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Joanie Sompayrac
University of Tennessee - Chattanooga, joaniecpa4@gmail.com

Katharine Linehart Trundle
University of Tennessee-Chattanooga, kate.linehart@elliottdavis.com

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Obesity: The Elephant in the Room We Can No Longer Afford to Ignore

Joanie Sompayrac, J.D., M.Acc., C.P.A., C.G.M.A., & Katharine Linehart Trundle, CPA,
University of Tennessee – Chattanooga

ABSTRACT

Everyone pays the price for the obesity-related illnesses of our fellow citizens – through increased premiums on our group health insurance policies, through reduced productivity of our co-workers, through taxpayer support of hospitals that provide indigent care and through soaring Medicare costs, to name a few. The fact that our entire society often ends up paying many of the costs for the obesity-related illnesses of not only ourselves but also our family members, our friends, our co-workers and even strangers raises questions: Why doesn't insurance pay to help overweight and obese people to make lifestyle changes that could save us all millions or even billions of dollars? Will The Patient Protection and Affordable Care Act or the health care plans that the Trump Administration offers as an alternative provide options to help the two-thirds of Americans struggling with obesity? Should Americans be considering taxing people who are obese (with Body Mass Index in excess of 30) at a higher rate to incentivize them to live healthier or to penalize them for the choices they have made? This paper attempts to answer these questions.

Keywords: Obesity Tax, BMI Tax

Introduction

"Do you want fries with that?" is a question that has become all too common in modern-day America. This question has become the unfortunate habit of Americans, who are taught and constantly bombarded with advertisements pushing the best "bang for your buck"; but is this really the right mentality to have when it comes to nutrition? Consider this: "the average size of a bagel more than doubled between 1983 and 2003, going from a three-inch diameter and containing 140 calories to a six-inch diameter with 350 calories." ("Portion Distortion," 2013). Over the past thirty (30) years, Americans have been entrenched by this "supersize" trend; therefore, it comes as no surprise that a combined two (2) out of every three (3) Americans are either overweight or obese, and 34.9% of Americans (or about million) are dangerously obese. ("Overweight and Obesity Statistics," 2017; "Adult Obesity Facts," 2018). The Trust for America's Health laments that:

> *The obesity epidemic is one of the country's most serious health problems. Adult obesity rates have doubled since 1980, from 15 to 30 percent, while childhood obesity rates have more than tripled. Rising obesity rates have significant health consequences, contributing to increased rates of more than 30 serious diseases. These conditions create a major strain on the health care system. More than one-quarter of health care costs are now related to obesity*. ("Obesity," 2018).

It is estimated that the annual health costs for obesity-related illnesses (which include, but are not limited to stroke, type 2 diabetes, cancer, hypertension, asthmas, osteoarthritis, heart disease, lung disease and depression) is just under $200 billion. (Cawley & Meyerhoefer, 2012).

In addition to the increased healthcare costs of being overweight and obese, there are economic costs because people who suffer from obesity-related illnesses are more likely to miss work, become disabled or lose their jobs as a result of their conditions. These circumstances are estimated to cost over $4 billion dollars annually. (Cawley, 2007) Individually, the Centers for Disease Control and Prevention (CDC) notes that the medical costs for people who are obese are, on average, $1,429 higher than the medical costs of people who are of normal weight. “Adult Obesity Facts,” 2018)

The common measure by which to determine overweight and obesity ranges is a number called the "body mass index" (BMI). BMI directly correlates with the amount of body fat because it is calculated using height and weight. According to the CDC, “an adult who has a BMI between 25 and 29.9 is considered overweight,” and “an adult who has a BMI of 30 or higher is considered obese.” ("Defining Overweight and Obesity,” 2016). Obesity raises the risk for numerous diseases including Coronary Heart Disease, High Blood Pressure, Stroke, Type 2 Diabetes, Cancer, Sleep Apnea, Gout, Gallstones, and more. ("Health Risks of Being Overweight," 2015). Many of the previously mentioned diseases have shown a dramatic increase over the past thirty (30) years in direct relation to the increase in obesity. The more overweight a person is, the greater the risk of developing any one or more of a large number of health problems including those listed above.

Aside from the “supersize” phenomenon, there are additional economic factors affecting this ever-growing trend. According to the United States Census Bureau, the median household income between the years 2012 and 2016 was $55.322 (with 12.7% reporting income below poverty level). (U.S. Census Bureau, 2018). These income levels have not kept pace with the dramatic exponentially increasing cost of living, nor have they kept pace with the rising costs of many healthy eating alternatives (*e.g., whole foods, organic fruits and vegetables, fresh meats, etc.*). Consequently, many families who feel pressed for time and money often turn to “dollar value meals.” The Food Research and Action Center (FRAC) refers to people in this situation as “food vulnerable.” FRAC’s research indicates that many lower income citizens are more likely to become obese because they have fewer opportunities for healthy physical activities, lack of access to healthy and affordable food, increased access to fast foot, high levels of stress and limited access to healthcare. (“Why Low-Income and Food-Insecure People are Vulnerable to Overweight and Obesity,” 2018).

Clearly, while there may be short-term expenses that advance a culture of overeating, inactivity and weight-gain, there are long-term costs associated with obesity, and those costs are affecting every level of society – individuals, families, employers, cities, states, and even the federal government.

The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010, for the purpose of providing Americans with more rights and protections and expanding access to affordable, quality healthcare to uninsured Americans. (“ObamaCare Facts: Affordable Care Act, Health Insurance Marketplace,” 2018). The law has been described as the new face of healthcare in America with intentions to provide all Americans with access to quality healthcare via a reconstruction of the insurance industry. Additionally, the law aims to implement subtle and gradual changes in an effort to create more health-conscious lifestyles and mindsets. An example of a lifestyle-related change implemented by the PPACA is the requirement that restaurants with more than 20 locations have calorie counts listed for every

menu item. (“The Affordable Care Act,” 2018). While neutral and proficient in theory, the PPACA has already faced some unforeseen challenges, both to its constitutionality and its implementation. The future has much to prove in regards to its functionality and effectiveness, but to date, many would argue that performance has fallen short against expectations.

The PPACA originally mandated that that all Americans obtain healthcare coverage by 2014 via private providers, employer-based coverage or the newly implemented State Health Insurance Marketplaces. (“The Affordable Care Act,” 2018).

Moreover, the PPACA includes protections against past industry practices including pre-existing condition exclusions, unjustified premium increases, lifetime coverage limits, limitations on doctor selection, barriers to emergency services, and it extends the age an individual is eligible to be covered under his or her parents’ insurance. Furthermore, the law has employed stricter reporting requirements and quality care standards including but not limited to improved case management programs, medication and care compliance initiatives, comprehensive hospital discharge programs and in an effort to reduce medical errors, patient safety activities. (“The Affordable Care Act,” 2018).

In addition to employing a nationwide insurance and healthcare system, the PPACA implements new health-geared mandates in an attempt to create a healthier America. Healthy Measures, a new health-contingent incentive/penalty mandate, reduces employee insurance premiums if they are, and stay, within certain limits on four medical risk factors: smoking, obesity, blood pressure and cholesterol. ("Employer Wellness Incentives Questionable Origin,” 2013). The obesity aspect of Healthy Measures works as follows: if an employee who fails the obesity test at the beginning of the year loses 10% of his or her body weight by the end of the year, he or she may receive a retroactive payment; however, if the BMI remains over thirty (30) at the beginning of the following year, the payment is withheld until the employee reaches the permanent goal of under thirty (30). Rebates are also awarded to those who achieve the goals pertaining to the four factors - $800 for individual employees or $1,600 for families. (The Affordable Care Act, 2018)

A newly implemented protection provided under the PPACA, potentially the most effective protection in the face of the American obesity crisis, is the coverage of preventative care. The PPACA is the first governmental attempt to address the lack of preventative services. Under the Act, new insurance providers are required to cover weight-loss and healthful lifestyle counseling based upon patient BMI screening results; the coverage of weight-loss plans varies from provider to provider. As of 2014, an astounding 88% of health plans do not cover weight-loss plans. (“Top 10 Healthcare Services Excluded Under Obamacare,” 2014). This is set to change in 2018, when all insurance plans including those which were “grandfathered” in under the Act, will be required to provide preventative coverage free of charge. (“Health Care Reform Timeline,” 2018).

The PPACA is among the first Federal government efforts in the fight against obesity. It is America’s first step toward the examination of the root of the cause of such extravagant healthcare spending that has so harmfully plagued the United States.

Consider this: “At the current rates of increase, obesity related healthcare costs are expected to exceed $300 billion by 2018 – more than double the $147 billion reported in 2008.” (Chou and Kane, 2012). In an effort to address this exorbitant spending rate, the PPACA has introduced the Prevention and Public Health Fund, a state grant program. The purpose of this fund is to promote wellness and to protect against the growing number of public health threats in conjunction with states and communities. Included in the primary public health concerns to be

addressed by the Prevention and Public Health Fund is obesity. Preventative Fund Grants support activities to improve nutrition and increase physical activity level. The goal of these grants is not only to decrease obesity but to decrease the associated conditions and healthcare costs as well. ("The Affordable Care Act's Prevention and Public Health Fund in Your State: Tennessee," 2012). While the PPACA is by no means a comprehensive approach to addressing what has become an obesity epidemic, it is the largest government effort to address obesity to date.

As the PPACA directs federal funding in an initial step toward making a healthier America, how will we know the effectiveness of the above described practices? The Act addresses this question through Section 2717(d) which states:

> *Not later than 180 days after the date on which regulations are promulgated under subsection (c), the Government Accountability Office shall review such regulations and conduct a study and submit to the Committee on Health Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report regarding the impact the activities under this section have had on the quality and cost of health care*. (PPACA, 2010).

While this requirement will reveal the immediate effects brought about by the PPACA, the long-term effects are those which will bring about truly noticeable and effective changes in government healthcare spending.

Costs of Obesity

Epidemics have historically been costly to those countries which have fallen victim to them. Obesity is no exception, and the inability to reduce the staggering numbers thus far is sure to be accompanied by detrimental economic consequences. The problem in combatting these present and future costs thus far has not been an inability to identify the source, which sufficient evidence reveals is obesity, but the lack of action taken against the source and a sole focus on the costly effects. Arguably, there are some experts who assert that preventing obesity means people will live longer, and that will increase healthcare costs over the long-term. The numbers, however, tell a different story. Most experts who see the numbers that have been presented above, as well as other numbers which will be discussed later in this paper, agree that the costs of obesity increase exponentially during even a shortened life span of the increasing number of obese Americans. Consequently, we must address costs with the ultimate goal of prevention in mind.

Beyond the human cost of obesity, which is approximately 112,000 deaths per year, both the direct and indirect costs are substantial. In regards to direct costs, otherwise known as those which result from health services, laboratory tests and drug therapy, the United States encountered $152 billion in direct medical costs associated with obesity in 2009. (Hoffman, 2013). This is approximately 10% of annual medical spending. ("Facts: Obesity and Cardiovascular Disease," 2013; *see also,* Finkelstein, Trogdon, Cohen, et al. 2009). Furthermore, the estimated annual medical spending attributed to obesity-related illnesses in the United States is $190.2 billion or nearly 21% of annual medical spending. (Cawley & Meyerhoefer, 2012) According to the George Washington University School of Public Health and Health Services, it is estimated that obesity accounts for 8.5 percent and 11.8 percent of Medicare and Medicaid expenditures, respectively. ("Fast Facts: The Cost of Obesity," 2010). As if these rates of spending were not exorbitant enough, it is predicted that obesity related healthcare costs could exceed $300 billion by 2018 if they continue at the current rates of increase. (Chou & Kane,

2012). Obesity is taking a toll in indirect areas such as value of lost work, insurance and lost wages, as well. In regards to value of lost work, the average cost of obesity-related loss of productivity is $30 billion. Obesity-related absenteeism costs employers $6.4 billion per year in lost work value, insurance premiums and compensations and lower wages. ("10 Flabbergasting Costs of America's Obesity Epidemic," 2013).

The evidence as to the costliness of obesity is strong and unmistakable, so then why do we continue to allow it to impede upon our medical spending? Prior to the passing of the Affordable Care Act, very few insurance plans offered coverage for obesity treatment. An overweight individual would see the doctor for a wellness visit and might be told that remaining at his or her current weight would soon cause additional health problems ranging from diabetes, stroke or any of those mentioned as caused by obesity above. If the individual were to request medically-assisted weight-loss treatment, under most health insurance plans, he or she would be denied coverage and left to pay these costs out of his or her own pocket. However, if the individual did not heed the advice of the doctor to lose weight and had a stroke as a result, insurance would undoubtedly cover the costs associated with the stroke. This process is counterintuitive and further proves the lack of preventative action being taken by insurance companies.

According to the U.S. Department of Health and Human Services (HHS), the leading reason behind the lack of utilization of preventative services prior to the passing of the PPACA was the high cost. Preventative services were used at half the recommended rate due to the common practice of cost sharing via co-payments, co- insurance and deductibles. ("Affordable Care Act Rules on Expanding Access to Preventive Services for Women," 2017). Prior to the passing of the PPACA, common practices of cost sharing in the United States included cost sharing for private coverage with, "exemptions or limits in the form of out-of-pocket spending maximums," cost sharing with income related exemptions and limits for those on Medicare and state required cost sharing under certain circumstances for those low-income individuals on Medicaid. (Medicaid.gov, 2018) These cost sharing policies have been eliminated with the passing of the PPACA. According to the HHS, "the Affordable Care Act requires most health plans to cover recommended preventive services without cost sharing." ("Affordable Care Act Rules on Expanding Access to Preventive Services for Women," 2017).

If the number of Americans suffering and dying from obesity and obesity-related conditions is not alarming enough for a call to action, then the astronomical rate at which the costs of medical spending related to obesity should be. The PPACA is not the first to recognize this need for change. The American Heart Association, the American College of Cardiology and the Obesity Society have addressed the issue by calling on doctors to calculate a patient's body mass index (BMI) each year, and recommend surgery for those who face the most serious health problems. ("Bariatric Surgery: Obese Battle Insurance Hurdles," 2014). The cost of performing such surgeries and other preventative measures is where further challenges lie.

What Role Should Insurance Play in Preventing or Reducing Obesity?

In examining the insurance debate, we must first define and determine its purpose. According to HealthCare.gov, health insurance is, "a contract that requires your health insurer to pay some or all of your healthcare costs in exchange for a premium." ("Health Insurance," 2014) Prior to the passing of the PPACA, the purpose of health insurance was solely to protect oneself

from high or unexpected healthcare expenses and maintain access to care. Health insurance plans work by pooling financial resources to pay the medical costs of group members who require health care services. Once the insured reaches the required level of payments including premiums, deductibles and co-pays, insurance will begin to pay a portion of medical claims. (Chew, 2013) The cost of insurance coverage is determined by estimating overall risk of healthcare expenses and determining the amount of money to be kept on reserve for the benefits stated in the insurance agreement. ("Health Care Insurance," 2018).

As mentioned above, the original purpose of health insurance upon which the health insurance industry was built excluded preventative services. Insurance was literally structured to diagnose existing problems. The primary function of insurance was only to react and distribute payment in relation to existing issues. (Umbehr, 2014) This, coupled with the only recent classification of obesity as a disease despite the overwhelming evidence of medical issues caused by obesity leading up to this official classification, could explain why there has been such a dramatic delay by the insurance industry in addressing the conditions caused as a result of obesity.

The PPACA has expanded the definition of health insurance to include access to preventative care, but will this mandate be truly effective without a reconstruction of the insurance industry from its foundation? A simple expansion of services in writing is the easy part; effectively putting into action these services within a program whose foundation is much narrower than the scope of services to be provided will be the true challenge for the PPACA.

As in any debate, both sides of the equation must be examined, the other side of the money-saving obesity treatment equation being the cost of treatment. The high cost of preventative care has been the primary dilemma faced by insurance companies in the fight against obesity during the past decade. While many argue that treating obesity before it leads to even more costly conditions could save the U.S. economy millions of dollars, it is often overlooked that implementing such treatment is costly in and of itself.

While it is difficult to estimate the cost of preventative care due to the number of assumptions which must be made, USA TODAY estimates the following costs of preventative care:

- *One trip to the doctor per year by an obese American would cost $60;*
- *A year-long basic nutrition/behavior modification treatment program at an estimated cost of $450 per person;*
- *Prescription diet medication for a total of one year would cost $960 per person (at a cost of $80 per month);*
- *A gastric bypass surgery would cost about $23,000 per surgery.* ("Weight Loss Surgery Insurance Coverage and Costs," 2018).

Although these rates do not sound like large amounts in the overall scheme of the medical industry, multiplying these individual costs by the 78.6 million Americans who are considered dangerously obese results in a staggeringly high cost of treatment. ("Overweight and Obesity Statistics," 2017; "Adult Obesity Facts," 2018). At this rate, doctors' visits would cost over $4.7 billion, nutrition/behavior modification treatment programs would cost over $35.3 billion, prescription diet medication would cost over $75.4 billion and gastric bypass would cost over $1.8 trillion. Obviously not every obese person would require each one of these treatments, but these numbers do provide a glimpse into the considerations of the insurance industry in providing preventative treatments.

Weight-loss surgery,[1] the most costly but arguably most effective of the preventative care measures, has posed one of the largest challenges to insurance companies in determining whether or not to provide coverage, and if so, how much coverage. Despite the staggering growth rate of obesity in the last decade, the 160,000 weight-loss surgeries performed in the United States last year has remained extremely consistent since 2004. While there are a number of contributing factors to this statistic, insurance barriers are by far the leading obstacle. According to *Modern Healthcare*, nearly two thirds of employer-sponsored health plans do not cover weight-loss surgery. The average bariatric surgery may cost between $15,000 and $25,000; therefore, it is considered a last resort by those plans which do offer surgery coverage.

It has been determined that the expense of coverage in combination with the legislative precedent of treating only existing problems is the primary hindrance of the insurance industry to cover obesity treatment. But the question of how much providing such treatment would save in future expenses begs to be asked. According to *Modern Healthcare*, the benefits of bariatric surgery are well worth the initial investment as expenses are recovered within a maximum of ten years:

> *The latest long-term studies show that the typical patient loses about 30% of their excess weight with the bypass procedure and 17% with the band after three years. That compares with weight loss of just 2 to 8% with diet and lifestyle changes. Researchers estimate the initial costs of surgery are recouped within 2 to 9 years, as patients cut down on prescriptions, trips to the doctor and emergency hospital care.* ("Bariatric Surgery: Obese Battle Insurance Hurdles," 2014).

As described above, there are some contradictory challenges faced by the insurance industry in the fight against obesity. While it is clear that preventative services are arguably the most effective step to combating obesity, the immediate costs of doling out such preventative services at the high rates which they are likely to be consumed is concerning and even impossible for some insurance companies. This long-time challenge presented an opportunity for the PPACA to overcome through the providing of preventative services at an affordable rate or under a system possible to uphold by insurance companies; however, it is being argued that the PPACA has set forth a lackluster attempt to create such a system. It is already evident that many of the same challenges seen in the private market have carried over to the new, state-run insurance exchanges implemented by the PPACA. ("Bariatric Surgery: Obese Battle Insurance Hurdles," 2014). For example: many of the state-run exchanges are already opting in and out of certain preventative care measures based on cost. With the choice left to the states, what is to stop all state exchanges from opting out? We could very well end up right where we started, with an extremely limited number of plans offering an extremely limited number of preventative services.

Will PPACA Offer Options to Help Americans Struggling with Obesity?

As mentioned earlier, the PPACA has put the first steps in the fight against obesity into writing. One of the primary categories of essential health benefits claimed by the plan as

[1] Weight-loss surgery is a general term that includes a variety of bariatric surgeries including adjustable gastric bands, sleeve gastrectomy, vertical banded gastroplasty, gastric plication, and the gastric balloon.

covered is preventative and wellness services and chronic disease management. Prior to the passing of the PPACA, health insurance providers offered little to no preventative care or obesity incentive programs. These severely underserved and, in some cases, ignored areas serve as the benchmark upon which the PPACA preventative care measures rely. The bulk of these measures, including weight-loss therapy, pharmaceutical drug assistance and in some cases bariatric surgery coverage, have already been put into effect. Despite taking the initial step in recognizing and combatting the detrimental effects of obesity on our healthcare system, economic system and society in general, there are many reservations and arguments against both the effectiveness and the legality of the Act. Many argue that the PPACA was a missed opportunity in combatting the nationwide obesity epidemic. While it is widely accepted that the Act is making an effort to promote health, the execution of its attempts, as well as some of the attempts themselves, are being questioned.

According to the HHS, the options available under PPACA to individuals struggling with obesity have already gone into effect. The first of these age-dependent, plan-dependent services offered under the PPACA, which consist of weight-loss and healthful nutrition counseling as well as blood pressure, diabetes and cholesterol testing, were implemented in 2010. ("Preventative Care," 2017). Preventative services provided under Medicare differ from those provided by independent providers. Beginning in 2011, Medicare began offering obesity screening and counseling, nutrition therapy services and in some cases in which certain conditions are met, select bariatric surgical procedures including gastric bypass surgery and laparoscopic banding surgery. ("Obesity Screening and Counseling, 2018).

Bariatric surgery is one of the most effective ways of combatting existing obesity as the effects are immediate. There was hope that bariatric surgery would be covered to a greater extent under the state marketplace exchanges, but the economic toll – an average of $42,000 per procedure – proved too high. In fact, an astounding 28 states have chosen benchmark plans that cover neither bariatric surgery nor intensive weight loss programs, due to the high expense. (Gallagher, 2012). The limited coverage is a direct result of the many first-time insurance holders purchasing insurance via state exchanges. According to Therese Hanna, Executive Director of the Center for Mississippi Health Policy, "the discussions around what should be covered under the exchange within the state…had to do with balancing cost versus the coverage." (Varney, 2013). With all of the information that we possess clearly pointing to obesity as the gateway to a vast number of other costly conditions and diseases, is this truly the area in which services should be sacrificed?

Stemming from the issue of limited state coverage is the inability to fairly impose employer incentive programs. A related employer wellness program regulation proposed that overweight or obese employees could be penalized up to 1/3 the cost of their health insurance plan if they failed to meet employer-determined standards relating to BMI or weight; however, the likelihood of the employer health care program or exchange not covering treatments needed to obtain such goals is extremely high. This is not the case for those diagnosed with high blood pressure, high cholesterol or type 2 diabetes, all
proven to develop as a result of being overweight or obese, for which treatments are covered without question the majority of the time. (Downey and Still, 2013).

The PPACA offerings have the potential to be effective in combatting obesity, but in the past two years since their implementation, have the newly offered preventative services truly imposed change? Since 2010 when the Act was signed into law and the first legislation was implemented, we have seen no considerable change in the rate of obesity in America.

According to the CDC, the rate of obesity has decreased from 35.7% in 2009/2010 to 34.9% in 2011/2012 while the age-adjusted percentage of overweight and obese Americans has decreased from 68.8 in 2009/2010 to 68.6 in 2011/2012. ("Health, United States," 2013) While even the slightest rate of reduction after the implementation of the PPACA's preventative care measures may appear to be the start of a downward trend, these reductions of less than one percent are considered insignificant.

Discrimination based upon weight is an additional issue that challengers of the PPACA have brought to light. The language of the PPACA, specifically Section 156.125, addresses provider discrimination by stating:

> *An issuer does not provide equal health benefits if its benefit design, or the implementation of its benefit design, discriminations based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.*

Despite the clarity of the language, there is still doubt that inherent prejudice and stigma directed at persons with obesity will be eliminated. Exclusion of preventative obesity treatment prior to the passing of the PPACA was due precisely to the above listed discriminations. Challengers of the law argue that the law failed in the sense that the ability of state marketplaces to exclude intensive weight-loss counseling, pharmaceutical treatment options and bariatric surgery, are in fact, discriminations against those with obesity.

Despite claims that PPACA is the face of change for obesity in America, the many obscured limitations on preventative obesity care as well as inherent discrimination still to be faced by obese persons prove that the Act may not be as innovative as it seems on its face. In any form, healthcare reform will be forced to address obesity, but the extent to which the PPACA addresses obesity has been exclusive in nature thus far. The exclusion of certain evidence-based care measures combined with the focus on conditions caused by obesity provides for an ineffective fight against obesity in America. The true measure of improvement will be evident in a reduction of healthcare costs related to those diseases and conditions caused by obesity, a reduction which we have yet to see.

With Obesity Driving up Costs, Should Taxpayers with Excess BMI Pay Higher Taxes?

> According to www.medicare.gov, Medicare is:
> *Medicare is health insurance for: People 65 or older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)*
>
> *The different parts of Medicare include:*
> *Part A (Hospital Insurance) helps cover: Inpatient care in hospitals, skilled nursing facility care, hospice care, and home health care. Normally, you don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working. This is sometimes called premium-free Part A. If you aren't eligible for premium-free Part A, you may be able to buy Part A, and pay a premium.*
> *Part B (Medical Insurance) helps cover: Services from doctors and other health care providers, outpatient care, home health care, durable medical equipment, and some preventive services. Most people pay the standard monthly Part B premium.*

Before getting into the specifics of obesity as it relates to Medicare spending, it is important to explain why examining Medicare spending in relation to the obesity epidemic is so critical. Medicare, like Social Security, was created to be a pay-as-you-go program, and Baby Boomers (people born between 1946 and 1964) have begun collecting the benefits of Medicare as they reduce or stop paying Medicare taxes. Add to this situation the fact that a baby born in 2011 has a life expectancy of 78.7 years.

Compare this to the year when Medicare was established (1965) when the average life expectancy was 66.8 years. ("Deaths and Mortality," 2017) Consequently, we have an increasing number of Medicare beneficiaries, they are living longer and as they retire, they are paying fewer dollars in Medicare taxes. Another potential complication for increasing Medicare costs that we cannot we predict is how much Medicare costs will increase if scientists discover a cure for Alzheimer's disease, certain cancers, diabetes or other illnesses that shorten lives. All of this is happening while the United States faces a federal debt crisis that is escalating at a frightening rate, putting our economy and our national security at risk.

On June 13, 2013, the American Medical Association classified obesity as a disease. ("A.M.A. Recognizes Obesity as a Disease," 2013). With this in mind, several members of Congress subsequently proposed "The Treat and Reduce Obesity Act of 2013." This bill, which has yet to leave committee, would provide:

> *Medicare beneficiaries and their healthcare providers with meaningful tools to reduce obesity by improving access to weight-loss counseling and new prescription medications for chronic weight management. The bill [would also require] the Health and Human Services Department to develop and implement a comprehensive new research and outreach plan to combat the obesity epidemic.* ("Treat and Reduce Obesity Act," 2013).

According to the National Institutes of Health, the rate of American seniors who are obese is continuing to grow, and the cost of healthcare for this group is outpacing the resources to care for them. Consequently, Medicare costs are about $50 billion higher than they might be for more fit beneficiaries because this increased rate of obesity has resulted in accelerated rates of high blood pressure, high cholesterol, heart disease, arthritis and diabetes – all preventable illnesses that might not be present except for the high rates of obesity. (Batsis & Bynum, 2016; "Budget and Economic Outlook: 2014-2024," 2014). A recent Urban Institute study attempted estimate how much the average worker pays in Medicare taxes over a lifetime, and then what that same average worker collects in Medicare benefits. The study indicated that the average single male worker tends to pay $91,000 in Medicare taxes while collecting $297,000 in lifetime Medicare benefits. The average female worker tends to pay $91,000 in Medicare taxes while collecting $341,000 in lifetime Medicare benefits. (Steuerle & Quackenbush, 2013). The authors of the study do not specifically address how or if obesity factors into their statistics at, but the numbers prompt a question: If Americans are reaping more than three times the dollars in benefits than we are paying into Medicare, should we be paying more Medicare taxes? More specifically, if the increased benefit payouts are directly linked to increased costs for obesity-related illnesses, should people with BMI's greater than 30 at the beginning of each calendar year be charged a higher Medicare tax? According to the Mayo Clinic, while there may be genetic links to obesity, most cases of obesity are actually related to lifestyle, habit, environment, or other factors that can be controlled. Consequently, the argument that a BMI tax that increases the Medicare tax on people with BMI over 30 is somehow unjustly

discriminatory does not hold weight (pardon the pun) because obesity is not a characteristic that people cannot change about themselves. Further, if the government is subsidizing a taxpayer's health costs, and the taxpayer engages in behaviors that increase those costs (being obese, smoking, high-risk activities, etc.), then the taxpayer should have to help pay those increased costs.

Alternatively, if other taxpayers stay healthy and reduce costs, why should they be responsible for the costs generated by fellow taxpayers who have chosen to be reckless with their health? Moreover, an increased Medicare tax might provide an incentive for some taxpayers with a high BMI to lose weight. One study has shown that a 4.2% weight loss among overweight and obese adults who are between ages 60 and 64 who are either pre-diabetic or at risk for heart disease could yield Medicare savings of between $3.8 billion and $4.7 billion over ten years. (Thorpe and Yang, 2011)

As if anticipating this question, some companies, such as Safeway, Inc., have recognized the need to be proactive in combating the unbalanced and unfair tax and/or insurance costs to their employees. Safeway, Inc. implemented its plan to combat the unfair balance of healthcare costs ahead of the curve in 2009. Safeway's plan uses two specific components of market data as its basis: firstly, that 70% of all healthcare costs are the direct result of behavior, and secondly, that 74% of all costs are confined to four chronic conditions (cardiovascular disease, cancer, diabetes and obesity), with more than 90% of obesity being preventable.

Similar to that of the auto-insurance industry,[2] Safeway utilizes a program which recognizes the role of personal responsibility for one's health, meaning that the portion of health insurance paid by employees reflects distinct differences in premiums that reflect each covered member's health-related behaviors. The ability of Safeway to implement such practices, which could be argued as discriminatory, utilizes a provision of the 1996 Health Insurance Portability and Accountability Act which allows employers to differentiate premiums based on behaviors. Safeway's plan is outlined below:

> *Employees are tested for the four measures cited above (tobacco usage, healthy weight, blood pressure and cholesterol levels) and receive premium discounts off a "base level" premium for each test they pass. Data is collected by outside parties and not shared with company management. If they pass all four tests, annual premiums are reduced $780 for individuals and $1,560 for families. Should they fail any or all tests, they can be tested again in 12 months. If they pass or have made appropriate progress on something like obesity, the company provides a refund equal to the premium differences established at the beginning of the plan year.* (Burd, 2009)

With five years having passed since the program's implementation, Safeway has deemed it successful, determining its obesity rate to be roughly 70% of the national averages and its healthcare costs having been held constant.

Although its plan has proven effective in keeping rates of obesity and other unfavorable health behaviors down, Safeway has been unable to overcome the underlying issue of exceeded use-per-pay-in also faced by Medicare. "We reward plan members $312 per year for not using

[2] For example, auto-insurance rates may differ based on a driver's accident record, age, number of traffic violations, legal issues like DUI convictions, etc.

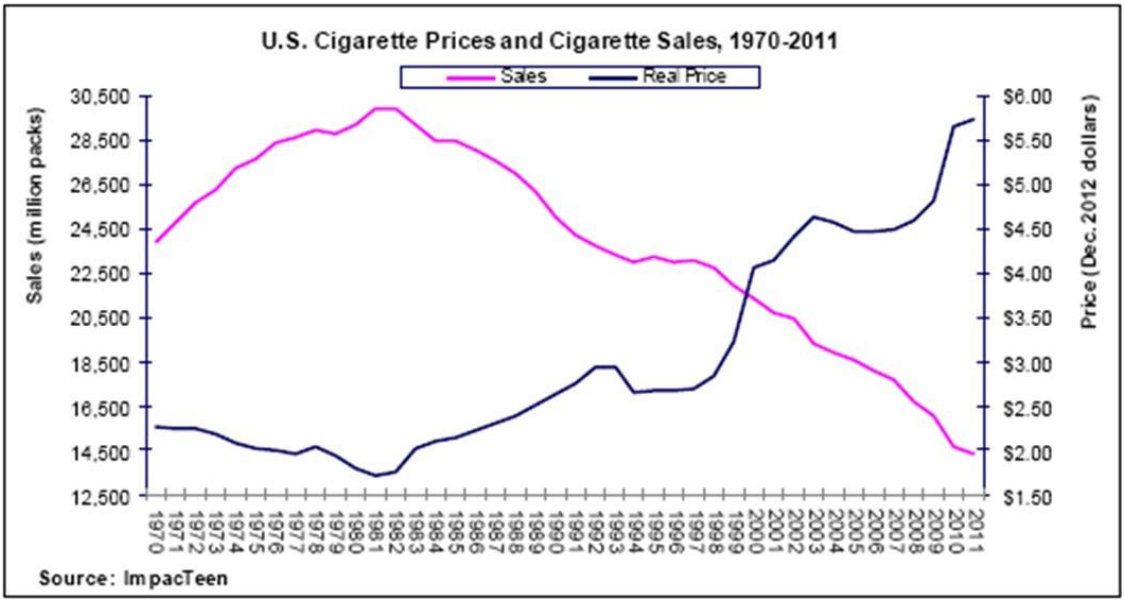
tobacco, yet the annual cost of insuring a tobacco user is $1,400." (Burd, 2009). These dramatic variances in the pay-in via taxes or the incentive pay verses the insurance services reaped pose the newest challenge to the legislation outlined in the PPACA. Although the PPACA is healthcare cost oriented legislation, much of which can be linked to the American obesity crisis, would it have been beneficial to address healthcare costs more wholly via the discrepancies in Medicare taxes? How can we make more equal the pay-in amount and the services obtained?

Conclusion

The evidence as to the high cost of obesity is apparent and compelling. While America has finally begun to make attempts to combat this fast-growing health and economic problem, the attempts have not been solid or proactive enough to truly make an impact. It must be recognized that there is a degree of personal accountability for one's personal health and wellness for which responsibility must be taken. Change cannot be imposed by government rule alone. It is due to this charge of personal responsibility that a BMI-based tax would be an ideal balance of government intervention and personal responsibility.

While some may argue that imposing yet another tax would fail and only anger the majority of Americans who are either overweight or obese, there is significant evidence that similar taxes have been successful in deterring and reversing bad health behaviors. From the year 2000 to 2011, the federal cigarette tax increased from 34 cents to $1.01 per pack and the average state tax increased from 42 cents to $1.46 per pack. ("Increasing the Federal Tobacco Tax Reduces Tobacco Use," 2013). As seen below in Figure 1.1, there has been a dramatic decrease in the number of American cigarette smokers as a result of this tax increase and it is expected that in the coming years there will be a decrease in the number of health-related problems due to smoking. (Tauras, 2002).

Figure 1.1



So, if there is significant evidence as to the effectiveness of a cigarette tax in prompting

personal responsibility to stop smoking, why not impose a BMI-based tax of similar design to fulfill the same function in the area of weight? A delicate balance of government intervention and personal initiative is the key to a successful BMI-based tax program. "Public health approaches, particularly those involving government action, are sometimes caricatured as forcing people to behave in certain ways." (Brownell, Kersh, Ludwig, et al., 2010). As with the cigarette tax, a BMI-based tax would not force an individual to change from an unhealthy lifestyle to a healthy one. It would help compensate for the costs that the taxpayer's obesity is likely adding to the medical care system, while, ideally, serving as a strong deterrent to an unhealthy lifestyle. Ultimately, however, it would should be left up to the individual taxpayer to make the personal choice of taking responsibility.

Behavior drives our lives. Behaviors are learned from a young age and eventually become habits and then lifestyles. Eating is no different. Eating behaviors, whether healthy or unhealthy, are developed from early childhood and carried on throughout our lives while we reap the benefits or bear the consequences. According to the CDC and Prevention, behavior is one of the leading factors in causing people to be overweight and obese. ("Adult Obesity Causes & Consequences," 2017). Although it may be argued that obesity is genetic and cannot be helped, the fact is that behavior can be helped and it can be changed.

While there is a strong environmental influence toward unhealthy lifestyles in America, whether it is the prevalence of processed food or the lack of activity due to the drive for productivity in American culture, the inherent trait of personal responsibility is central to the functional American society. It could also be argued that we live in an environment of violence and tragedy, but do we dismiss individuals who commit such violent acts of their personal responsibility simply because there is a strong societal influence? Absolutely not; therefore, as with all issues which involve some degree of personal choice, individuals who choose to lead and maintain an unhealthy lifestyle should be held to a standard of personal responsibility as well.

The astronomical rates at which obesity, obesity-related disease and obesity- related expenditures are continuing to rise have already caused detrimental damage to America's healthcare system, budget and population. The combination of individual choice and collective responsibility offered by a BMI-based tax would have a considerable impact both American lifestyles and the national budget which has suffered both directly and indirectly as a result of obesity. It is time that we take both individual and collective responsibility for the health and wellbeing of our nation -- both physically and fiscally.

Works Cited

10 Flabbergasting Costs of America's Obesity Epidemic. (2013, April 10). PHIT America, Retrieved from www.phitamerica.org/News_Archive/10_Flaggergasting_Costs.htm

Adult Obesity Causes and Consequences. (2017, August 29). Centers for Disease Control and Prevention, Retrieved from https://www.cdc.gov/obesity/adult/causes.html

Adult Obesity Facts. (2018, August 13). Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/obesity/data/adult.html

The Affordable Care Act. (2018, October 30). Retrieved from www.healthcare.gov/where-can-i-read-the-affordable-care-act/

Affordable Care Act Rules on Expanding Access to Preventive Services for Women. (2017, December 7). U.S. Department of Health and Human Services, Retrieved from www.hhs.gov/healthcare/facts/factsheets/2011/08/womensprevention08012011a.html

The Affordable Care Act's Prevention and Public Health Fund in Your State: Tennessee. (2012, February 14, October 30). U.S. Department for Health and Human Services, Retrieved on October 30, 2018 from www.hhs.gov/healthcare/facts/bystate/publichealth/tn.html

Bariatric Surgery: Obese Battle Insurance Hurdles. (2014, February 15). Associated Press, Retrieved October 28, 2014, from www.modernhealthcare.com/article/20140215/INFO/302159935

Batsis, John A. and Bynum, Julie P.W. (2016, September). Uptake of the Centers for Medicare and Medicaid Obesity Benefit: 2012-2013. Obesity, 24(9), 1983-1988

Brownell, Kelly D., Farley, Thomas, Willett, Walter C., Popkin, Barry M., Chaloupka, Frank J., Thompson, Joseph W., and Ludwig, David S. (2009, October 15). The Public Health and Economic Benefits of Taxing Sugar-Sweetened Beverages. *The New England Journal of Medicine*, 361(16), 1599-1605

Brownell, Kelly D., Kersh, Roger, Ludwig, David S. et al. (2010, March). Personal Responsibility and Obesity: A Constructive Approach to a Controversial Issue. Health Affairs, 29(3), 379-387

Budget and Economic Outlook: 2014-2024. (2014, February 4). Congressional Budget Office, Retrieved from https://www.cbo.gov/publication/45010

Burd, Steven A. (2009, June 12). How Safeway Is Cutting Health-Care Costs. *The Wall Street Journal*, Retrieved from http://online.wsj.com/articles/SB124476804026308603

Cawley, John. (2007). Occupation-Specific Absenteeism Costs Associated with Obesity and

Morbid Obesity. *Journal of Occupational and Environmental Medicine*, 49(12),.1317-1323

Cawley, John and Meyerhoefer, Chad (2012). The Medical Care Costs of Obesity: An Instrumental Variables Approach. *Journal of Health Economics*, 31(1), 219-230

Chaloupka, Frank J., Yurekli, Ayda, and Fong, Geoffrey T. (2012, May 1). Tobacco Taxes as a Tobacco Control Strategy. *Tobacco Control*. Retrieved from https://tobaccocontrol.bmj.com/content/21/2/172.full

Chew, Cassie M. (2013, August 16). What Is the Major Purpose of Health Insurance?" *LiveStrong.com*, Retrieved from http://www.livestrong.com/article/167620-what-is-the-major-purpose-of-health-insurance/

Chou, Joey and Kane, Jason. (2012, May 8). Obesity in America: By the Numbers. *PBS News Hour*; Retrieved from www.pbs.org/newshour/rundown/obesity-in-america-by-the-numbers-1/

Cost Sharing Out of Pocket Costs. (2018). Medicaid, Retrieved from www.medicaid.gov

Deaths and Mortality. (2017, May 3). Centers for Disease Control and Prevention. Retrieved from www.cdc.gov/nchs/fastats/deaths.htm

Defining Overweight and Obesity. (2016, June 16). The Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/obesity/adult/defining.html

Downey, Morgan and Still, Christopher D. (2013, October 1). The Affordable Care Act's Impact on Persons with Obesity: The Full Report. *The Downey Obesity Report*, Retrieved from http://www.downeyobesityreport.com/tag/affordable-care-act/

Economic Costs of Obesity. National League of Cities. Retrieved November 4, 2018 from www.healthycommunitieshealthyfuture.org/learn-the-facts/economic-costs- of-obesity/

Employer Wellness Incentives Questionable Origin. (2013, January 30). *The Downey Obesity Report.* Retrieved from http://www.downeyobesityreport.com/2013/01/employer-wellness-incentives-questionable-origin/

Facts: Obesity and Cardiovascular Disease. (2013). American Heart Association, Retrieved from www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_305059.pdf

Fast Facts: The Cost of Obesity. (2010) *The George Washington School of Public Health and Health Services,* Last Retrieved on November 4, 2018 from stopobesityalliance.org/wp-content/themes/stopobesityalliance/pdfs/Fast%20Facts%20Cost%20of%20Obesity%201-2012.pdf

Finkelstein E.A., Trogdon, J.G., Cohen J.W. et al. (Sept/Oct 2009). Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates. *Health Affairs*, 28.5: w822–

Fryar, Cheryl, Carroll, Margaret, and Ogden, Cynthia. (2012, September). Prevalence of Overweight, Obesity, and Extreme Obesity Among Adults: United States, Trends 1960–1962 Through 2009–2010. The Centers for Disease Control and Prevention, Retrieved from www.cdc.gov/nchs/data/hestat/obesity_adult_09_10/obesity_adult_09_10.pdf

Gallagher, Christopher. (2012, December 4). *OCC Health Policy Memo: Summary of State Benchmark Plan Coverage of Obesity Treatment Services*. Retrieved November 4, 2018, from www.obesityaction.org/wp-content/uploads/1212-OCC-Summary-of-Obesity-Treatment-State-Benchmark-Plan-Coverage.pdf

Health Care Reform Timeline. (2018, October 30) Obamacare Facts. Retrieved from obamacarefacts.com/health-care-reform- timeline.php

Health Care Insurance. (2018). HealthPAC Online, Retrieved from www.healthpaconline.net/health-care-insurance.htm

Health Insurance. (2014). Retrieved from www.healthcare.gov/glossary/health-insurance/

Health Risks of Being Overweight. (2015, February). National Institute of Diabetes and Digestive and Kidney Diseases. Retrieved from https://www.niddk.nih.gov/health-information/weight-management/health-risks-overweight

Health, United States. (2013). Centers for Disease Control. U.S. Department of Health and Human Services, Retrieved from http://www.cdc.gov/nchs/data/hus/hus13.pdf#064

Hoffman, Beth. (2013, March 22). The Business of Obesity, What It Costs Us. *Forbes*, Retrieved from www.forbes.com/sites/bethhoffman/2013/03/22/the-business-of-obesity/)

Increasing the Federal Tobacco Tax Reduces Tobacco Use (And the Tobacco Companies Know It). (2013, April 11). Campaign for Tobacco-Free Kids, Retrieved from www.tobaccofreekids.org/research/factsheets/pdf/0021.pdf

ObamaCare Facts: Affordable Care Act, Health Insurance Marketplace. (2018, September 4). Retrieved from obamacarefacts.com/

Obesity. (2018, June 29). Trust for America's Health. Retrieved from http://healthyamericans.org/obesity/

Obesity Screening and Counseling. (2018). Medicare.gov, Retrieved on November 4, 2018 from www.medicare.gov/coverage/obesity-screening-counseling

Overweight and Obesity Statistics. (2017, August). National Institute of Diabetes and Digestive and Kidney Diseases. Retrieved from http://win.niddk.nih.gov/statistics/

Patient Protection and Affordable Care Act. (2010, March 23). Public Law 111-148. Retrieved October 28, 2014, from http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

Patient Protection and Affordable Care Act, Compilation. (2010, May). Department of Health and Human Services, Retrieved from https://www.hhs.gov/sites/default/files/ppacacon.pdf

Pollack, Andrew. (2013, June 18). A.M.A. Recognizes Obesity as a Disease. *New York Times*, Retrieved from https://www.nytimes.com/2013/06/19/business/ama-recognizes-obesity-as-a-disease.html

Portion Distortion. (2013, September 30). National Heart, Lung and Blood Institute. Retrieved from https://www.nhlbi.nih.gov/health/educational/wecan/eat-right/distortion.htm

Preventative Care. (2017, February 1). U.S. Department of Health and Human Services, Retrieved from www.hhs.gov/healthcare/rights/preventive-care/index.html

Salahi, Lara, and Meaney, Samantha. (2012, May 16). 'Fat Tax' to Lower Obesity. ABC News, Retrieved from https://abcnews.go.com/Health/Wellness/fat-tax-lower-obesity/story?id=16353067

Steuerle, C. Eugene and Quackenbush, Caleb. (2013, November 11). Social Security and Medicare Taxes and Benefits over a Lifetime. *Urban Institute*, from https://www.urban.org/research/publication/social-security-and-medicare-taxes-and-benefits-over-lifetime

Tauras, John A. (2002, April 15). The Impact of Unit Price Increases for Cigarettes. *ImpacTeen*, Retrieved from https://impacteen.uic.edu/generalarea_PDFs/idph2002_taxationJT.pdf

Thorpe, Kenneth E., and Yang, Zhou. (2011, September). Enrolling People with Prediabetes Ages 60–64 in a Proven Weight Loss Program Could Save Medicare $7 Billion or More. *Health Affairs*. 30(9), 1673–1679

Top 10 Healthcare Services Excluded Under Obamacare. (2014, May 15). *Medical Benefits*, 31(9), 10-11

Treat and Reduce Obesity Act. (2013). HR 2415 and S.1184, 113th Congress.

Umbehr, Josh MD. (2014, June 28). Obesity is a Disease: Does that Change the Way Doctors Practice? *KevinMD.com*, Retrieved from www.kevinmd.com/blog/2014/06/obesity-disease-change-way-doctors-practice.html

U.S. Census Bureau. (2018). Retrieved from https://www.census.gov/search-results.html?q=median+income&page=1&stateGeo=none&searchtype=web&cssp=SERP

Varney, Sarah. (2013, May 27). Obamacare Insurance Won't Cover Weight-Loss Surgery in Many States. *Kaiser Family Foundation.* Retrieved October 28, 2018, from https://khn.org/news/bariatric-surgery-obesity-exchange-marketplace-mississippi/

Weight Loss Surgery Insurance Coverage and Costs. (2018, September 28). Retrieved from www.obesitycoverage.com/weight-loss-surgery-insurance-coverage-and-costs/

Why Low-Income and Food-Insecure People are Vulnerable to Overweight and Obesity. (2018, October 30, 2018). Food Research and Action Center. Retrieved from frac.org/obesity-health/low-income-food-insecure-people-vulnerable-poor-nutrition-obesity