

Fast Facts: The Cost of Obesity

Obesity is associated with significantly increased risk of more than 20 chronic diseases and health conditions that cause devastating consequences and increased mortality. Beyond the significant personal toll, obesity and related health complications are driving up health care costs and threatening employers' bottom lines. This fact sheet is one in a series of 'Fast Facts' that provides information to help shed light on this complex health issue.

- *Direct costs* are costs for medical care, including preventative, diagnostic and treatment services.
 - In 2008, medical spending attributable to obesity is estimated to have been \$147 billion, which is 9.1 percent of annual medical spending.ⁱ
- A study in the journal *Health Affairs*ⁱⁱ, noted that per person health care spending for obese adults is 56 percent higher than for normal-weight adults. Over 15 years, the additional costs incurred by obese adults with private health insurance versus normal-weight adults increased from \$272 to \$1,244 per person per year.
- A sustained 10 percent weight loss will reduce an overweight person's lifetime medical costs by \$2,200-\$5,300 by lowering costs associated with hypertension, type 2 diabetes, heart disease, stroke and high cholesterol.ⁱⁱⁱ
- Obesity is the prime culprit behind the recent sharp increases in Medicare spending. The number of obese Medicare recipients nearly doubled between 1987 and 2002 and the cost of treating them almost tripled.
- Many direct medical costs of the obese are paid by taxpayer dollars.
 - Obesity-attributable expenditures for Medicare and Medicaid make up 8.5 percent and 11.8 percent of spending, respectively.^{iv}
- Obesity is associated with higher medical, disability and insurance premium costs.
- Nearly \$40 billion of increased medical spending in 2006 was found to be due to the increased prevalence of obesity.^v
 - In 2006, per capita medical spending for an obese adult was \$1,429 greater than for a normal adult.^{vi}
 - Medicare beneficiaries who are obese cost \$600 more per year than normal-weight beneficiaries.^{vii}
- Total health care expenditures for adults that were obese increased by more than 80 percent when comparing 2001 and 2006 data (rising from \$166.7 to \$303.1 billion).^{viii}
- According to a 2008 study, if obesity prevalence continues to rise following current trends, total health care costs attributable to obesity and overweight will more than double every decade by 2030.^{ix}
 - This could lead to health care costs from \$860 to \$956 billion, which would account for 15.8-17.6 percent of total health care costs.^x
- Research has shown that moderately obese workers (Body Mass Index (BMI) of 30-34.9) have health care costs about 21 percent higher than health care costs for normal weight workers, costing employers an additional \$670 per employee each year.^{xi}
 - Health care costs are 75 percent higher for severely obese workers (BMI \geq 35) (an additional \$2,441 annually per employee).^{xii}

- *Indirect costs* are costs that are lost to morbidity and mortality, such as wages lost due to sickness and early death. The indirect costs of obesity were estimated to be \$56 billion in 2000.^{xiii}
 - *Morbidity-related costs* measure the loss of human resources, such as losses in labor-force participation from decreased productivity, restricted activity, absenteeism and bed days due to increases in health-related problems, including type 2 diabetes, heart disease, certain cancers, stroke and depression.^{xiv}
 - The total cost of obesity-attributable absenteeism in the U.S. was estimated to be \$4.3 billion in 2004, which was 9 percent of the nationwide cost of all sickness-related absenteeism.^{xv}
 - *Mortality-related costs* measure the cost of the value of future income lost due to premature death.

About the STOP Obesity Alliance

The Strategies to Overcome and Prevent (STOP) Obesity Alliance is a collaboration of consumer, provider, government, labor, business, health insurers and quality-of-care organizations united to drive innovative and practical strategies that combat obesity. The STOP Obesity Alliance is directed by Research Professor Christine C. Ferguson, J.D., of The George Washington University's Department of Health Policy and former Health Commissioner for the State of Massachusetts. Richard H. Carmona, M.D., M.P.H., FACS, 17th U.S. Surgeon General (2002-2006) and President of the non-profit Canyon Ranch Institute, serves as Health and Wellness Chairperson of the Alliance. The Alliance Steering Committee is comprised of the following public and private sector organizations: American Diabetes Association, American Heart Association, America's Health Insurance Plans, American Medical Group Association, Canyon Ranch Institute, the Center for Disease Control and Prevention's Division of Nutrition, Physical Activity and Obesity (DNPAO), DMAA: The Care Continuum Alliance, National Business Group on Health, National Quality Forum, Partnership for Prevention, Reality Coalition, Service Employees International Union, The Obesity Society and Trust for America's Health. The Strategies to Overcome and Prevent (STOP) Obesity Alliance receives funding from founding sponsor, sanofi-aventis U.S. LLC, and supporting sponsors, Allergan, Inc. and Amylin Pharmaceuticals, Inc. For more information, visit www.stopobesityalliance.org.

ⁱ Finkelstein E.A., Trogdon J.G., Cohen J.W., Dietz W. (2009) Annual medical spending attributable to obesity: payer- and service-specific estimates. *Health Affairs*. 28: w822-w831.

ⁱⁱ Finkelstein E.A., Trogdon J.G., Cohen J.W., Dietz W. (2009) Annual medical spending attributable to obesity: payer- and service-specific estimates. *Health Affairs*. 28: w822-w831.

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^v Finkelstein E.A., Trogdon J.G., Cohen J.W., Dietz W. (2009) Annual medical spending attributable to obesity: payer- and service-specific estimates. *Health Affairs*. 28: w822-w831.

^{vi} Finkelstein E.A., Trogdon J.G., Cohen J.W., Dietz W. (2009) Annual medical spending attributable to obesity: payer- and service-specific estimates. *Health Affairs*. 28: w822-w831.

^{vii} Finkelstein E.A., Trogdon J.G., Cohen J.W., Dietz W. (2009) Annual medical spending attributable to obesity: payer- and service-specific estimates. *Health Affairs*. 28: w822-w831.

^{viii} Stagnitti M. (July 2009) Trends in Health Care Expenditures by Body Mass Index (BMI) Category for Adults in the U.S. Civilian Noninstitutionalized Population, 2001 and 2006. Agency for Healthcare Research and Quality, Statistical Brief #247.

^{ix} Wang, Y., et al. (2008). Will all Americans become overweight or obese? Estimating the progression and cost of the U.S. obesity epidemic. *Obesity*. 16: 2323–2330.

^x Wang, Y., et al. (2008). Will all Americans become overweight or obese? Estimating the progression and cost of the U.S. obesity epidemic. *Obesity*. 16: 2323–2330.

^{xi} Huse, D.M. (2007). Obesity in the Workforce: Health Effects and Healthcare Costs. Thomson Healthcare Research Brief. Available at: http://www.medstat.com/uploadedFiles/Cost_of_Obesity_in_the_percent20Workplace.pdf

^{xii} Huse, D.M. (2007). Obesity in the Workforce: Health Effects and Healthcare Costs. Thomson Healthcare Research Brief. Available at: http://www.medstat.com/uploadedFiles/Cost_of_Obesity_in_the_percent20Workplace.pdf

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