Their Companies More Than Twice as Much as Healthy-weight Employees | BenefitsPRO." BenefitsPRO, 12 Nov. 2021, www.benefitspro.com/2021 /11/12/obese -employees-cost-their-companies-more-than-twice-as-much-as-healthy-weight-employees.
3. Cawley, John, et al. "Job Absenteeism Costs of Obesity in the United States." Journal of Occupational and Environmental Medicine, vol. 63, no. 7, Mar. 2021, pp. 565–73. https://doi.org/10.1097/ jom.0000000000002198.
4. Chronic Disease Fact Sheet: Workplace Health Promotion | CDC. www.cdc.gov/chronicdisease /resources/publications/ factsheets/workplace-health.htm.
5. Gates, Donna, et al. "Obesity and Presenteeism: The Impact of Body Mass Index on Workplace Productivity." Journal of Occupational and Environmental Medicine, vol. 50, no. 1, Lippincott Williams and Wilkins, Jan. 2008, pp. 39–45. https://doi.org/10.1097/jom.0b013e31815d8db2.
6. Cawley, Richard V. Burkhauser &. John. "Obesity, Disability, and Movement Onto the Disability Insurance Rolls." ideas.repec.org, Oct. 2004, ideas.repec.org/p/mrr/papers /wp089.html.
7. Trust for America's Health. "State of Obesity 2022: Better Policies for a Healthier America - TFAH." TFAH, 28 Jan. 2023, www.tfah.org/report- details/state-of-obesity-2022.
8. "New Adult Obesity Maps." Centers for Disease Control and Prevention, 17 Mar. 2023, www.cdc. gov/obesity/data/ prevalence-maps.html.
9. Cawley, John, et al. "Direct Medical Costs of Obesity in the United States and the Most Populous States." Journal of Managed Care and Specialty Pharmacy, vol. 27, no. 3, Mar. 2021, pp. 354–66. https://doi.org/10.18553/jmcp.2021.20410.
10. ---. "Job Absenteeism Costs of Obesity in the United States." Journal of Occupational and Environmental Medicine, vol. 63, no. 7, Mar. 2021, pp. 565–73. https://doi.org/10.1097/jom. 0000000000002198.
11. Obesity Medicine Association. "Which Diseases Are Related to Obesity? | Obesity Medicine Association." Obesity Medicine Association, 19 Dec. 2022, obesitymedicine.org/diseases-related-to-obesity.
12. "Healthy Changes in Diet, Activity Improved Treatment-resistant High Blood Pressure." American Heart Association, newsroom.heart.org/news/healthy-changes-in-diet-activity-improved-treatment-resistant-high-blood-pressure.
13. Chaput, Jean-Philippe. "Widespread Misconceptions About Obesity." PubMed Central (PMC), 1 Nov. 2014, www.ncbi.nlm.nih.gov/pmc/articles/PMC4229150.
14. Belluz, Julia. "Opinion | Scientists Don't Agree on What Causes Obesity, but They Know What Doesn't." The New York Times, 22 Nov. 2022, www.nytimes.com/2022/11/21/ opinion/obesity-cause.html.
15. Using a Phenotype-guided Approach for the Treatment of Obesity - Mayo Clinic. 17 June 2021, www.mayoclinic.org/ medical-professionals/digestive-diseases/news/using-a-phenotype-guided-approach-for-the-treatment-of-obesity/mac-20515481#:~:text=The%20team%20stratified%20obesity%20into%20four%20phenotypes%3A%201,fullness%204%20Slow%20burn%20%E2%80%94%20decreased%20metabolic%20rate.
16. Carpenter, Julia. "One Type of Diversity We Don't Talk About at Work: Body Size." CNN Business, 3 Jan. 2019, www.cnn.com/2019/01/03/success/weight-bias-work/index.html. Accessed 4 Aug. 2023.
17. Shrm. "New SHRM Research Details Weight Discrimination in the Workplace." SHRM, 9 May 2023, www.shrm.org/about-shrm/press-room/press-releases/Pages/New-SHRM-Research-Details-Weight-Discrimination-in-the-Workplace.aspx.
18. Charlesworth, Tessa Elizabeth Sadie, and Mahzarin R. Banaji. "Patterns of Implicit and Explicit Attitudes: IV. Change and Stability From 2007 to 2020." Psychological Science, vol. 33, no. 9, SAGE Publishing, July 2022, pp. 1347–71. https://doi.org/10.1177/09567976221084257.
19. "6 in 10 Overweight American Workers Have Experienced Weight Discrimination - ResumeBuilder.com." ResumeBuilder.com, 15 May 2023, www.resumebuilder.com /6-in-10-overweight-american-workers-have-experienced-weight-discrimination.
20. Wolf, Amy. "Overweight Women Lose in the Labor Market: Vanderbilt Study." Vanderbilt University, 21 Oct. 2014, news.vanderbilt.edu/2014/10/21/overweight-women-labor-market/?tpcc=nlchrodaily#:~:text=Overweight%20women%20are%20more%20likely%2cto%20a%20new%20Vanderbilt%20study.
21. Sutin, Angelina R., et al. "Weight Discrimination and Risk of Mortality." Psychological Science, vol. 26, no. 11, SAGE Publishing, Sept. 2015, pp. 1803–11. https://doi.org/10.1177 /0956797615601103.