Medicaid Report: New Hampshire and Vermont

Preventative Care and Obesity

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EXECUTIVE SUMMARY

New Hampshire and Vermont, like many states, face the challenge of providing affordable, high-quality Medicaid programs while operating under budget constraints. One component of these medical expenses is the cost of caring for the steadily rising proportion of obese citizens. Medicaid costs attributable to obesity in New Hampshire and Vermont have been gradually increasing over the past 25 years. Reducing the growing numbers of obese and overweight citizens will eventually reduce the Medicaid expenses attributed to these problems. This report examines preventative care measures such as improved nutrition and physical fitness programs as possible methods of reducing obesity. It also identifies potential funding sources that are available to New Hampshire and Vermont to alleviate the costs of implementing obesity-preventative programs.

1. TRENDS IN OBESITY

Obesity is a major problem across the United States. 30 percent of the adult population aged 20 and above (over 60 million people) are obese. This problem has been worsening for the past 20 years. The percentage of young people aged 6 – 19 years who are overweight has more than tripled since 1980 to its current rate of 16 percent (over 9 million youth). The Centers for Disease Control and Prevention (CDC) reports that, in 2002, 65 percent of the national population suffered from being either obese or overweight, up from 56 percent in 1994.[1]

New Hampshire and Vermont have a similar rising trend of obesity but at a lower prevalence compared to the national average. Data from the National Center for Chronic Disease Prevention and Health Promotion reveals a significant, gradual increase in the prevalence of obesity in the two states from 1990 to 2002. In New Hampshire, the obesity rate grew from 11.1 percent of the population to 17.9 percent during this period. In Vermont, the obesity rate rose from 10.7 percent to 18.9 percent.

2. MEDICAL COSTS OF OBESITY

The increasing prevalence of obesity is associated with significant medical costs. Health care costs in obese populations are higher primarily due to the need for prescription drugs.[2] In addition, obese patients have a higher prevalence of hospitalizations, specialist claims, and outpatient tests. Obese persons are known to have a higher risk for heart disease, stroke, high blood pressure, diabetes, gallbladder disease, arthritis, stress fractures, high cholesterol, breathing problems and some forms of cancer (including endometrial, gallbladder, cervical, ovarian, breast, colorectal and prostate). Nearly 70 percent of cardiovascular disease cases and almost half of both breast and colon cancer cases in the U.S. are associated with obesity. Obesity leads to decreased life span.[3]

Healthcare expenditure data from the National Health Accounts (NHA) estimates that

medical costs attributed to overweight and obesity accounted for 9.1 percent of total U.S. medical expenditures in 1998 and may have reached as high as $78.5 billion. Approximately one-half of these costs are borne through Medicaid and Medicare programs. 10.6 percent of adult Medicaid expenditures are attributed to obesity.[4]

In New Hampshire and Vermont as well, obesity-related expenses comprise a significant portion of medical expenditures. Although both Vermont and New Hampshire have a lower percentage of obesity-related expenses that go through Medicaid than the national average of 10.6 percent, Medicaid still bears a disproportionate burden of the obesity-attributable medical costs.[5] In New Hampshire, five percent of total medical expenses ($302 million) are spent annually on obesity-attributable ailments but within the Medicaid program, 8.6 percent of the total Medicaid spending ($79 million) are spent for all obesity-related expenses.[5] Similarly, in Vermont, a total of $141 million—5.3 percent of total medical expenditures—are spent on obesity-attributable diseases. However, within the Medicaid program, 8.6% of total Medicaid expenses ($40 million) are expended. Table 1 shows the estimated percentage of total, Medicare, and Medicaid adult medical expenses that are attributable to obesity in New Hampshire, Vermont, and across the country.

Table 1. Obesity-Related Medical Expenditures (2000 figures)

	United States	New Hampshire	Vermont
Percentage of Total	5.7%	5.0%	5.3%
Total Medical Expenses	$75 billion	$302 million	$141 million
Percentage of Medicaid	10.6%	8.6%	8.6%
Medicaid Dollars	$21.3 billion	$79 million	$40 million
Percentage of Medicare	6.8%	5.4%	6.9%
Medicare Dollars	$17.7 billion	$46 million	$29 million

Note: The proportion of Medicaid dollars spent on obesity-related diseases is higher than the proportion of overall healthcare expenditure dollars spent on obesity-related expenses.

3. PREVENTIVE METHODS TO REDUCE OBESITY

Obesity results when energy intake is greater than energy expenditure—when calories taken in from food and drink exceed calories burned from metabolism and physical activity.[6] Thus, efforts to reduce the prevalence of obesity must target healthy eating campaigns and exercise initiatives for both youth and adults. Children and young adults in particular are prime targets for such programs as the eating and exercise habits they develop will likely remain for a lifetime. Obesity preventative programs need not

specifically target Medicaid recipients; universal programs targeted to the general population will produce medical cost reductions for both the Medicaid and general population alike. Since the Medicaid population is disproportionately affected by obesity and overweight, universal preventative care programs will likely disproportionately reduce medical costs for them and be socially beneficial to the entire population. These programs will also create the secondary economic and social benefits of a healthier, more productive workforce. Following is a list of potential program types that might be successful in reducing the prevalence of obesity:

- *School nutrition programs:* School nutrition programs can include the promotion of healthy snacks at school; the implementation of nutrition education curricula; the development of coordinated menu planning that strives to serve healthy hot-line lunch items; and the restriction of soda and high-calorie (junk) food sales in vending machines. Whole grains, fruits, vegetables, lean meats, and other healthy foods can be included in school lunches at the elementary level up to the high school level. Parents can also be made aware of school nutrition programs so that they can incorporate similar foods into children's diets at home.

- *Exercise/physical education requirements in school:* Promoting physical education participation from elementary school all the way through high school will help increase students' caloric expenditure and thus reduce the prevalence of obesity. Daily participation in high school physical education classes dropped from 42 percent in 1991 to 28 percent in 2003.[7] Such shifts away from physical education have been widespread across the U.S., in both high school and elementary schools. Reversing this trend and increasing physical education requirements will be an important step towards preventing obesity.

- *Adult exercise incentives:* Various adult exercise incentives include "point-of-decision" advertising campaigns promoting, for example, the use of walking and stairs as an alternative to elevators. Additionally, workplaces can help promote exercise independently by offering fitness perks like gymnasium facilities or fitness center memberships.

- *Reduced costs of produce:* The price of fruit and vegetables has been linked to weight in young children.[8] Efforts to provide affordable produce and nutritious foods are an important component of obesity and overweight prevention. Such efforts could be coordinated through farm-to-home or farm gleaning programs.

- *Food taxation:* Some policymakers suggest a tax on junk foods such as soda and other energy-dense foods to reduce the prevalence of obesity.[9] A 2001 medical study found that consumption of sugar-sweetened drinks, primarily soda, is associated with obesity in children.[10] A high tax on both sodas and energy-dense, nutrition-poor foods such as candy might help to dissuade children and families from consuming such foods—particularly low-income families that turn to such foods as affordable alternatives.

Further research will have to be conducted to determine which options will be most suitable for New Hampshire and Vermont communities. As practiced in some other states, several methods can be simultaneously implemented to strengthen their effects. For example, Washington, with an overweight rate of 58 percent in adults and 21 percent in high school students began implementing the *Washington State Nutrition and Physical Activity Plan* in 2003. It uses several interventions under this plan to combat the growing rates of obesity and the associated negative health consequences in different communities.[11] Some of the interventions are:

- increasing opportunities for physical activity through a trail maintenance and creation program;
- increasing the availability of fresh fruit and vegetables by increasing land space for gardens;
- supporting breastfeeding in health care facilities, work sites and other community locations;
- training child care providers to reduce sedentary behavior, such as television watching, in children;
- creating safe routes to school to encourage physical activity in children through walking and biking to school.

Although the impact of this program is not yet conclusive, it is a useful example in understanding how other governments have begun to combat the challenge of obesity. Further research will need to be undertaken to evaluate which programs will be the most effective for the specific New Hampshire and Vermont regions in which they will be placed. In addition, policymakers will have to address the question of whom the programs will benefit – if they will specifically be targeted to Medicaid recipients or if they will be universal programs designed for the benefit of all.

4. FUNDING SOURCES FOR PREVENTIVE CARE PROGRAMS

A primary drawback to pursuing preventative care plans is the cost of program implementation. Planning and implementing statewide, school or work programs will require a significant capital outlay. However, there are a number of possible solutions to this problem.

First, the capital necessary for preventative programs need not be absorbed entirely by the state. The Centers for Disease Control and Prevention (CDC), for instance, offers funding for state-based nutrition and physical activity programs to prevent obesity. Their major goals are balancing caloric intake and expenditure, increasing the prevalence of breastfeeding, reducing television time, increasing physical activity, and improving nutrition through increased consumption of fruits and vegetables. In 2005-2006, CDC funded 21 states at $400,000-$450,000 for capacity building and an additional seven states at $750,000-$1.3 million for basic implementation. Vermont is already receiving

funding from the CDC at the capacity building level; however they have not yet embarked on implementation for these preventative care programs. New Hampshire is one of 22 states not receiving any funding for preventative care capacity building and planning.[12] New Hampshire could consider applying for these funds to pursue the design and implementation of such preventative care programs.

A second source of funding might come from within the state itself. Establishing food taxes on sodas and other energy-dense, nutritionally-poor foods as described above would potentially generate a significant source of additional revenue. These additional revenue sources could be reinvested into preventative care programs aimed at reducing the negative health consequences partially caused by those foods, thereby helping provide capital for preventative care programs without cutting into the state budget.

Although initial capital costs to implement programs will result in additional expenses for the government, in the long run, New Hampshire and Vermont stand to save up to 8.6 percent of Medicaid costs, plus additional money saved through Medicare. Though it is unlikely that preventative care measures will reduce obesity 100 percent, a reduction of obesity to half its current level will still enable the state governments to save over four percent of its Medicaid expenses. Further research should include an in-depth analysis of the cost of preventative care programs and the projected savings from implementing them.

5. CONCLUSIONS

At a time when providing affordable, quality Medicaid programming is a growing challenge, it is important to look for comprehensive and effective solutions that will cut Medicaid costs while maintaining quality of health. Preventative care options such as school nutrition programs, junk food taxation initiatives, exercise and physical education requirements at school, work-site exercise incentive programs, and affordable healthy food initiatives for low-income persons might provide such a solution. Addressing obesity problems at an early stage will reduce costs in the long run, as well as lessen the percentage of obese individuals over the next decade. Targeting obesity education and prevention programs at students in the elementary, middle, and high school level will encourage the formation of lifelong healthy habits. Further research should include a comparative analysis of the proven benefits of various obesity prevention initiatives as well as an in-depth analysis of the cost of preventative care programs.

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