Dear State Leader,

Welcome to the fourth and final 2012 installment of the Strategies to Overcome and Prevent (STOP) Obesity Alliance's "Weight and the States" bulletin. In this edition, we've identified key obesity-related trends at the state level from 2012 and then forecasted those that appear to be emerging for 2013. While most of the trends won't surprise you, there are some interesting developments:

- **Majority of State Benchmark Plans Lacking in Obesity Prevention and Intervention:** As many states work toward implementing the Affordable Care Act, the possibility of including obesity-related services as part of a state's "Essential Health Benefits" (EHB) package remains of significant interest to many. In this issue, we review obesity coverage levels for states that have already selected their benchmark EHB plan, as well as states that have indicated they are leaning toward a particular plan. While many advocates hoped that obesity services would be included, the trend seems to be going the other way. Most states have selected the least inclusive small-employer plan, which generally offers very limited obesity-related services. The vast majority of states will have to supplement their currently selected EHB plans to include intensive behavioral counseling services on or before 2014.
- **Proposed Essential Health Benefit Rule May Exclude Coverage of Obesity Modalities Through 2016:** On November 20, the U.S. Department of Health and Human Services released a proposed rule on Essential Health Benefits (EHB). Unfortunately, much ambiguity around obesity coverage remains and a potential benefit "freeze" may limit coverage of obesity modalities through 2016.
- **Obesity is a Family Affair:** Our research shows that whether it is parents talking about obesity with their kids or the protective role of breastfeeding, addressing obesity is a family issue.
- **Consolidating Efforts to Treat and Prevent Obesity:** As encouraged by a recent Institute of Medicine report, states are consolidating obesity efforts underway to maximize efficiency and reach of their state-wide obesity efforts.
- **Draft Legislation Seeks Supportive Environments to Promote Healthier Choices:** We also reviewed legislative trends and found robust activity on improving food environments and increasing opportunities for physical activity. However, the passed legislation represents a small proportion of the total proposed legislation.

While obesity prevention has gained traction in recent years, obesity interventions remain few and far between. Supporting individuals affected by obesity should be important to any state due to the enormous burden of obesity on aggregate medical expenditures. States not only incur costs through publicly funded insurance programs but the typical non-coverage of obesity services results in higher rates of absenteeism and presenteeism, among other consequences, that may negatively impact the state's overall economic wellbeing.

Thoughts on one or more of these trends and whether or how they are shaping up in your state? Let us know! We would be pleased to hear from you on these issues and can be reached anytime through our website at www.stopobesityalliance.org or by email at obesity@gwu.edu.

Sincerely,

Scott Kahan, MD

Scott Kahan, M.D., M.P.H.
Director, Strategies to Overcome and Prevent (STOP) Obesity Alliance
http://www.stopobesityalliance.org/

Majority of State Benchmark Plans Lacking in Obesity Prevention and Intervention

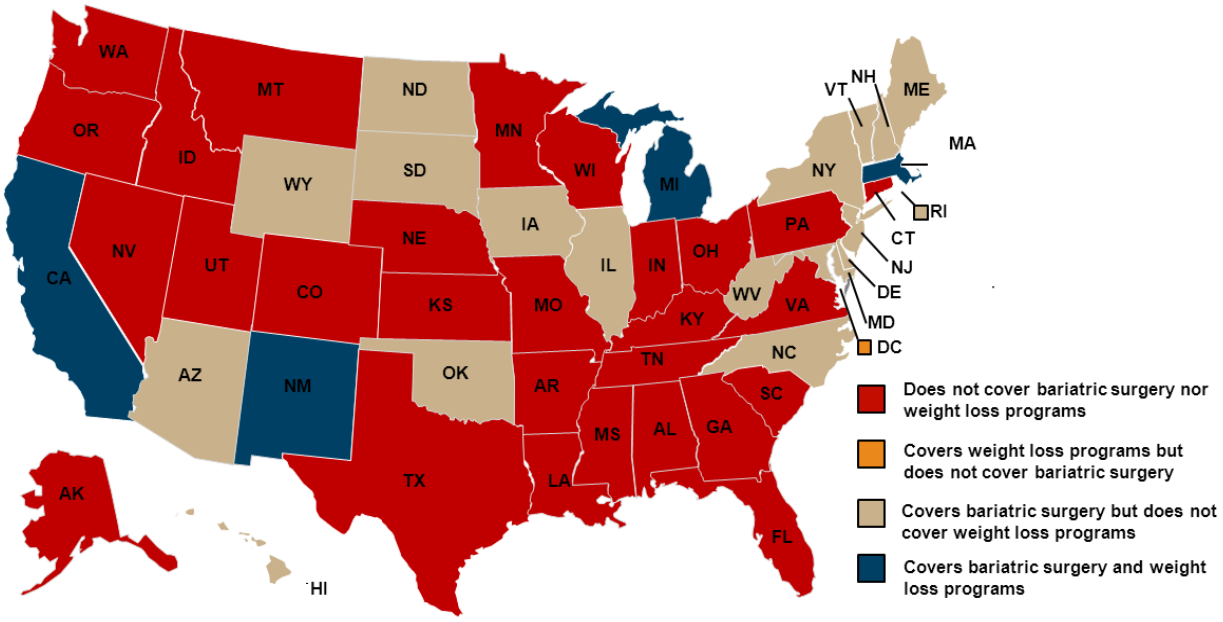
The Affordable Care Act (ACA) ensures Americans have access to quality health insurance by requiring health plans in the individual and small group market, both inside and outside the Exchanges, to offer a comprehensive package of items and services, known as Essential Health Benefits (EHBs). Beginning in 2014, insurance policies must cover these benefits in order to be certified and offered in Exchanges.

In the first *Weight and the States* bulletin of this year, we reviewed the three largest small-group employer plans that states could select as their benchmark plan. We suggested it was likely states would choose a small-group plan as they tend to offer a cheaper, but more restrictive, set of benefits. Now that more than half of the states have made a decision or indicated a plan likely to serve as their EHB benchmark, we thought it would be helpful to see how many states have selected benchmarks that cover weight-related services.

State officials had a "soft" deadline of September 30 for identifying a state benchmark plan. As of late November, only 27 states had made a preliminary or final benchmark plan decision. The majority of states (18 and DC) chose a small-group plan, while four states chose an HMO plan, three states chose a state employee plan, and Nebraska selected a high-deductible health savings plan for review and approval by the U.S. Department of Health and Human Services (HHS).

The Center for Consumer Information and Insurance Oversight recently released coverage summaries for all 50 states based on each state's current EHB benchmark plan selection, with states that have not selected an EHB benchmark plan defaulting to the largest small-group employer plan in the state.

Map 1: Essential Health Benefit Benchmark Plan Coverage of Weight-Related Services



Source: CCIIO summary of EHB benchmark plans based on 2012 benefits
Note: "Weight-loss programs" is a category that insurers are required to report to CCIIO; we were unable to identify what, if any, criteria plans have to meet in order to claim they cover weight-loss programs.

Summary of Coverage

- Twenty-two states chose benchmark plans that cover bariatric surgery
  - Arizona, California, Delaware, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Rhode Island, South Dakota, Vermont, West Virginia and Wyoming
- Five states chose benchmark plans that cover weight loss programs
  - California, District of Columbia, Massachusetts, Michigan, New Mexico
- Twenty-eight states chose benchmark plans that cover neither bariatric surgery nor weight loss programs
  - Alabama, Alaska, Arkansas, Colorado, Connecticut, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington and Wisconsin
- One state covers weight loss programs but not bariatric surgery
  - District of Columbia

Only Massachusetts selected a plan that clearly meets the United States Preventive Services Task Force's (USPSTF) 'B' recommendation for obesity screening and intensive behavioral counseling, services which must be covered as EHBs beginning in 2014, indicating that the vast majority of states will have to supplement their currently selected EHB plans to include obesity services on or before 2014. States could look to the Medicare national coverage determination on obesity screening and intensive behavioral counseling for guidance on coverage limits as it meets the USPSTF recommendation and was determined as a standard coverage level for all Medicaid beneficiaries.

States may need further regulatory guidance on what level of coverage qualifies as meeting the USPSTF recommendation. For example, states with budgetary issues may seek to cover the minimum number of USPSTF recommended intensive behavioral counseling sessions – 12 sessions during the first year – instead of covering 12 to 26 visits as recommended. This may become a somewhat contentious policy issue in 2013.

Proposed Essential Health Benefit Rule May Exclude Coverage of Obesity Modalities Through 2016

On November 20, HHS released a proposed rule regarding EHBs[i]. The rule largely follows previous information guidance released by HHS and gives states until December 26, 2012 to select an EHB plan. The proposed rule remains ambiguous on obesity coverage. For example, the proposed rule includes language that, "prohibit(s) benefit and network designs that discriminate on the basis of an individual's medical condition, or against specific populations." Treatment of obesity, when regarded as a clinical medical condition, should fall under this language. However, as our review of coverage shows, current benefit designs include limited coverage of obesity treatment modalities, and whether or not HHS will require states to supplement EHB plans to include obesity coverage remains to be seen.

The rule proposes that "the state's benchmark plan selection in 2012 would be applicable for the 2014 and 2015 benefit years." This benefits freeze seems to preclude coverage of new safe, effective and evidence-based treatments developed and/or approved between 2011 and 2016. For obesity treatments, this would mean the exclusion of two drugs (Qsymia and Belviq) recently approved by the Food and Drug Administration (FDA) from state formularies until at least 2016. On the other hand, a benefits freeze in and of itself could be construed to be discriminatory against populations for which

treatments do not currently exist or for which currently available therapies are inadequate, and there is unmet medical need.

Additional language around prescription drug coverage requires EHBs to include "at least the greater of: 1) one drug in every category and class; or 2) the same number of drugs in each category and class as the EHB benchmark plan," per the United States Pharmacopeial (USP) Convention guidelines. The three drugs currently approved by the FDA for weight loss fall under categories not recognized by USP (anoretics and lipase inhibitors), as the USP system was designed for Medicare, which explicitly excludes obesity drugs under Part D. However, for drugs in classes not recognized by the USP, insurers must cover at least one drug in every category and class. Classes distinguish chemically unique drugs, which mean that at least two obesity drugs should be covered, even if grouped under larger categories. Orlistat, as the only FDA-approved lipase inhibitor would be covered in this scenario, as would Qsymia or Belviq, the only two FDA-approved drugs considered anorectics. It is possible that if Qsymia or Belviq were to be classified according to their individual chemical components rather than a compound, that they might not be covered.

States likely will require further guidance from HHS around the benefits freeze and/or anti-discrimination to clarify the applicability of each provision, and how they are or are not contradictory of one another. States will also likely need further guidance on specific drug categories and classes for which they must provide coverage.

Multi-State EHB Plans

On November 30, the Office of Personnel Management (OPM) released regulations regarding multi-state EHB plans. Through contracts with OPM, health insurance issuers must offer "at least two multi-state plans (MSPs)," one at the silver level of coverage and one at the gold level of coverage, "on each of the Affordable Insurance Exchanges (Exchanges)." MSP benefits packages in all states must be substantially equal to either 1) each state's EHB benchmark plan in each state in which it operates or 2) any EHB benchmark plan selected by OPM. OPM has proposed that states select one of the three largest Federal Employee Health Benefits Plan (FEHBP) enrollment options that are open to Federal employees. HHS determined that as of March 31, 2012, these plans consisted of the following: Blue Cross Blue Shield (BCBS) Standard Option, BCBS Basic Option, and Government Employees Health Association (GEHA) Standard Option 40. Plan coverage of obesity-related services is as follows:

Plan	Obesity Counseling	Weight Loss Programs	Obesity Drugs	Bariatric Surgery
BCBS Standard	Covered	Excluded (other than nutritional counseling)	Excluded	Covered
BCBS Basic	Covered	Excluded (other than nutritional counseling)	Excluded	Covered
GEHA Option 40	Non-covered	Excluded	Excluded	Covered

MSP issuers must "offer a benefits package that is uniform in each state and consists of the essential health benefits described in section 1302 of the Affordable Care Act." This means MSP plans must meet the 10 EHB categories of coverage stipulated under the ACA and, as of 2014, must begin covering obesity screening and counseling without cost sharing as the USPSTF recommends coverage of these services as a "B" rated service. This also means that MSP plans must offer pharmaceutical coverage that may require coverage of obesity drugs, as described in the previous section of this bulletin.

Both BCBS plans began offering obesity screening and counseling services to beneficiaries as of 2012. None of the OPM suggested benchmark plans cover obesity pharmaceuticals. Issuers utilizing the OPM suggested FEHBP plans may have to supplement coverage in order to meet the 10 EHB stipulated categories.

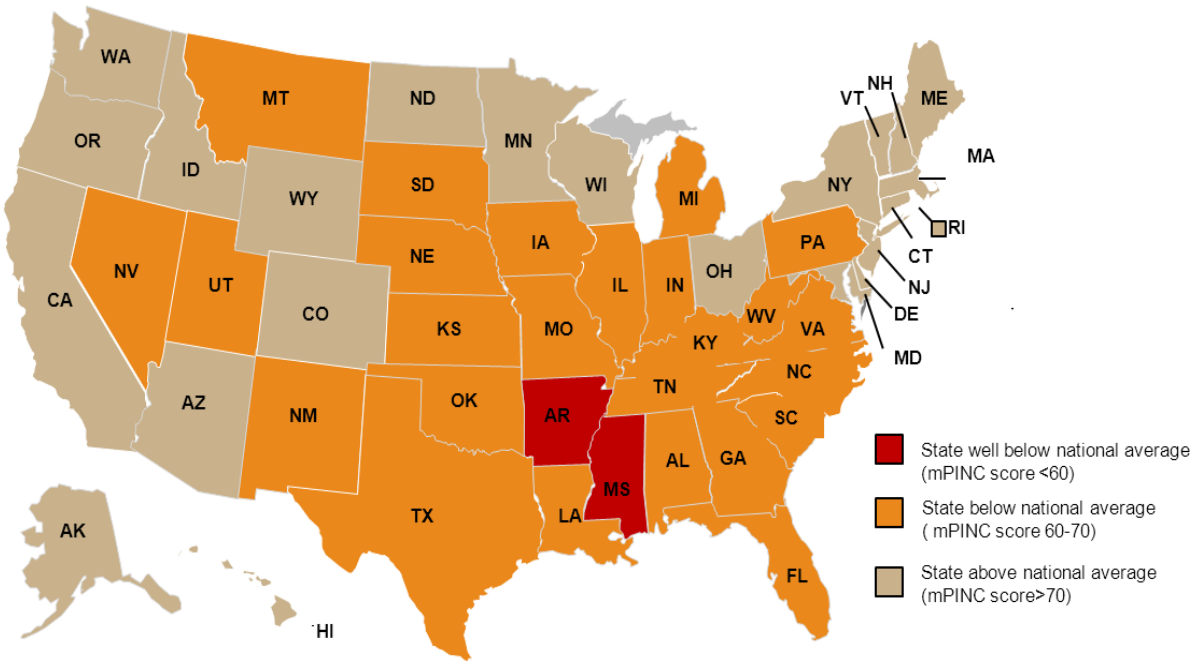
Obesity is a Family Affair

Public health organizations are beginning to recognize that the familial unit is an essential group to target for preventive interventions for childhood obesity because of strong linkages between parent-child obesity. We found a number of states that are encouraging hospitals to move towards "baby-friendliness" by supporting breastfeeding education and practices based on strong evidence that breastfeeding promotes infant health and healthy weight. Given broad societal support for childhood obesity prevention efforts due to the fact that children make few decisions on their own, states might easily gather support around this issue.

This year the Alliance launched an initiative to help parents address weight and health with their children. "Weigh In: Talking to Your Children About Health and Weight," a discussion guide designed to aid parents in addressing weight in a productive and caring way, resulted from this initiative. One of the recurring points we found in the literature was the reference to the strong linkages between familial behaviors and child obesity. For example, parents' weight is significantly correlated with a child's weight.[ii,iii]

While the *Weigh In* guide is intended to be a responsive tool to aid those already affected by obesity, in the best of worlds, prevention strategies would prevent or limit childhood obesity. One preventive factor, breastfeeding, has been shown to have a significant positive effect on the nutritional status and weight of children.[iv,v] The beneficial effects of breastfeeding extend well into adolescence and, possibly, later in life.[vi] The Centers for Disease Control and Prevention (CDC) issued a "Breastfeeding Report Card" that highlights where states stand in terms of breastfeeding practices. The map below details maternity practice in infant nutrition and care from 2012's report card.

Map 2: Baby-Friendly States as Indicated by CDC Maternity Practices in Infant Nutrition and Care (mPINC) Scores



Note: CDC mPINC scores range from 0-100, with higher scores representing better care

The map indicates that when it comes to maternity practices in infant nutrition and care, two states (AR and MS) rank relatively low. Twenty-five states rank at or below the national average of 70 and 24 states exceed the national average.

To address maternity practices and infant nutrition and care, some state public health agencies have begun encouraging hospitals to move towards "baby-friendliness." One way states can improve maternity practices in infant nutrition and care is by encouraging and supporting "baby-friendly" hospitals, as recommended by the World Health Organization and UNICEF. As of 2012, only 6 percent of babies were born in "baby-friendly" hospitals. "Baby-friendly" hospitals are voluntarily certified by Baby-Friendly USA for their adherence to 10 steps for successful breastfeeding.[vii] Essentially, "baby-friendly" hospitals ensure that mothers are equipped with the knowledge and resources to support higher uptake and longer duration of breastfeeding, which help promote health and prevent obesity.

Consolidating Efforts to Overcome and Prevent Obesity

The Institute of Medicine recently released a report on obesity prevention outlining strategies for preventing obesity and highlighting the need for coordination of anti-obesity efforts.[viii] In order to assess existing levels of coordination of obesity efforts, we surveyed the Department of Health websites for each state. We found varying levels of coordination of obesity efforts. A significant majority of states have created specific coalitions, task forces, committees, or state plans aimed at combating obesity. While these are important steps, many public health officials express frustration over what is often a fragmented and slow system.

Some states have sought to enhance their obesity efforts through consolidation of obesity programming into one central organizing body. In a few states, there are clear efforts being made to minimize duplication of effort. For example:

- In 2011, Virginia created a program within their existing Division of Prevention and Health Promotion to coordinate obesity prevention efforts within the state. This "Chronic Disease Prevention Collaborative" began by convening stakeholders to create a shared agenda. Collaborative members include representatives from state coalitions, state agencies, universities, hospitals, health insurers, pharmacies, advocacy groups and faith-based organizations. The Collaborative also provides funding to local communities to support evidence-based strategies and the development of systems to promote healthy communities. Semi-annually, the Collaborative gathers data on stakeholder activities and evaluate their progress using a set of performance indicators.
    - We found 10 states that are pursuing similar strategies: Colorado, Maine, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, Tennessee and Utah.
- Georgia has taken a slightly different approach. Instead of housing their obesity coordination efforts under an existing department, the state has created a new position tasked with coordinating all obesity efforts within the state, both in the private and public sector, and separate from the state health commissioner. According to state representatives, the structural hierarchy of this position limits confusion over who is responsible for the state's obesity prevention efforts and gives greater latitude for the state to quickly and efficiently implement a shared agenda.

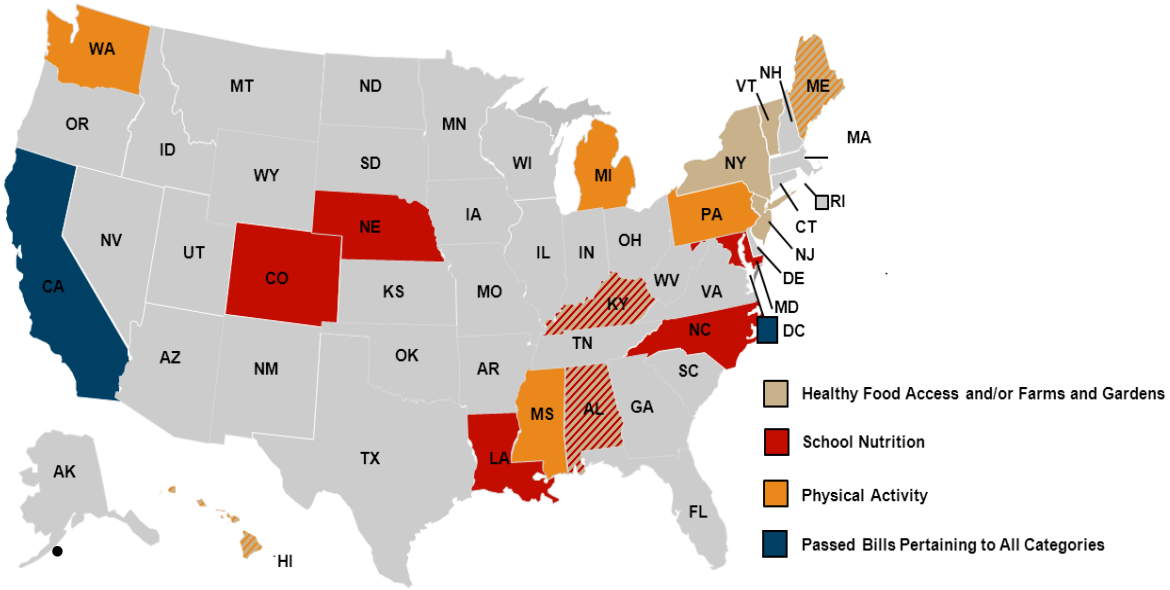
While different approaches to coordinating obesity efforts might be warranted in states, there is a clear trend towards coordinating obesity efforts by consolidating responsibility for overall programmatic implementation. States might consider implementing similar models due to the relatively low cost to do so, coupled with potential benefits such as increased reach and efficiency.

Draft Legislation Seeks a Supportive Environment to Promote Healthier Choices

Within the states, a total of 459 obesity-related bills were proposed during the 2012 legislative session. 62, or roughly 14 percent, of the total proposed bills were enacted into law.

Of the 62 bills that passed, the vast majority focused on prevention. For example, more than half (34) of the passed bills concentrate on creating healthy food environments through improving access to healthy food, improving school nutrition, supporting local agriculture, and encouraging physical activity through creating safe neighborhoods and improved access to existing infrastructure.

Map 3: Obesity-Related Legislation Passed in 2012 Legislative Session



Source: Author's interpretation of information from Yale's Rudd Center Legislative Database

- Bills aimed at improving access to healthy food in low-income or "food desert" communities passed in five states. Four (DC, NJ, NY and CA) of the five bills pertained to increasing the prevalence of healthy food options in food deserts. The legislation proposed solutions including offering favorable financing and grants to existing retailers so they can improve their product selection and by selling fresh fruits and vegetables and establishing mobile farmers markets. In Kentucky, a nutrition program focusing on education and improving access to low-cost nutritious food was passed.
- Bills aimed at reconnecting with our food system – often focusing on incorporating gardening into school curricula – were passed in six states. Seven bills in six states (AL, CA, HI, ME, NY(2) and VT) supported farms and gardens. Of those, three were related to increasing local food purchased by schools and three focused on providing financial support to local producers to facilitate bringing their products to local markets. Schools in California are now allowed to establish school gardens and to sell produce.

- Bills pertaining to school nutrition remained a significant trend, with fourteen bills passing in ten states (AL, CO, DC(2), DE, HI, LA, MD, ME(3), NC and NE). A majority of these initiatives overlapped with the farm and garden category, but a significant number also focused on trans-fat restriction in school meals, improving access to safe drinking water, emphasizing nutrition education and overhauling the contents of vending machines to include healthy snack options for students.
- While only one bill pertaining to sugar-sweetened beverages (SSB) passed, there were 34 bills on that topic proposed throughout the year. The bill that passed banned SSB sales in Boston municipal buildings. The vast majority (30) of these proposed bills sought to either impose an excise tax or remove SSBs from tax exemption. One bill sought to submit a waiver to the Department of Agriculture to ban Supplemental Nutrition and Assistance Program (SNAP) beneficiaries from purchasing SSBs with their benefits. Despite the lack of successful state-wide legislation, individual cities and school districts are making significant efforts to remove SSBs from vending machines, increase access to free, potable water, and/or limit the size of SSBs being sold in stores throughout the country.
- Bills pertaining to physical activity were passed in seven states. Three bills focused on improving street design, traffic patterns, and paths to increase safe pedestrian and cycling routes. Two bills focusing on removing liability from public school systems for non-school related use of facilities that promote physical activity, such as play grounds, fields, and tracks, were passed. The final two bills included one that created a “screen-free week” and one intended to create recreational and workplace wellness programs to promote physical fitness, health and nutrition.

Summary and 2013 Predicted Trends

We expect obesity-related prevention efforts to continue to gain traction in the coming year. Initiatives targeting children and adolescents have broad public support and are relatively inexpensive and easy to implement. However, given the complex relationships between adult and child obesity, states should implement programming to aid obese adults as well. Prevention and intervention go hand in hand, and supporting both may make a greater impact in reducing the prevalence and severity of obesity.

We expect more states will support “baby-friendliness” efforts, as they are generally socially accepted and support obesity reduction as well as a number of other health and wellness benefits.

We anticipate states to continue streamlining obesity efforts through mechanisms such as collaboratives or creation of a single authority to coordinate all their respective state’s public and private obesity efforts.

Despite preventive efforts gaining traction, medical prevention and intervention strategies for adults continue to be limited. Also, even though public programs like Medicare and most Medicaid programs provide coverage for at least bariatric surgery, less than half of states’ selected or intended EHB benchmark plans cover bariatric surgery. We predict one significant trend of 2013 to be a focus on adult intervention, particularly relating to the implementation of the ACA, which requires that insurers begin covering intensive behavioral counseling for obesity. While states should cover the entire range of 12 to 26 intensive behavioral counseling visits per year recommended by the USPSTF, the number of reimbursable visits under each state’s EHB package may become a contentious topic as states may look to minimize reimbursed visits. Furthermore, the lack of clarity around coverage of obesity drugs may require further guidance from HHS.

We hope you found this bulletin useful and we’ll continue to monitor state and national obesity efforts to keep you apprised.

References

[i] 45 CFR Parts 147, 155, and 156.
[ii] Cutting TM, Fisher JO, Grimm-Thomas K, Birch LL. Like mother, like daughter: Familial patterns of overweight are mediated by mothers' dietary disinhibition. *Am J Clin Nutr*. 1999;69(4):608-613.
[iii] Burke V, Beilin LJ, Dunbar D. Family lifestyle and parental body mass index as predictors of body mass index in australian children: A longitudinal study. *Int J Obes*. 2001;25(2):147-157.
[iv] Arenz S, Rückerl R, Koletzko B, Von Kries R. Breast-feeding and childhood obesity - A systematic review. *Int J Obes*. 2004;28(10):1247-1256.
[v] Von Kries R, Koletzko B, Sauerwald T, et al. Breast feeding and obesity: Cross sectional study. *Br Med J*. 1999;318(7203):147-150.
[vi] Gillman MW, Rifas-Shiman SL, Camargo Jr. CA, et al. Risk of overweight among adolescents who were breastfed as infants. *J Am Med Assoc*. 2001;285(19):2461-2467. Accessed 7 November 2012.
[vii] Baby-Friendly USA. http://prod-bfusa.herokuapp.com/
[viii] National Research Council. *Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation*. Washington, DC: The National Academies Press, 2012.