

Health Plans Emerging As Pragmatic Partners in Fight Against Obesity



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EXECUTIVE SUMMARY

The physical cause of obesity is simple. Calories taken in exceed calories expended. However, an effective response to the obesity epidemic is not so simple. It requires an understanding of a variety of complex and interrelated contributing factors. As obesity in America has reached epidemic proportions, it has prompted the need for real time responses guided by information about what obesity prevention and weight reduction strategies work for distinct subgroups of the population. In general, we know that the best strategy for combating obesity is a multifaceted one involving the efforts of many stakeholders, including individuals, families, employers, health plans, schools and government. Though the need for partnerships is clear, the evidence base supporting specific strategies requires further research to develop a more solid basis for action.

In this NIHCM Foundation report, we focus on the emerging role of health plans in the fight against obesity. We profile a cross section of 11 large health plans and find numerous examples of active partnerships with other stakeholders. Health plans are emerging as partners in the fight against the obesity epidemic by:

- Educating providers about screening for obesity in children,
- Creating incentives for plan members to participate in weight loss programs,
- Covering weight loss drugs and surgical treatment when necessary,
- Sponsoring worksite programs,
- Encouraging physical activity in schools, and
- Creating and funding community-based weight management programs.

In many cases plans are evaluating these strategies to develop better ways to combat this epidemic. This is an important role for plans because they have the ability to collect data on populations over a long time period in order to evaluate the long-term effects of different obesity prevention and reduction and weight management strategies. Conducting such analyses is in the interest of all stakeholders and society at large.

For this NIHCM Foundation report, we also solicited perspectives from seven of the nation's prominent health care leaders on how to combat the epidemic of overweight and obesity. Their essays, included at the end of this report, reflect a range of points of view. However, all agree that health plans alone cannot solve the obesity problem, nor can any single strategy or program. From this body of expert opinion, we draw five main themes needed in a national strategy for combating obesity:

- A range of specific actions that can be taken immediately (such as use of body mass index [BMI] or related measures as a vital sign),
- Evidence of effectiveness,
- New models of care, moving away from acute treatment to prevention and chronic care,
- Coordination of public and private resources, and
- Cultural change.



INTRODUCTION

The purpose of this report is to describe the activities of a diverse national sample of leading health plans to combat the obesity epidemic. The report features innovative, forward-thinking strategies that are already in place or are nearing implementation at 11 health plans across the country. It also features essays by seven leading experts, representing a range of stakeholders in the fight against obesity, who present their views on what can and should be done – not just what is being done – to combat obesity.

In this introduction, we include a brief description of the obesity problem in this country – a crisis of epidemic proportions that has attracted considerable media attention. Next, we summarize key themes that emerge among our guest essayists about what should be done to combat the obesity epidemic, provide illustrations of current plan practices that implement or approach these ideals, and identify gaps between what is being done and what could be done. Finally, we provide an overview of the health plan interventions featured in the body of the report, which we broadly classify as childhood, adult and community-based programs.

Obesity has Reached Epidemic Proportions in the United States

Facts about the growing obesity epidemic in the United States feature prominently in the media and in medical and health policy journals, but repetition has not diminished their “shock value”:

- Nearly two-thirds of the adult population is overweight and 30 percent of this number are obese. The prevalence of adult obesity has doubled over the last 20 years.¹
- Fifteen (15) percent of children and adolescents are overweight and another 15 percent are at risk of becoming overweight.² Seventy (70) to 80 percent of obese adolescents will become obese adults.³
- Among adults, the impact of being obese on health status is equivalent to aging 20 years.⁴
- Overweight adults have a 60 percent increased risk of diabetes, an 80 percent increased risk of high blood pressure, and a 50 percent higher likelihood of elevated cholesterol levels. For those with moderate obesity, the

risk of diabetes or high blood pressure is increased more than threefold, and the likelihood of a high blood cholesterol level or arthritis doubles.⁵

- The percent of children and adults who are overweight or obese is growing at an alarming rate (see Figure 1).

The economic consequences of the nation’s obesity epidemic are substantial:

- On average, health care costs for obese Americans are 36 percent higher than for people of normal weight (See Figure 2).⁶
- Estimates of the total direct and indirect costs attributed to obesity vary but may be as high as \$117 billion annually.⁷
- Obesity accounted for between 5 and 9 percent of total health care expenditures in 1998 and accounted for more than 25 percent of the increase in health care costs between 1987 and 2001.^{8,9}

The nation’s obesity epidemic is the result of numerous complex and intertwined factors, including: diet, sedentary lifestyles, genetics, community planning, stressful work schedules, low literacy, cultural issues, resistance to change practice patterns within the health care provider community, the availability of relatively few medical interventions, and competition for scarce public dollars. The complexity of the problem requires solutions that go far beyond the medical. Indeed, only a broad public health approach – one that brings together all levels of government, medical and public health researchers, health care providers, health plans, and individual communities – will be successful.

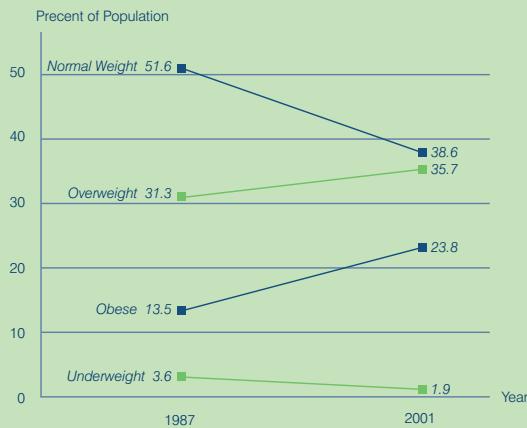
The focus of this report is largely on health plans, which have a critical role to play in combating the obesity epidemic, both in the development of their own programs and in working cooperatively with other stakeholders.

Table 1. World Health Organization Obesity Definitions for Adults

Category	Body Mass Index (BMI)
Ideal Weight	20-24.9
Overweight	25-29.9
Moderate Obesity	30-34.9
Severe Obesity	35-39.9
Morbid Obesity	40-49.9
Super Obesity	>50

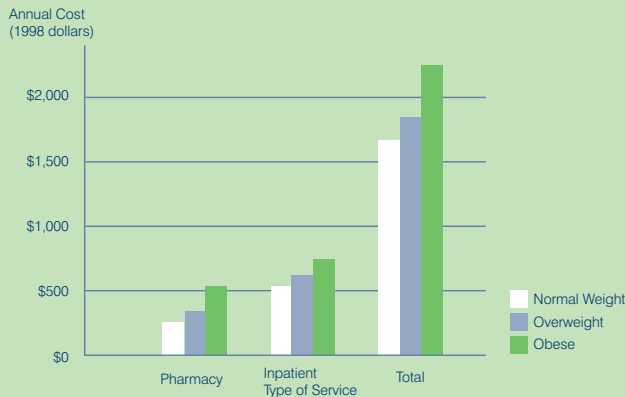
Source: Caro JF. "Definitions and Classification of Obesity- Chapter 2" www.endotext.org/obesity/obesity1/obesity1.htm

Figure 1. Changes in the Prevalence of Obesity (1987-2001)



Source: Thorpe K et al. "The Impact of Obesity on Rising Medical Spending" *Health Affairs Web Exclusive* W4-480; October 20, 2004.

Figure 2. Annual Cost of Medical Care Services Relative to Weight Categories (1990-1998)



Source: Thompson D et al. "Body Mass Index and Future Healthcare Costs: A Retrospective Cohort Study" *Obesity Research* 9(3):210-218.

Report Findings

Guest Essays: Key Themes for Success

The NIHCM Foundation invited seven prominent health care leaders to write about the obesity problem. The resulting collection of essays represents the views of a cross-section of stakeholders, including representatives of health plans, government, providers, employers and academia. They present a wide range of viewpoints and insights on this complex issue and highlight what needs to be done to initiate effective, comprehensive programs for prevention and treatment.

The health plans featured in this report have emerged as pragmatic partners in addressing obesity and will likely continue to do so as evidence of effectiveness builds and community partnerships demonstrate success. The urgent need to prevent and reduce obesity is leading health plans to rethink old strategies – for example, by shifting from acute treatments like drugs and surgery to chronic care management, weight management programs, and partnerships within the community. Some health plans have begun to implement specific measures that can have an immediate impact, such as encouraging the use of Body Mass Index (BMI) as a vital sign and educating providers on weight management counseling strategies. However, experts agree that effectively managing the obesity problem will require significant cultural changes, which are beyond the reach of health plans alone. Clearly, providers, payers and communities also have important roles to play – independently and in collaboration with other stakeholders.

In the essays written for this report, we found that several common themes emerged from our guest essayists. We list these themes below and briefly illustrate them with existing interventions that we describe in detail in the plan profile section of the report (beginning on page 11.)

- First, and perhaps most broadly, our society as a whole must undergo **cultural change** to promote healthy lifestyles. We should increase our physical activity and improve our nutrition, and parents should model this behavior for their children. Our schools should provide healthy food options for children, and our buildings and communities should encourage physical activity.

Many of the plans featured in this report are actively engaged in community-based efforts to promote healthy lifestyles. For example, Highmark works with

numerous community partners and provides substantial funding to schools to introduce nutritional curricula and physical activity programs. Highmark also offers the KidShape® program, a nationally recognized pediatric weight management program targeting overweight children and teens and their parents, in its service region. Horizon has launched employee wellness programs in Southern New Jersey and has taken a leadership role in focusing the state's health policy agenda on the growing obesity epidemic. Premera has joined with Microsoft to offer a comprehensive weight management program for plan participants and Microsoft employees. Blue Cross Blue Shield of Massachusetts' Healthy Choices program provided grants to a third of Massachusetts middle schools last year to implement an interdisciplinary curriculum focused on nutrition and physical activity.

- Second, we must **coordinate public and private sector resources** to communicate the dangerous medical consequences of obesity. Health plans can lead this effort by initiating collaborative educational activities. Also, public and private payers can create economic incentives to encourage providers to educate patients, and for members to participate in weight management programs and engage in healthy lifestyles. The federal government can help identify evidence-based strategies for implementers, and local and state governments can work in collaboration with schools and other organizations interested in combating the obesity epidemic.

Blue Cross and Blue Shield of North Carolina, through corporate contributions and the BCBSNC Foundation, supports a number of community-based initiatives, such as the Kids Café Program, Be Active North Carolina, Inc., and Fit Together. Horizon's co-sponsored community-based programs include the following: a youth mentoring program, the Shape It Up Program, the Horizon Walks for Health Campaign, the Horizon Health Kit, and Horizon Health Future. WellPoint has collaborated with the American Dietetic Association to develop a bilingual print and web-based guide called Healthy Habits for Healthy Kids, which provides practical strategies for engaging families in healthy eating and physical activity. Kaiser Permanente and HealthPartners have coordinated with the Centers for Disease Control and Prevention to translate and disseminate evidence-based recommendations for weight management and the prevention and reduction of obesity.

- Third, the obesity epidemic requires a **new model of care** involving a shift from treatment of acute conditions to prevention and chronic care. This new model utilizes electronic health records for better care management and empowers individuals and families to manage their health. It also involves non-traditional providers like nutritionists and social workers in care delivery. Moreover, the model also looks to the environment, such as schools, the workplace, and communities, as potential sources of change to improve the nation's health.

The plans profiled in this report have developed a variety of educational tools to educate providers and members. Empire Blue Cross Blue Shield has established a 360° Health program that makes available numerous educational tools to address weight management across its membership. The plan has dedicated a department staffed with clinical personnel, registered nurses (RNs), and registered dietitians, who are focused on enhanced awareness and behavior modification through member health education. WellPoint has established health improvement programs led by health coaches that include RNs, dietitians, social workers, exercise physiologists and other health professionals. Premera has formed a Comprehensive Obesity Strategy Team to define, develop and implement a weight management strategy for members and employers. The team designed a five-tier program to balance coverage with choice. In many of the ways mentioned above, other plans, including Horizon, Aetna and Affinity are moving toward a new model of care that helps individuals better manage their own health.

- Fourth, the **evidence of effectiveness** of specific weight reduction and management initiatives must be demonstrated to motivate health plans and other stakeholders to address this issue broadly, especially in view of the private, employer-based health care system and the mobility of the American worker. Through research and evaluation of program effectiveness, government and health plans can support evidence-based initiatives that improve member and community health, are cost-effective, and ultimately generate a return on investment.

Many of the plans profiled in this report are adding to the evidence base on effective interventions. For example, Highmark is currently conducting an independent evaluation of a nationally recognized pediatric weight management program, KidShape®. Blue Cross and Blue Shield of North Carolina is evaluating the success of its Healthy Lifestyle ChoicesSM program. Empire Blue Cross

Blue Shield is evaluating its pilot program, The Healthy Weigh to Change, which is based on the BCBS Walking WorksSM program. HealthPartners also has evaluations underway in the areas of adolescent obesity and weight maintenance for adults.

- Fifth, there are **specific actions that can be taken immediately** to address obesity. The adoption of BMI as a vital sign, more and better education of providers on obesity treatment and prevention options, and tightened criteria for bariatric surgery and weight loss drugs are some first steps that the health community could take toward effective care.

WellPoint has collaborated with a number of partners to develop a web-based continuing medical education (CME) program to provide health care practitioners with the knowledge, attitudes and skills necessary to help them detect, assess and manage overweight and obese children and adolescents. Blue Cross and Blue Shield of North Carolina is also implementing programs to help pediatric providers better recognize, counsel and treat patients who are overweight or at-risk. Kaiser Permanente has begun to implement an aggressive effort to collect BMI as a vital sign.

Plan Profiles: Summary of Interventions

The health plans profiled in this report have developed a variety of obesity prevention and reduction initiatives that are consistent with the themes expressed by our guest essayists. These plans grasp the enormity of the obesity problem and the need to act before “gold standard” evidence emerges on the most effective treatments for various groups. Their initiatives span an array of interventions and partnerships that can serve as models for other health plans looking to combat obesity in their communities.

Approach

The NIHCM Foundation selected health plans to be featured in this report that are leaders in the fight against obesity. We identified plans that are broadly representative – in size, geography and populations served – of the industry. We conducted an “environmental scan” that included reviews of the literature and the popular press, discussions with industry and obesity experts, and “word of mouth” referrals. Information for the plan profiles was

gathered through a series of interviews with plan representatives, as well as a review of documentation related to the plans’ obesity efforts.

Some of the plans profiled in this report were chosen because they are applying and testing the latest evidence-based approaches to obesity and weight management for adults, children, and adolescents. Other plans were chosen because they are leaders in their communities in raising awareness about the issue of obesity through educational programs, grants, and participation in the public policy process. By highlighting health plans with innovative obesity programs, these new approaches and successful interventions can be shared and modeled among other health plans eager to address obesity in their communities.

Organizing Framework

For simplicity, we have organized health plan interventions into three categories: childhood obesity programs, programs for adult members, and community-based initiatives. Interventions are broadly classified and summarized in Figure 3 on pages 8 and 9. It should be noted, however, that many of the plans featured in this report have programs in place that fall into two or even all three of these categories. We present individual plan profiles in this report in alphabetical order, with childhood, adult, and community-based efforts highlighted in each profile.

Programs for Children

Many feel that preventing and reducing childhood obesity is the greatest national public health challenge as well as the greatest opportunity for health plans, providers, and society at large. Nearly a third of American children are overweight or obese, and the long-term consequences for the public’s health, health care costs, and demand on the health care system are significant. Overweight children are at substantially greater risk for developing serious conditions, including diabetes, heart disease, and certain types of cancer. As Dr. Kenneth Melani, President and CEO of Highmark, Inc., notes in his essay, “In addition to the price these children eventually will pay in terms of their health, there also will be a substantial financial price to be paid – a price the nation simply may not be able to afford.”

There are various complicating factors that make treatment and prevention of childhood obesity even more difficult

than in adults. Pediatric providers are beginning to see obesity-related conditions that had until recently been seen only by adult medicine providers. In addition, the teasing and bullying so common among children can be particularly devastating for a child who is battling a weight problem.

Because the behaviors of children, including those related to diet and physical activity, are heavily influenced by their parents and other family members, the country has a tremendous opportunity to head off the debilitating consequences of obesity through education, awareness and prevention efforts aimed at children and their families.

Physician Tools and Resources

Dr. Robert Kushner of Northwestern Memorial Hospital's Wellness Institute writes in his essay that physicians are "woefully unprepared" to treat or prevent the underlying causes of obesity. Instead, he argues, physicians are trained to treat the consequences of obesity, such as diabetes and high blood pressure. This is particularly true of pediatric primary care providers, according to a recent survey published in the journal *Pediatrics*.¹⁰ Several of the plans we profile have established programs to address this problem. For example, WellPoint is developing a web-based CME program to help providers recognize, prevent, and treat childhood obesity. Horizon has developed and distributed a web-based pediatric assessment tool to measure overweight and obesity risk in children. The assessment tool is available to all physicians both inside and outside of Horizon's network.

Weight Loss Programs

Several plans profiled herein have developed weight loss programs specifically designed for children. For example, Affinity, a Bronx-based health plan that primarily serves the Medicaid and SCHIP populations, implemented a pediatric obesity pilot program in 2004. The program employs a multi-disciplinary approach with a special emphasis on family involvement and focuses on changing unhealthy family behaviors. In addition, Highmark is evaluating a nationally recognized pediatric weight management program at multiple sites in Pennsylvania. During the pilot, the program will be available to both Highmark members and non-members who meet qualifying criteria.

Programs for Adults

Traditionally, insurers have limited obesity-related benefits to surgical treatments for the morbidly obese and treatment of chronic diseases that result from or are exacerbated by obesity. Treatment of obesity in the absence of co-morbid conditions was generally not reimbursed by insurers and, as a result, was rarely even coded by providers. However, today, this situation is beginning to change. As an example, Blue Cross Blue Shield of North Carolina recently announced that it would cover up to four office visits for the evaluation and treatment of obesity.

Increasingly, health plans are developing and implementing innovative, evidence-based strategies to prevent and treat obesity. Some of these programs are relatively new, while others have been in place for several years and are generating data that can be used to evaluate relative program effectiveness.

The adult-focused interventions featured in this report fall into three broad categories: access to weight loss tools and resources, weight loss programs, and weight loss drugs and bariatric surgery. We also describe common problems the plans encountered when implementing their programs.

Weight Loss Tools and Resources

Many of the plans profiled in this report provide members (and sometimes the community at-large) with an array of educational resources, including web-based and printed materials, to help them make healthy choices and encourage simple behavioral changes that can improve their overall health. For example, WellPoint has developed several print and web-based resources to help families achieve a healthier lifestyle. These resources are available in multiple languages, and some are specifically written for a low-literacy audience. Some plans, such as Aetna and HealthPartners, also provide members with weight management tools, including BMI wheels, pedometers, and daily food and activity logs. While these resources are but a part of a larger obesity strategy, they are an important component, as families depend on their health plan as a source for reliable information about improving their health.

Weight Loss Programs

One of the adjustments plans are making in addressing the obesity epidemic is recognizing that solely clinical interventions are limited, largely, to the morbidly obese.

Dr. William Dietz of the Centers for Disease Control and Prevention (CDC) notes in his essay that a new model of obesity care “must move towards helping overweight and obese patients develop the skills for self-management of their condition.” He adds that care, while overseen by physicians, will likely be delivered by nutritionists, nurse practitioners, social workers and others trained in behavior modification techniques.

Many of the plans profiled have adopted this approach by establishing multi-session weight loss programs led by multi-disciplinary teams. The format (individual, group, or a combination of both), means (in-person or telephone based), eligibility criteria (open or limited) and curricula vary, but all emphasize behavior modification and healthy lifestyles. For example, Premera Blue Cross developed a comprehensive weight management program for its Microsoft employer group and will begin offering similar programs as an option for others in 2005. Employees who qualify for the Microsoft program can enroll in approved medically-supervised weight management programs that provide a minimum of ten sessions with a physician, a personal fitness trainer, a dietician and a behavioral health therapist.

Weight Loss Drugs and Bariatric Surgery

Two of the most controversial strategies to reduce overweight and obesity are coverage of weight loss drugs and bariatric surgery. While the debate over the efficacy and safety of weight loss drugs continues, the medical community is considering a new role for these medications. While not the magic bullet some had hoped for, there is growing evidence that weight loss drugs can play an effective supporting role in the treatment of some obese individuals. At present, the evidence on these drugs is far from overwhelming, and variability among health plan coverage policies reflects this lack of consensus. With an average price tag of \$35,000 and somewhat mixed evidence on safety and long-term benefits, coverage of weight loss surgery is a difficult decision for many health plans. While several large plans have recently dropped coverage for weight loss surgery due to high costs and conflicting evidence on safety and efficacy, most of the plans profiled in this report do cover weight loss surgery or at least offer it as a purchasable rider. Among the plans profiled that do offer coverage, all condition eligibility for the surgery on specific criteria (typically the NIH-recommended criteria of a BMI >40, or a BMI >35 with one or more co-morbid conditions). In addition, many plans require extensive pre- and post-surgical counseling as well as participation in ongoing weight management programs. In an effort to improve

quality and outcomes, several plans, including WellPoint and Horizon, have identified Centers of Excellence for their bariatric surgery candidates.

Common Barriers

Several health plans noted that attrition from weight loss programs is a common problem. Some are addressing attrition by offering incentives, such as pedometers and discounted health club memberships, at various intervals throughout the weight loss program. Others are considering offering financial incentives for members who successfully complete weight loss programs. Empire Blue Cross Blue Shield decided to take its weight loss program to the employer's worksite to make it easier for members to participate. Data—or rather the lack thereof—was also cited as a barrier by several plans. Providers have not yet widely adopted BMI as a vital sign, and the health care community is only slowly implementing an electronic health record (EHR), both of which are hampering efforts aimed at prevention and care coordination. Some plans, such as Kaiser Permanente, have launched aggressive efforts to implement EHRs and collect BMI for all members.

Community-Based Programs

A common theme expressed by several guest essayists in this report is the importance of private-public collaboration in the battle to combat the obesity epidemic. This strategy dovetails with the generally accepted view that a multi-faceted approach to intervention will have greater benefit than pursuing a single strategy. In our review of health plan activities, we found that in addition to implementing a range of interventions for their members, health plans have begun to partner with stakeholders in local communities to combine their resource base and broaden the impact of either party individually.

Grants and Community-based Partnerships

Many of the plans profiled in this report have active grant-making programs aimed at supporting healthier schools and communities. Some grant programs help fill funding voids resulting from cuts to schools' and parks' budgets. Other plans have established ongoing relationships with community-based organizations around shared goals. For example, Horizon Blue Cross and Blue Shield of New Jersey has implemented several programs in conjunction with Boys and Girls Clubs and other community-based organizations to improve health literacy among

Figure 3. Matrix of Health Plan Initiatives

	Programs for Children	Programs for Adults				Community-Based Programs
Plan	Childhood Obesity Programs	Weight Loss Tools and Resources (e.g., web-based information, discounted health club memberships, etc.)	Weight Loss/Management Programs	Coverage of Approved Weight Loss Drugs	Coverage of Bariatric Surgery/Centers of Excellence (COEs)	Sponsorship of Community-Based Weight Management/Obesity Programs
Aetna		Available to all members at no additional cost	Pilot program for specific groups launched 10/04 Telephone counseling available to pilot program participants	Not covered if sole purpose is weight loss; purchasable as rider	Offered as rider except where mandated. COEs being identified in areas where bariatric surgery is mandated	
Affinity	Pilot pediatric obesity program			Covered, with prior approval, for non-Medicaid membership Drugs are carved out of Medicaid managed care	Covered for members meeting criteria	Under development for 2005
BCBS Massachusetts	Community-based programs that target children Middle School-based obesity prevention program	Available to all members at no additional cost	Web Based program Registered dieticians available to members who meet criteria Disease management program under development for 2005 Pilot telephonic walking program \$150 benefits for health club or Weight Watchers™	Covered benefit to members who meet specific criteria	Covered for members meeting criteria. COEs are currently being considered	Several grant programs for senior fitness programs and youth-serving organizations Statewide distribution of a pediatrician tool kit
BCBS North Carolina	Community-based programs that target children	Available to all members at no additional cost	Available to members meeting criteria	Covered with prior authorization	Covered with prior authorization COEs have been designated	Several active partnerships with community based nutrition, fitness, and wellness programs
Empire BCBS	In development for 2005	Available to all members at no additional cost	Online 4-week program for members Pre-recorded telephone educational modules available Worksite pilot program in progress	Covered with prior authorization	Covered with prior authorization	
HealthPartners	Community-based programs that target children	Available to all members at no additional cost	Phone-based weight management/disease management program for members meeting criteria; web-based program available to all members	Covered for members meeting criteria with prior authorization	Covered for members meeting criteria COEs have been designated	Partnership with Be Active Minnesota
Highmark	Grants for youth nutrition/physical education programs Community-based programs that target children	Available to all members at no additional cost	Personalized web-based program offered to all members at no cost Eat Well for Life weight management/nutrition program Blues on Call telephone health coaching program	Covered for underlying conditions related to obesity	Covered for members meeting criteria	Implementing a nationally recognized pediatric weight management program in several communities

Plan	Programs for Children	Programs for Adults				Community-Based Programs
	Childhood Obesity Programs	Weight Loss Tools and Resources (e.g., web-based information, discounted health club memberships, etc.)	Weight Loss/ Management Programs	Coverage of Approved Weight Loss Drugs	Coverage of Bariatric Surgery/Centers of Excellence (COEs)	Sponsorship of Community-Based Weight Management/ Obesity Programs
Highmark	Grants for youth nutrition/physical education programs Community-based programs that target children	Available to all members at no additional cost	Personalized web-based program offered to all members at no cost Eat Well for Life weight management/nutrition program Blues on Call telephone health coaching program.	Covered for underlying conditions related to obesity	Covered for members meeting criteria	Implementing a nationally recognized pediatric weight management program in several communities
Horizon	Community-based programs that target children	Available to all members at no additional cost Discounts for commercial weight loss programs and health clubs under consideration	Health and Wellness Education pilot for fully insured HMO members Weigh to Live pilot program Pilot telephone counseling program in place for fully insured HMO members	Covered when prescribed by a physician	Covered for members meeting criteria COEs have been designated	Developed and sponsor numerous community-based programs, including educational programs and health literacy-focused tutoring programs
Kaiser	Child/Adolescent weight management programs available in most KP regions	Available to all members at no additional cost	Available in all regions; programs vary by region	Coverage varies by region	Covered for members meeting criteria. KP's goal is to be a center of excellence; currently reviewing KP programs against criteria	Varies by region, but includes efforts to work with community clinics and other safety net providers on obesity and other health issues
Premera		Available to all members at no additional cost	Individualized, group-based and obesity disease management programs available as purchasable options Telephone counseling provided through Disease Management and Health Risk Management programs	Not covered	Offered as rider Requires prior authorization	
WellPoint	CME program on childhood obesity Educational tools for families and providers	Available to all members at no additional cost	Weight management integrated into several disease management programs	Coverage varies by market	Coverage varies by market COEs designated in California and are being evaluated in Georgia and Wisconsin	

children and teens, with a particular emphasis on weight management. Blue Cross and Blue Shield of Massachusetts and Highmark have established grant programs to help community-based organizations and middle schools establish fitness and nutrition programs.

Influencing Public Policy

In a recent editorial in *The American Journal of Managed Care*, Yale University's Kelly Brownell writes, "Changing the environment through public policy may be the most effective means of preventing obesity, and such changes could benefit the healthcare system in general and managed care organizations in particular."¹¹ Several of the plans profiled in this report are actively engaged at the federal and state levels in shaping public policy approaches to overweight and obesity. These efforts aim to bring together representatives of health care plans, providers, employers, researchers, the food industry, and policymakers to identify short- and long-term policy actions that modify social and organizational structures that contribute to the obesity epidemic.

At the state level, Horizon Blue Cross Blue Shield sponsors an annual Health Policy Forum each October, which convenes New Jersey policymakers, clinical experts, and health leaders to discuss obesity and health literacy, among other important issues. At the 2004 forum, Horizon launched the New Jersey Health Policy Consortium, which will bring together diverse expertise and is designed to influence the health policy agenda in the state. At the federal level, Kaiser Permanente's Care Management Institute sponsored a major national roundtable discussion in 2003 titled "Prevention and Treatment of Overweight and Obesity: Toward a Roadmap for Advocacy and Action," which gathered together researchers, health plans, and community organizations to discuss public policy interventions. The results were widely disseminated.

Conclusions

Dr. Peter Briss, Chief of the Community Guide Branch at CDC, has suggested several actions that health insurers could take to help prevent and treat obesity in the U.S.¹² According to Dr. Briss, health insurers can be providers of information, creating awareness of the problem in the population and encouraging evidence-based practices in health care systems. Health insurers can also encourage referrals to community-based weight management programs. Health plan partnerships with employers and

other purchasers of health insurance can support healthy worksites and inclusion of obesity prevention and weight management programs in benefits packages. Health plans can work with their own employees to promote physical activity, healthy nutrition, and healthy work environments. Finally, health plans can act as good corporate citizens, partnering with and advocating for effective community approaches, developing evidence-based recommendations, and identifying research gaps.

In our profiles of selected health plans for this report, we found that, as a group, plans are doing the above and more. As the evidence for "what works" continues to grow, many health plans have implemented or are in the process of implementing innovative programs to address overweight and obesity. Plans are employing evidence-based strategies that emphasize long-term behavior modification and strict criteria for weight loss surgical procedures to improve efficacy and patient safety. They are developing and strengthening partnerships to help build healthier communities. Many plans are also evaluating their obesity and weight management programs in an effort to continue to expand the evidence base.

The plans featured in this report were chosen because they are implementing innovative, forward-thinking strategies in the fight against obesity and have emerged as partners in translating theory and concept into practical options to address this epidemic. Significant work remains, however, if we are to get the obesity epidemic under control. In the short term, there are specific measures – including the use of BMI as a vital sign – that can be implemented across the health care system to better identify and monitor obesity. In the longer term, the obesity epidemic requires a new model of care and significant cultural change to address its non-medical causes and management. Obesity is a complex problem that requires an equally complex solution. Experts agree that only through a broad public-health based approach that leverages public and private resources and expertise can we begin to make progress against this epidemic.

PLAN PROFILES



Aetna

As a national insurer with a number of Fortune 500 accounts, Aetna is eager to work collaboratively with employers to address the growing problem of overweight and obesity. Aetna is a founding member of the National Business Group on Health's Institute on the Costs and Health Effects of Obesity (www.wgbh.com/healthy/about.cfm), which is examining employer focused solutions to obesity and overweight. On June 3, 2004, Aetna announced it was launching a pilot weight management program, *Healthy Body, Healthy WeightSM*, that it hopes will inform the development of programs for broader rollout in 2005 and beyond. The announcement was made at the 2004 Time/ABC News Summit on Obesity.

Obesity and Weight Management Pilot Program

Aetna's pilot program was designed to meet the needs of the morbidly obese, as well as those who are moderately overweight, and everyone in between. The focus of the program is the development of healthy lifestyles; early intervention is seen as critical to change behaviors prior to the onset of costly co-morbid conditions.

Participating members receive follow-up calls at regular intervals that vary based on risk level. The purpose of the follow-up calls is to assess progress and medication adherence, help the members stick to their weight loss programs, and make any modifications needed.

All members are asked to complete a general health risk assessment via the web or on paper, which evaluates eligibility for a number of Aetna programs and also assesses the member's receptiveness to outreach activities, including mailings and phone calls. Members who qualify for the weight management program must opt to participate and may opt out at any time. Aetna has decided not to use claims analysis to identify potentially eligible members at this time due to inconsistencies in coding that make it difficult to identify obese members who do not have one or more co-morbid conditions. The pilot program is open to adults only at this stage. As with other health issues, ethnic disparities and cultural differences are important concerns that require tailored and flexible approaches, and Aetna has taken that into consideration in designing

the pilot program, which includes materials that are culturally and ethnically appropriate.

Based on the results of the health risk assessment, members determined to be eligible for the program are assigned to one of three groups:

- Low risk: BMI of 25 to 29.9 with no co-morbid conditions
- Intermediate risk: BMI of 30 to 34.9 with co-morbid conditions but no hospitalizations
- High risk: BMI of 35 or greater with co-morbid conditions and hospitalizations

All participants, regardless of risk group, receive an initial phone call from a nurse and a dietician to set up a weight loss program and coordinate the member's participation in any other Aetna programs, such as disease management programs for diabetes or coronary artery disease. Participating members receive follow-up calls at regular intervals that vary based on risk level. The purpose of the follow-up calls is to assess progress and medication adherence, help the member stick to their weight loss program, and make any modifications needed. Members in the high-risk group are also contacted by a weight loss therapist to assist them with behavior modification related to their weight loss program.

At various points during the program, participating members receive motivational tools and non-financial incentives to encourage them to continue their efforts. The incentives are strategically implemented at three, six and nine months to encourage success and reduce attrition. Examples of incentives include pedometers and coupons for community-based weight management programs. The use of financial incentives is under consideration.

Aetna sees several benefits to its weight management program, beyond helping members achieve and maintain a healthy weight. Additional benefits include:

- Members who lose weight should be able to discontinue medications used to treat co-morbid conditions;
- Counseling patients on appropriate medications per disease state should improve medication effectiveness and adherence to regimen;
- Decreased existence of co-morbid conditions;

- Decreased utilization of medical services; and
- Decreased rate of progression to bariatric surgery.

Coordination with Physicians

An important component of the Aetna pilot program is outreach and coordination with network physicians. Aetna recently sent primary care physicians (PCPs) in its network educational materials and tools (e.g., BMI charts) designed to help them reinforce messages in the clinical setting that their patients are receiving in the pilot. In addition, PCPs for all participating members are notified which of their patients are participating in the pilot program. For patients in the high-risk group, PCPs are also contacted directly by Aetna to review the patient's medical history, medications and assessed status, as well as guidelines for treating co-morbid conditions and medical follow-up.

Bariatric Surgery and Weight Loss Medications

Bariatric surgery is typically not covered unless purchased as a separate rider or required by law. In states where bariatric surgery is required, Aetna is working to establish Centers of Excellence. Drugs used for the sole purpose of weight loss are generally not a covered benefit under most Aetna policies unless purchased as a rider. If they are covered, members must meet specific criteria to demonstrate medical necessity.

Pilot Feedback May Drive Further Program Refinement

At the conclusion of the pilot program, Aetna will evaluate the program's impact by looking at "before and after" measurements of BMI, weight, and blood lipid and glucose levels. The results of the evaluation will inform future changes and additions to the program as Aetna prepares for a broader rollout next year.

Affinity Health Plan

Of all the statistics about the obesity epidemic in this country, perhaps the most alarming are those concerning rates of overweight and obesity among children. A recent study by the New York City Department of Health and Mental Hygiene, for example, found that almost 50 percent of New York City children were overweight or obese. Some experts have speculated that unless we reverse current trends, this generation of children will be the first that fails to outlive its parents. Statistics show that childhood obesity is especially prevalent among the poor. As a result, health plans that serve predominantly low-income populations are especially feeling the impact of overweight and obesity.

Childhood Obesity Pilot

Affinity Health Plan—a Bronx-based health plan that serves nearly 200,000 Medicaid and SCHIP members in the five New York City boroughs and surrounding counties—recognized that obesity was becoming a significant issue for its membership, especially among children. As a condition of participation in the Medicaid program, health plans are required to implement ongoing Performance Improvement Projects (PIPs) for their members. Affinity believed that obesity was an ideal candidate for a PIP. The state Medicaid agency agreed, even granting Affinity an extension on its evaluation timeline for the program because it believes the findings are so important for the Medicaid program.

In late 2003, Affinity launched a pediatric weight management pilot program aimed at obese members between the ages of eight and eighteen. Members must be referred by their primary care physician (PCP) but can also request that their PCP evaluate them for the program. Final eligibility determinations are made by Affinity, based on the PCP's examination. Program enrollment is typically limited to children and adolescents who are considered obese. Once identified for the pilot, members must be evaluated by a specialist—usually a pediatric endocrinologist—to identify any important medical issues that would preclude participation or that need to be monitored by the member's PCP during participation in the program. This is a unique and important feature of the Affinity pilot and one that highlights the clinical challenges of treating overweight and obese children and adolescents.

Members who are not disqualified by a medical condition can enroll in an 8-12 week group program at one of five pilot sites based primarily on geographic proximity and space availability.

Content and Structure. The specific content of the programs and the degree of medical versus behavioral orientation vary across sites but are typically centered on one or more of the following categories:

- Goal setting
- Environmental management
- Diet planning
- Fitness activities
- Cognitive training

Sessions are led by health professionals, including primary care physicians, physical therapists, health educators, nutritionists and psychologists. Most of the sites incorporate parent involvement as an important aspect of the program.

Since the pilot began, 72 members have enrolled with a mean BMI of 35. An evaluation of the program is expected to be released in early 2005 and will help guide a broader rollout of the program. The evaluation will compare medical indicators between the baseline and exit assessments and will compare utilization and cost six months prior to and after study participation. The effectiveness of the site-specific teaching models in encouraging and retaining parent involvement will also be a key part of the evaluation.

Challenges and Future Efforts

While proud of their accomplishments thus far, Affinity is also candid about the challenges it has faced in implementing its pilot programs. As anticipated, they have struggled with attendance and attrition among the children and adolescents and their parents. Several sites that were originally part of the pilot were unable to maintain sufficient enrollment with Affinity members alone and had to discontinue their programs. Affinity also encountered several unexpected challenges, including the need to rapidly credential nutritionists for the program to participate in their provider network.

These challenges have sparked an effort to develop several “lessons learned” papers and a complete documentation

of the steps required to start and maintain a program site. It is hoped that these documents, which are currently under development, in conjunction with the forthcoming evaluation report, will help simplify a broader roll-out of the program in the near future as well as help other plans that are interested in implementing similar programs. It is also hoped that other plans will implement similar programs using the existing pilot sites so that the sites can maintain sufficient enrollment to continue operating. To further this goal and to develop ideas for additional clinical and community-based interventions, Affinity hosted a

To develop ideas for additional clinical and community-based interventions, Affinity hosted a roundtable meeting in February 2005 with local researchers, health plans and providers as well as representatives from the pilot sites.



roundtable meeting in February 2005 with local researchers, health plans and providers as well as representatives from the pilot sites.

Bariatric Surgery and Weight Loss Medications

Affinity covers bariatric surgery for adult members who meet medical necessity criteria (based largely on the NIH guidelines). Affinity has also been a leader in the effort by a consortium of New York health plans and providers to

develop a set of “consensus guidelines” to serve as standards for selecting the most appropriate patients, the most experienced surgeons and the best equipped facilities across the state for weight loss surgery. In cases where there are serious co-morbidities involved, Affinity has approved weight loss surgeries for adolescent members.

Weight loss drugs are covered, with prior approval, for Affinity’s non-Medicaid membership. Drugs are “carved out” of New York’s Medicaid managed care program and provided through the traditional fee-for-service Medicaid program.

Medicare and Medicaid – Major Insurers with Major Roles

With 52 million members and \$300 billion in expenditures in 2004, Medicaid is the nation’s largest health care program. Following close behind, Medicare covered 40 million members and had \$290 billion in expenditures in 2004. A recent study by Eric Finkelstein, Ph.D. and colleagues estimated that total annual expenditures attributable to obesity in the United States were approximately \$75 billion in 2003, of which more than half were financed by Medicare (\$17.7 billion) or Medicaid (\$21 billion). As with the private insurers profiled in this report, Medicare and Medicaid are struggling to find solutions to the problems of overweight and obesity that are affecting the lives of millions of their members.

How Medicare and Medicaid Program Policies Have Addressed Obesity

Medicare Coverage

Federal Medicare law dictates that payments are not to be made by Medicare if expenses are not “reasonable and necessary for the diagnosis or treatment of illness...” In July 2004, Secretary of Health and Human Services Tommy Thompson announced a major Medicare policy change, which removed language that had specifically prohibited payment for obesity treatments because obesity was not classified as an illness. Medicare has always paid for treatments (with the exception of drug treatments) if obesity was caused by, aggravated by, or otherwise directly related to another disease. Medicare did not pay for obesity

treatments if there were no other co-morbid conditions, however. This policy change is significant because it opens the door to a review by the Medicare Coverage Advisory Committee of clinical trial data on the effectiveness of various obesity treatments. This policy change is also significant because Medicare coverage decisions often have far-reaching implications for private insurance coverage and reimbursement policies, as well as medical research and teaching priorities.

Medicaid Coverage

Unlike Medicare, which is a federally operated and financed program, Medicaid is a joint federal-state program. Within broad federal guidelines, states have flexibility in determining the type, amount, duration and scope of services. Federal law also provides that a state may exclude and restrict coverage of prescriptions if they are not for medically accepted indications. As a result, many states have long covered anti-obesity pharmaceutical products despite the fact that consensus has only recently emerged that obesity is an illness. While states typically apply criteria similar to the Medicare “reasonable and necessary” language, each state has a different coverage policy with respect to what is covered, for what purposes, and whether prior authorization is required.

Many states have implemented disease management programs to help coordinate care for their beneficiaries with chronic conditions such as asthma, diabetes, and congestive heart failure. As with the private health plans profiled in this report, state Medicaid programs will likely start to more closely coordinate weight management

programs with existing disease management programs, and some will establish freestanding obesity disease management programs.

Implications for Medicare and Medicaid Health Plans

Many Medicare and Medicaid beneficiaries receive their benefits through managed care plans under the Medicare Advantage program and through health plans that contract with state Medicaid agencies.

Medicare and Medicaid programs typically permit managed care organizations to use any savings generated to provide additional services — beyond those required by law — as a means of attracting members to their plan. Many Medicare and Medicaid managed care plans also offer care coordination activities that are not part of the traditional program. It remains to be seen how Medicare and Medicaid health plans will respond to the growing problem of obesity, but plans are starting to look at what combination of benefits and care coordination are most effective for their overweight and obese members. For example, the Affinity and WellPoint profiles in this report provide two good examples of how health plans are addressing obesity among their pediatric Medicaid members.

Sources:
Finkelstein et al. “State-Level Estimates of Annual Medical Expenditures Attributable to Obesity”, Obesity Research, January 2004. Other studies have estimated total annual obesity costs of up to \$117 billion in 2000. See, Wolf AM, Colditz GA. “Current estimates of the economic cost of obesity in the United States.” Obesity Research. 1998 Mar;6(2):97-106.

Blue Cross Blue Shield of Massachusetts

Blue Cross and Blue Shield of Massachusetts (BCBSMA) has developed and implemented an array of products and community-based initiatives that address the weight management, nutrition and physical activity needs of Massachusetts residents. Both members and non-members of the health plan benefit from BCBSMA's support of evidence-based programs that prevent eating disorders and promote healthy nutrition and activity as opposed to dieting.

Community-Based Wellness Initiatives

In response to data indicating that children's participation in physical activity was in significant decline and childhood obesity was on the rise, BCBSMA initiated a youth wellness program called *Jump Up and Go!* (www.jumpupandgo.com) in 1998. *Jump Up and Go!* was developed to help children and families throughout Massachusetts become more physically active and adopt more nutritious eating habits. Today, *Jump Up and Go!* is comprised of four primary initiatives:

- A community initiative,
- A school initiative,
- A clinical initiative, and
- A public awareness campaign.

Jump Up and Go! Community Initiative

Through grantmaking, BCBSMA aims to increase the capacity for community-based organizations, such as YMCAs, the Girl Scouts, and Boys' and Girls' Clubs, to provide youth physical activity programs.

Jump Up and Go! School Initiative

Through the awarding of grants each year, BCBSMA funds the implementation of *Healthy Choices*, a school-based fitness and nutrition program, in public middle schools throughout Massachusetts.

Administered by the Massachusetts Department of Public Health, individual *Healthy Choices* grants total \$9,000 over the course of a three-year-period. The grant-recipient schools are selected through a review process that requires the selected schools to implement the Planet Health curriculum, an interdisciplinary curriculum for

teaching middle school students about nutrition and physical activity, which was designed by researchers at Harvard University's Prevention Research Center on Nutrition and Physical Activity.

Jump Up and Go! Clinical Initiative

The clinical initiative includes three components:

■ Clinicians' Toolkit

In 2003, BCBSMA introduced a toolkit comprised of educational materials to assist pediatric clinicians in addressing childhood obesity with their patients. BCBSMA, in coordination with the Massachusetts Department of Public Health, made the *Jump Up and Go! Clinicians' Toolkit* available free-of-charge to all family and pediatric providers throughout Massachusetts. The toolkit includes nutrition and physical activity fact sheets, physical activity and nutrition surveys, prescription for better health forms, body mass index (BMI) growth charts for patients aged 2-20, BMI calculation wheels, 5-2-1 *Jump Up and Go!* weekly logs, and other educational tools and charts to assist doctors in incorporating BMI measurements into their regular check-up routines.

One-third of Massachusetts' public middle schools received *Healthy Choices* grants from BCBSMA for the 2004-05 academic year.

■ WebMD CME course

BCBSMA, in partnership with WebMD/Medscape and the Centers for Disease Control and Prevention, has developed online continuing medical education (CME) courses that physicians nationwide can enroll in free of charge (www.medscape.com/viewprogram/3221). The courses are designed to further educate physicians about the clinical tools and methods available for treating obesity and communicating with at-risk patients.

■ Outpatient Treatment Research

Recognizing the unique role that community health centers and hospitals play in urban areas where many youth are at high-risk for obesity and obesity-related diseases, BCBSMA initiated a research study in 2004

of best practices among existing community health center and hospital programs that treat overweight youth. The study's findings will be used to develop a treatment protocol for health center and hospital-based overweight intervention programs.

Jump Up and Go! Public Awareness Campaign

BCBSMA hosts a multitude of community events and sponsors television campaigns to continually support the program's messages. In addition, BCBSMA has committed to establish a permanent *Jump Up and Go!* exhibit at the Children's Museum of Boston. BCBSMA is also currently developing toolkits for parents and teachers and is creating a series of educator training sessions targeted specifically to elementary school teachers.

Other Community-Based Interventions

BCBSMA has additional community-based programs in place for adults throughout Massachusetts:

- **GoWalking! 5K Walk and Health Fair.** This annual family-oriented community 5K walk and health fair provides the Boston community with an opportunity to learn more about the healthy benefits that come from starting and maintaining a regular walking program.
- **GoWalking! Web-Based Program.** This web-based program, recently created by BCBSMA, contains educational information, a list of walking resources and mapped-out walking routes in Massachusetts, and it provides details on upcoming walking events. Through this website, participants have the ability to customize a walking program, receive motivational e-mails, and use interactive tools to track distance walked, calculate

In 2005, BCBSMA will award grants for the development and implementation of health center-based treatment programs that incorporate the best practices protocol identified in the 2004 study.

calories burned, set monthly goals, document comments, and view progress reports.

- **“Keep Moving” Program.** BCBSMA provides financial support and guidance as a board member for this statewide senior walking program. Keep Moving (www.mass.gov/dph/tch/elderhealth) is a network of community-based walking groups that meet several times a week.
- **MA Senior Games.** BCBSMA is a lead financial sponsor and board member of this annual statewide athletic competition, as well as the host of a health fair at the event.

Weight Management Benefits for BCBSMA Members

BCBSMA members have access to a range of programs and services to encourage and assist them in their efforts to make healthy lifestyle changes, including:

- A fitness benefit of \$150 annually towards membership dues or exercise class fees at any qualified health club;
- Discounts of up to 30 percent off standard retail rates for personal visits to network registered dietitians;
- A \$150 annual benefit towards Weight Watchers® or a hospital-based weight management program, and free registration for all Weight Watchers® programs;
- *A Medical Nutrition Therapy Benefit*, which encourages members with medical conditions warranting weight loss interventions to seek a referral from their primary care provider for covered visits to BCBSMA's network of registered dietitians;
- Access to www.Ahealthyme.com, a website launched in 1999, which features hundreds of articles, resources, and interactive tools on fitness and nutrition;
- MyBlueHealth, an online resource launched in February 2004 to provide members with easy access to wellness tools such as a personal health assessment, a fitness behavior change program module, a nutrition behavior

change program module, and “trackers” for monitoring biometrics;

- A new telephonic walking advisory program for members who are enrolled within specific provider groups; and
- Worksite wellness implementation kits for physical activity and weight management, which are provided to all BCBSMA accounts. In addition, BCBSMA has been offering one-hour educational seminars for employee populations to all accounts since 1997.

Bariatric Surgery and Weight Loss Medications

Gastric stapling, bypass and banding are covered at BCBSMA-approved facilities for adult members who meet the following criteria:

- A BMI greater than 40, or greater than 35 with one or more co-morbid conditions;
- Failed attempts at weight loss in the past;
- At least five years of obesity; and
- Obesity is not due to an untreated metabolic cause.

The weight loss drug Orlistat (Xenical) is available to members with BMI greater than 30, or a BMI greater than 27 if also diagnosed with hypertension, diabetes or hyperlipidemia.

Blue Cross and Blue Shield of North Carolina

Blue Cross and Blue Shield of North Carolina (BCBSNC) is addressing weight management issues for plan members, as well as for residents of North Carolina, through a new nationally recognized weight management program and through the activities of its Community Relations department. BCBSNC continues to provide and promote tools to encourage healthy lifestyles for BCBSNC members, in addition to at-risk populations throughout North Carolina.

BCBSNC recently analyzed member data and data from the U.S. Department of Health and Human Services that indicated nearly 60 percent of all North Carolina residents and 55 percent of adult BCBSNC plan members are either overweight or obese. BCBSNC conducted additional analyses of the BCBSNC membership using claims data, which revealed that overall medical and pharmacy claims for obese members were costing 32 percent more than members within normal weight guidelines, and overweight members cost 18 percent more. Overweight and obese

BCBSNC found that ER visits for obese members were 240 percent higher than for members of a normal weight. Outpatient utilization for obese members was 40 percent higher and they had 25 percent more office visits.

members were found to account for \$83 million in excess medical and pharmacy claims costs to BCBSNC in 2003.¹³

In response to these findings, BCBSNC launched several initiatives to encourage healthier lifestyles, while simultaneously reducing excess medical and pharmaceutical costs exacerbated by unhealthy lifestyles. These initiatives include:

- A new weight management program available to plan members, which includes coverage for up to four physician office visits per year for the evaluation and treatment of obesity;
- Additional value-added weight management initiatives for plan members; and
- Community-based initiatives that target all residents of North Carolina.

BCBSNC Weight Management Initiatives for Members

The Healthy Lifestyle ChoicesSM program (www.bcbsnc.com/members/hmp/healthylifestyle.cfm) is the most recent BCBSNC initiative to address obesity within the BCBSNC plan. The program, launched in August 2004, has a member and provider component.

Member Component

Member participation in the Healthy Lifestyle ChoicesSM program is voluntary. Currently, BCBSNC promotes this program to members who are identified through claims data as having conditions that are related to being overweight (i.e., hypertension, metabolic disorders, etc.). General plan promotion of the program is planned to occur in the future, at which time physician and member self-referrals into the program will be made available to all plan members.



Once enrolled into the program, members are risk-stratified based on clinical factors in addition to readiness to change. Standard program components, offered to members in all risk levels, include educational self-help materials and access to a unique web-based interactive program that offers customized feedback to members. Supplementary nutrition counseling and access to FDA approved weight loss medications will also be made available to members after October 1, 2005, as determined appropriate based on individual risk levels. Bariatric surgery options are currently available through BCBSNC with appropriate prior-authorization.

Provider Component

The provider component of the Healthy Lifestyle ChoicesSM program includes an obesity prevention “toolbox”. This “toolbox” is one mechanism used to encourage providers to integrate the body mass index (BMI) and waist circumference as a vital sign. The “toolbox” contains guidelines on obesity assessment and treatment options, chart stickers to assist the provider in tracking progress, waist circumference measurement tools and patient education tear sheets. The “toolbox” available at this time is for adult members; however, a pediatric “toolbox” will also be available in early 2005. Participation in the Healthy Lifestyle ChoicesSM program is strictly voluntary for providers, and as of April 1, 2005, will allow for coverage of four office visits for assessment and treatment of obesity per benefit period. Providers who may participate include both primary care providers and specialty care providers.

All physicians in the BCBSNC physician advisory committee have expressed an interest in the provider component and have assisted in the development of the “toolbox”.

An additional and important component of the Healthy Lifestyle ChoicesSM program is the development and identification of Centers of Excellence for obesity surgical procedures. Although members who receive prior-authorization for bariatric surgery may choose any provider to perform the procedure, those facilities that are established as Centers of Excellence are strongly encouraged. The Centers of Excellence are objectively established by BCBSNC based on the volume of

bariatric surgeries performed in addition to quality, based on analysis of data and associated outcomes. As of August 2004, identified Centers of Excellence are listed in the BCBSNC provider directory.

Program Outcomes

The primary goals of the Healthy Lifestyle ChoicesSM program are to reduce the incidence of diabetes, cardiac disease and obesity prevalence; to enhance the management of members with lifestyle-related illness; to provide safe and effective treatment models; to increase provider assessment and counseling; and to encourage national leadership and innovation. BCBSNC will evaluate the success of the Healthy Lifestyle ChoicesSM program through ongoing measurement of key outcome and process measures, including the following:

- Utilization and costs
- Incidence of Type II diabetes onset
- Pounds lost
- Waist circumference inches lost
- Member satisfaction with program
- Provider assessment of BMI and counseling
- Utilization of program components
- “Blue ExtrasSM” program utilization

Other Weight Management Initiatives for Members

BCBSNC members diagnosed with diabetes, congestive heart failure, or coronary artery disease are enrolled in disease management programs that are specific to those conditions. These programs include lifestyle and weight management components as appropriate and as related to the underlying diagnosis. At this time, the initiatives within the disease management programs are not directly coordinated with the Healthy Lifestyle ChoicesSM program. However, as the new Healthy Lifestyle ChoicesSM program evolves over time, BCBSNC will determine an appropriate way to incorporate components of the program into the specific disease management programs, to ensure that members enrolled in disease management programs have access to all components of an inclusive weight management program as needed.

In addition to the new Healthy Lifestyle ChoicesSM program and disease management programs, BCBSNC members have access to an array of value-added programs collectively referred to as Blue ExtrasSM. Blue PointsSM is one

such program that encourages BCBSNC members to be physically active. Based on the honor system, members record their physical activity levels and are awarded prizes for being physically active.

The Blue PointsSM program is highly utilized by members, with over 45,000 members taking advantage of it to date. Although the program has not been formally evaluated, feedback has been very positive.

Community-Based Programs/Initiatives

BCBSNC is actively involved in many community-based initiatives that are available to all residents of North Carolina. BCBSNC offers grants and resources for health related initiatives to communities and organizations through both corporate contributions and the BCBSNC Foundation.

BCBSNC has recently partnered with the Food Bank of Eastern and Central North Carolina to expand the Kids Café Program to all 34 eastern counties of North Carolina over a five-year period. This after school program helps children at risk of hunger by providing nutritious meals, nutrition education, tutoring and mentoring, and physical activity.

BCBSNC is also the founding sponsor of **Be Active North Carolina, Inc. (BANC)**, a non-profit organization whose mission is “to increase physical activity and encourage healthy lifestyles among North Carolinians through people, programs and policies.” (www.beactivenc.org) BANC administers physical activity programs targeting different age groups through grants and sponsorships from BCBSNC, the BCBSNC Foundation and many other funders.

Most recently, BCBSNC has developed a partnership with the North Carolina Health and Wellness Trust Fund Commission to create and develop **Fit Together** (www.FitTogetherNC.org). This 3-year prevention initiative, which began April 2004, incorporates:

- Motivational ad campaigns;
- A web-site that promotes initiatives available within individual communities;

- A business outreach component that promotes work-site wellness “best practices”;
- Fit Together initiatives in designated communities to highlight local community efforts to promote physical activity and healthy eating through assessment, collaboration and resources; and
- Grants to community-based obesity prevention initiatives.

The BCBSNC Foundation, whose mission is to provide financial support to improve the health and well-being of North Carolinians, was started in November 2000. The Foundation funds programs that increase access to health care and promote preventive care. One of the foundation’s four focus areas is physical activity. Programs funded by the BCBSNC Foundation include:

- **Be Active Kids:** An interactive nutrition and physical activity initiative for children ages four and five. BCBSNC provided the initial resources to develop this program in 1997 and continued funding until the Foundation began funding the program in 2001. Be Active Kids (www.beactivekids.org) is in all 100 North Carolina counties, has won over 16 national awards and is administered by Be Active North Carolina.
- **Active Blue Van:** A brightly colored van that attends community events across the state to promote physical activity. Those who visit the van may receive literature about physical activity and nutrition, participate in fun activities including hula-hooping and jump roping, and, beginning in January 2005, complete a physical activity assessment.

Empire Blue Cross Blue Shield

Empire Blue Cross Blue Shield has established models of awareness and behavior modification through a department fully dedicated to this effort. Established in 1995, the Health Education Department distinguishes Empire from other health plans in that this department is staffed with clinical personnel, registered nurses (RNs) and registered dietitians (RDs), whose focus is member health education. The department provides education for the development and maintenance of healthful lifestyles with nutrition and weight management, smoking cessation and stress management being the most integral. Interventions originating from the Health Education Department are numerous and include:

- Preventive health reminders by mail and telephone
- Member newsletters
- Worksite wellness programs
- Topic-specific worksite health events

Empire, aware of the many health and quality-of-life consequences of being overweight or obese, established numerous educational tools to address weight management across its membership. The tools are part of Empire's 360° Health program, which was established to integrate resources available to members. The tools include:

- A robust web site, established for membership, with educational content on nutrition, physical activity and healthy living, developed and maintained by the Health Education Department;
- An online four-week weight loss program, featuring live chat sessions with a physician instructor;
- Access to pre-recorded education modules via telephone on such topics as nutrition and physical activity;
- Worksite wellness programs ("lunch and learn" type sessions as well as on-site multi-week sessions);
- Educational mailings to adults and parents;
- A partnership with WebMD, which allows Empire members to access WebMD via the Empire web site and utilize some of their special promotional events on healthy living; and

- A 24 x 7 NurseLine to assist members in accessing appropriate services to address their needs.

However, despite this array of programs, enhanced benefits, and educational components, Empire found that a large portion of its membership was not being reached because of various barriers impeding accessibility. Empire determined that programs offered would need to be convenient for members to join and maintain participation and be personalized to achieve impact. This determination was the driving impetus that led Empire to develop a new and innovative grassroots education program for its customer accounts.

Worksite Intervention Program

The challenge in developing this new program was to maintain participation, achieve long-term changes in daily activity levels, and have participants consistently make correct food choices. With these goals in mind, Empire developed a new worksite wellness program, *The Healthy Weigh to Change*. This program was piloted at one large employer worksite and is being expanded to their other locations beginning in 2005.

The program strategy is to achieve success by encouraging incremental lifestyle changes leading to permanent healthy habits. *The Healthy Weigh to Change* meets one hour a week for eight weeks and is taught by RDs certified in adult weight management training. Although each participant's weight and BMI are checked during the first and last class, the program is open to all individuals regardless of BMI. The focus of each session is to teach participants how to maintain a healthy lifestyle through behavior changes, as opposed to just losing weight quickly. Each session includes a lecture, small group discussions, and question and answer session. The RD reviews the participants' weekly homework assignments and provides incentives that have been aligned to support the class topic, such as water bottles and insulated lunch bags.

Each participant receives a binder with all session content and homework assignments, as well as activity logs, food diaries, a pedometer and sample food menus to assist with meal planning. Empire integrated Blue Cross Blue Shield's Walking WorksSM into *The Healthy Weigh to Change*,

Obesity-Related Prescription Drug Treatments

While much is known about the positive benefits of diet, exercise and lifestyle changes, less is known about the effectiveness, safety and appropriateness of obesity-related prescription drug treatments.

Background, Efficacy and Risks

Traditionally, medication for the treatment of obesity was proposed as a short-term "solution" for patients, who would presumably adopt the lifestyle changes necessary to continue to lose weight and reach and maintain an "ideal body weight." In the 1990s, the public health community began to view obesity as a chronic disease and the long-term use of medications as potential treatment strategies. However, in addition to recurring questions about their effectiveness, safety concerns about anti-obesity drugs surfaced. Today, it is well known that Redux, "Fen Phen", and over the counter drugs containing Ephedra, have serious side effects. Nevertheless, despite these effectiveness and safety concerns, the class of anti-obesity drugs has experienced strong growth in international sales.

Over the course of the forecast period in Figure 4, it is estimated that the total retail and hospital market for obesity will rise by more than \$1 billion to reach \$1.6 billion in 2011, according to a leading market forecaster. This projection is primarily driven by the reimbursement and wider availability of anti-obesity preparations, as there is a growing body of thought that treatment leads to a reduction in co-morbidities.

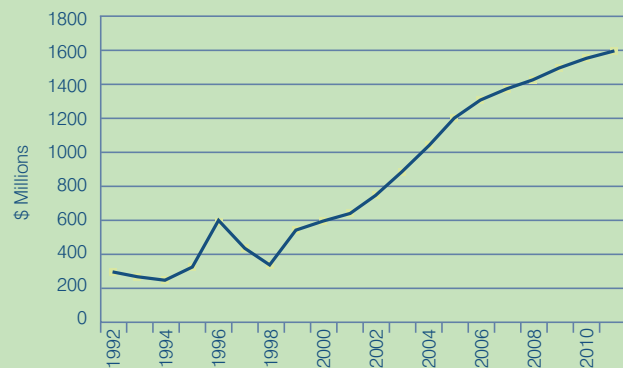
At present, drugs used for the treatment of obesity tend to fall into three categories: stimulants, appetite suppressants and fat-absorption blockers. It is commonly known that many drugs with approved indications for other purposes, such as depression, are prescribed and used "off-label" for obesity treatment.

The role of pharmaceuticals and obesity is becoming clearer as research focuses on the appropriate balance of pharmaceuticals and other treatment options. In focusing on effectiveness, the Agency for Healthcare Research and Quality in a recent Evidence Report stated that the weight loss associated with the most studied drugs has been modest (less than 5 kg at 1 year) and that while this amount may be clinically significant, surgical treatment is more effective than non-surgical treatment for weight loss and the control of some co-morbidities in morbidly obese patients. Therapies that involve more than one treatment option, or combination therapies, are generally considered to be the most likely way to achieve efficacy of greater than 10 per cent weight loss.

Health Plan Coverage

Health plans vary in their coverage policies of prescription drugs. Coverage policies range from not covering weight loss drugs at any level, covering under prior authorization, covering with a related condition, or requiring enrollment in a comprehensive weight-management program prior to coverage. This wide-range of policies reflects the current state of knowledge as reflected in this sidebar discussion.

Figure 4. *Global Sales of Anti-obesity Drugs (1992-2011)



*Global = The combined markets of Canada, France, Germany, Italy, Spain, UK, and USA.
Source: "The ballooning obesity market: tough to burst." IMS Therapy Forecaster, November 2004.

Sources:
"Pharmacological and Surgical Treatment of Obesity" AHRQ No. 103, July 2004.
"Obesity – The Science Behind Pharmacological Intervention." Dr. Brian Huber, April 28, 2004 presentation at North Carolina Biotechnology Center. Summary available at www.ncabr.org.
"Pharmacological and Surgical Treatment of Obesity" AHRQ No. 103, July 2004.

which encourages participants to form walking groups for regular exercise.

100% of the Spanish-speaking participants who started the program completed the program, and the Spanish-speaking participants in the class became the leaders of an on-site daily walking group.

Early in the pilot program, Empire realized that almost 30 percent of participants spoke only Spanish. Identifying this significant participation barrier, Empire added a bilingual instructor to assist the two English-speaking teachers and prepared a Spanish version of all didactic materials as well as supportive logs, diaries and brochures. As a result, 100% of the Spanish-speaking participants who started the program completed the program, and the Spanish-speaking participants in the class became the leaders of an on-site daily walking group.

Measurement and evaluation are a key part of the pilot. The success of the program will be determined by:

- Participation Rate
- Weight Loss
- Health Habits Behavioral Survey (conducted both pre- and post-intervention)

Clinical Interventions

Empire BCBS has additional benefits available to members who are considered morbidly obese. Empire allows four physician office visits annually for treatment of morbid obesity. Physicians are required to measure and track the member's BMI if prescribing any weight loss prescriptions or if bariatric surgery is planned. Individuals classified as morbidly obese who also have associated co-morbid conditions may be eligible for bariatric surgery and/or pharmaceutical interventions. Candidates for bariatric surgery must have a thorough medical and psychiatric evaluation indicating they are physically and mentally prepared for the surgery and must participate in ongoing group support sessions before Empire will consider approving payment for the surgery.

Empire currently has condition management (CM) programs available to members who are diagnosed with con-

ditions such as diabetes or coronary artery disease, and weight management is addressed within these programs as appropriate. CM enrollees are eligible to participate in other educational weight management programs offered by Empire; however, the educational programs are not coordinated with the enrollee's CM program at this time.

Future Initiatives

As Empire continues to delve into the future of obesity and weight management, additional programs and integration of existing programs will be explored and implemented as appropriate. A childhood obesity program is currently in development as the next step. Empire is also actively considering the addition of a telephone-based counseling component to make access to weight management even easier.



HealthPartners' data indicate that participants in the 10,000 Steps® Program who followed the weight loss strategies alone lost an average of seven pounds over an eight-week period; taking 10,000 steps a day is correlated with approximately a five percent weight loss.

HealthPartners

HealthPartners is well known for its research in the areas of the economic impact of obesity and the effective implementation of weight management programs to address obesity. Through the HealthPartners Center for Health Promotion and the HealthPartners Research Foundation, numerous studies have been conducted that strongly support the value of implementing weight management programs. In response to this research, HealthPartners has actively pursued strategic investments in weight management programs and interventions to promote healthy lifestyles among plan members and non-members alike.

The 10,000 Steps® Program

The 10,000 Steps® Program (www.10k-steps.com), a 2004 winner of the Innovation in Prevention Award from the Department of Health and Human Services and the National Institute of Health Foundation, was initially launched in 1999 by HealthPartners. The program has evolved as both a broad prevention program to increase physical activity as a way to improve overall health, and as an intervention to promote weight loss for targeted individuals. The 10,000 Steps® Program includes the following program components:

- A pedometer;
- Daily motivational support; and
- Tools and resources, including online tracking logs to measure progress, nutritious recipes and customer service.

The new Lose Weight component of the 10,000 Steps® Program, added in February 2004, incorporates additional tools for self-management, including an innovative eating plan that assists participants with increasing physical activity to boost metabolism and decreasing calories while staying full. Data indicate that participants who follow the weight loss strategies lose an average of seven pounds over an eight-week period.

The 10,000 Steps® Program is available to members of HealthPartners for a \$20 fee, in addition to nonmembers for a slightly higher fee of \$30. Non-member populations include individuals from the general population who are interested in participating, individuals who are members of other health plans that purchase this program from HealthPartners, or employees of an employer group that purchases the program. Kaiser Permanente has recently partnered with HealthPartners to obtain the

10,000 Steps® Program for its members and employees, available at www.kaiserpermanente.org/10000steps, effective October 1, 2004.

As of May 2004, approximately 67,100 individuals were participating in the 10,000 Steps® Program.

A Call to Change... Healthy Lifestyles, Healthy Weight®

A *Call to Change...Healthy Lifestyles, Healthy Weight®* is a telephone-based weight management program available, for a nominal fee, to adult members of HealthPartners who are enrolled in another HealthPartners disease management program. Individuals may self-refer into the program, be referred by a provider or a disease management program in which the member is enrolled, or via a health risk appraisal completed at their worksite.

Screening process

All potential enrollees in this telephone-based program participate in an initial enrollment call to ensure that the phone program is an appropriate intervention for them. This initial call includes an extensive triage assessment to evaluate the presence of any eating disorders or medical management issues, and to indicate if the potential participant is ready to change. Research conducted by HealthPartners found that individuals who are willing to communicate about health improvement options are more likely to be “ready to change”. Individuals are only enrolled in the program after a determination is made that there are no associated eating disorders or medical conditions that would affect participation, and that the individual is committed to changing.

Coordination with primary care physicians

All notes from the initial call and subsequent calls are tracked and provided to the participant’s primary care physician (with approval from the participant). Therefore, changes in members’ health status receive prompt attention by physicians, which allows them to positively reinforce behavior changes that are key to preventing chronic diseases and promoting risk reduction.

Program Components

A *Call to Change...Healthy Lifestyles, Healthy Weight®* utilizes an evidence-based written curriculum. Participants receive up to ten sessions of personalized counseling with a registered dietitian and exercise specialist and up to six supplemental sessions with content related to co-morbid conditions and/or body image issues associated with obesity. In addition, the 10,000 Steps® Program is fully incorporated into the curriculum of the phone course. After completion of the telephone-based program, participants are provided with a post-course session that occurs six months after completion of the curriculum.

Outcome data (clinical, behavioral, functional, and satisfaction variables) are collected at the initiation and completion of course and at other defined times.

Early results show that participants in the weight management Call to Change course lost an average of 13 pounds (2BMI units) between baseline and six-month post-course follow-up.

Other Weight Management Programs Available to Members

In addition to the programs described above, additional weight management interventions and initiatives are available to HealthPartners members.

Medical Interventions

Bariatric surgery is a covered benefit for HealthPartners members; however, there are defined criteria. Currently, the member must be evaluated and treated by a designated weight loss surgeon who documents that the member has actively participated in non-surgical methods of weight reduction for a significant period of time. HealthPartners is currently in the process of exploring the possibility of incorporating additional specific requirements to integrate HealthPartners weight management programs as a component of both the pre-surgery and post-surgery process for bariatric surgery.

HealthPartners also covers some prescription weight loss drugs for members. However, prior approval must be granted, and the member must meet certain criteria. Furthermore, enrollment and participation in the *Call to*

Change...Healthy Lifestyles, Healthy Weight® program is required of all members who receive these drugs. HealthPartners has a variety of disease management programs available for members with specific chronic diseases, including diabetes, congestive heart failure, coronary artery disease, asthma and chronic obstructive pulmonary disorder. These disease management programs are fully coordinated and integrated with the *Call to Change...Healthy Lifestyles, Healthy Weight*® program, as appropriate.

Other Weight Management Interventions

Incentives for HealthPartners members to stay fit are provided through the HealthPartners **Frequent Fitness Program**, which includes discounts at numerous fitness facilities and exercise equipment retailers. If a member works out at least eight times a month at a participating health club, they are rewarded for improving their health with monthly savings off their club membership fees.

In addition, HealthPartners offers the **Worksite Health-e-KitSM** web-site, consisting of four programs (physical activity, healthy eating, stress management, and self-care) which last three months each. This web-based program is available to employers and provides tools for employers to roll out programs to reach employees at all levels of health risk and readiness to change. The program integrates scientifically proven approaches to promote behavior change.

Other Initiatives

HealthPartners is actively exploring new weight management initiatives that may hold promise as future interventions. The HealthPartners Research Foundation is a strategic partner in the Minnesota Obesity Center, an Obesity Nutrition Research Center funded by the National Institute of Diabetes, and Digestive and Kidney Diseases of the National Institutes of Health. In addition, HealthPartners, in collaboration with the Institute for Clinical Systems Improvement (ICSI) and other sponsors, has been involved in the writing of the new ICSI guidelines on prevention and management of obesity, released in November 2004. The ICSI is sponsored by six Minnesota health plans.

HealthPartners Research Foundation is actively involved in several grants related to the study of obesity:

- **Adolescent obesity.** The HealthPartners Research Foundation, in collaboration with the University of Minnesota, has embarked on a study to better understand adolescent and parent perceptions regarding weight, health promotion and types of weight management programs that would work for adolescents. This study will ultimately provide the data for a large-scale clinical trial to help adolescents manage weight problems.
- **Weight loss maintenance for adults.** A current research project addressing weight loss maintenance will be used to propose a full-scale randomized trial evaluating the efficacy of weight maintenance interventions over a two-year period.
- **Keep Active Minnesota (KAM) Project.** Funded by the National Institute on Aging, this study will test new ways to help older adults (ages 50-70) to maintain active lifestyles.

Increased physical activity among older adults is associated with lower health care charges within two years, relative to those who were persistently inactive.

Another recent initiative, being conducted in collaboration with the Centers for Disease Control, Kaiser Permanente and HealthPartners, is the translation of community guide recommendations into clinical actions and solutions. The goals of this initiative are to identify actionable solutions to address overweight and obesity in medical care settings based on scientific evidence and professional experience; to assess solutions in the context of clinical effectiveness, administrative reality, and financial feasibility; and to make final recommendations which enumerate specific solutions to be targeted for expanded implementation and dissemination.

To coordinate and formalize organizational goals, strategies and measures related to the full care spectrum for overweight and obese individuals, HealthPartners has created the HealthPartners Enterprise Obesity Steering Committee. This multidisciplinary team is charged with exploring a number of specific interventions, including new approaches to incorporate and encourage the use of physician tools to promote the use of BMI as a vital sign and to incorporate pharmacotherapy as appropriate.



One out of every four children or adolescents is overweight and therefore at greater risk for a number of chronic and debilitating diseases including high blood pressure, worsened asthma, and even heart disease.

Highmark, Inc.

Highmark recognized the impact and prevalence of childhood obesity and responded by initiating a comprehensive approach to address childhood obesity in late 2001. Since that time, Highmark has brought together numerous community partners to address this issue, including the Pennsylvania chapter of the American Academy of Pediatrics, the Western Pennsylvania Hospital Council, local and state health departments, the Pittsburgh Foundation and Pittsburgh Public Schools.

Working in committees, the group has identified and implemented strategies to address the epidemic regionally. Additionally, Highmark has funded several significant regional initiatives, including a policy forum and a media campaign around childhood obesity. The Highmark Challenge for Healthier Schools has provided \$400,000 in grants to schools within its service region to introduce nutrition and physical activity programs and a \$500,000 three-year grant to the Pittsburgh Board of Education to fund a system-wide physical education and nutrition curriculum in grades K-8 affecting 28,000 children. In Central Pennsylvania, over 32,000 elementary students have received daily planners that include health messages and tips. A partnership with the Susan P. Byrnes Health Education Center in York has enhanced the initiative by affording field trips to reinforce student health education. To provide support to physicians, Highmark developed a tool kit that includes obesity identification and treatment guidelines, parent self-help materials on nutrition and activity, a BMI calculator and other materials.

KidShape® Evaluation

To complement broad, population-based prevention initiatives, Highmark offers the KidShape® program (www.kidshape.com), a nationally recognized pediatric weight management program targeted at overweight children and teens (aged 6 to 14) and their parents. Highmark's introduction of the program in its service region was in part a response to physicians who expressed a need for clinical interventions for their overweight and obese patients. The KidShape® program was first launched in California in the late 1980s by a pediatric endocrinologist, and it is now available at 18 sites in Southern California and is also licensed to providers in San Antonio, Texas and Los Cruces, New Mexico. The KidShape Foundation reports that, to date, 87 percent of the 1,500

The KidShape Foundation reports a favorable impact from program participation on serum insulin, blood pressure and triglyceride levels among program participants.

participating kids lost weight during the program, and 80 percent kept the weight off for up to two years.

Highmark has licensed the KidShape® program for use in Pennsylvania and is financing this program in sites chosen to emphasize access for and referral of primarily minority and underserved families. The program was initially launched in two pilot sites in the fall of 2002. As of October 2004, Highmark supports nine sites and expects to launch the program in five to ten additional sites by mid-2005. Sites include, on average, two to three cohorts annually with 15-20 families in each cohort. By the end of 2005, Highmark hopes to have served close to 1,000 families through KidShape®. Highmark covers costs for any qualified individual to participate, regardless of whether they are a Highmark member. However, a doctor referral indicating that the enrollee's BMI is higher than the 85th percentile is required for enrollment.

The KidShape® program, which is offered in English and Spanish, encompasses eight two-hour classes conducted once a week at community-based sites. At least one parent is required to attend with an enrolled child. A structured interactive curriculum is presented with standardized materials. Registered dietitians and mental health and fitness professionals serve as instructors and must undergo a two-day training. Follow-up contact and physician involvement represent integral components of the program.

Preliminary data (Jan.–Aug. 2004) from the Kidshape Program indicate that average BMI dropped from 29.02 to 28.48 among 114 participating children across five sites.

Highmark is piloting the KidShape® program to determine if it would be cost-effective to reimburse providers to deliver programs such as KidShape® in the future. Highmark researchers will collect data, including height

and weight, at the first class with follow-up measures taken eight weeks later at the last class. Participants will also complete the Rosenberg Self-Esteem Scale and a self-administered survey of consumption of different food groups and frequency of physical activity during the first and last sessions. Highmark will also assess program effectiveness through monitoring enrollment levels and attendance, drop out and participation rates.

Longer-term follow-up data will be collected in coordination with the enrollee's family physicians when possible. Cost savings will be projected based on average decrease in BMI and published data indicating likely future medical costs for children with high BMI. To allow for this comprehensive evaluation, participating families are asked to sign an informed consent form explaining the research project and how confidential data is handled and secure an authorization from their physician for the release of height and weight information. However, participants are not denied program entry if they do not wish to participate in the research component, and they have the option to rescind their agreement to participate in the research project at any time.

Highmark's evaluation of the program in Pennsylvania will be the first time the program is evaluated by an outside entity, other than the KidShape Foundation.

The formal launch of the KidShape® program has been a significant commitment for Highmark. Although there have been challenges in educating physicians about the program's efficacy and in training service delivery teams at several new sites simultaneously, Highmark believes it has now rounded the learning curve. An initial 50 percent dropout rate was addressed by Highmark through improved intake procedures to afford parents a better understanding of the commitment level necessary to be successful in the program, thereby enrolling those with the highest readiness levels. Low graduation rates also appeared to be affected by holiday absences. Sites are addressing this by holding cohorts based on a typical school year schedule, with breaks for winter holidays and summer. Current graduation rates (based on enrollees who attend at least six of the eight sessions) are approximately 80 percent.

Weight Management Initiatives for Members

Highmark offers online programs, programs through partner organizations, worksite wellness programs and clinical interventions to assist members in addressing weight management issues.

Online Weight Management Programs

As of January 2004, Highmark began offering online health programs free of charge to all adult members. Two programs, which specifically address weight management, include:

- **HealthMedia Balance**[®], which provides participants with weight management tips and self-monitoring activities through personalized electronic messages. The program also focuses on physical activity and body image to address all of the components that lead to excess weight.
- **HealthMedia Nourish**[®], another self-management program that focuses on nutrition and provides an initial action plan with three follow-up plans delivered at two, four and eight weeks. It includes personalized techniques for making appropriate food choices when dining out, shopping and preparing meals.

Partnership Programs

Through its Preventive Health Services Division, Highmark works with partner organizations including local YMCAs and community hospitals to provide member services that address weight issues, including:

- Personal nutrition coaching for children and adolescents who are overweight (>95 percentile BMI for age and sex) or at risk for overweight (BMI between 85 and 95 percentile for age and sex), and
- **Eat Well for Life**, a program that helps participants develop skills for eating appropriately and making healthy food choices.

Worksite Wellness

Through the Preventive Health Services Division, Highmark offers a data-driven worksite wellness program in which Highmark worksite wellness professionals consult with employer groups to develop strategies or design

programs to address wellness issues among employees. Highmark offers the following services through worksite wellness programs:

- Analysis of the employer's population, based on data gathered from claims utilization, clinical screenings and health risk appraisals. This enables participants to be risk-stratified to assess the need for various interventions;
- Assistance in selecting the most effective lifestyle change programs available from Highmark and/or local and national resources and in defining measurable program goals to monitor progress; and
- Assistance in a communication campaign, program implementation and program evaluation.

Blues On Call (health coaching via phone) is an integrated condition management program that provides members with information and support and helps callers develop the skills needed for ongoing chronic condition management. The program focuses on diabetes, congestive heart failure, coronary artery disease, asthma, chronic obstructive pulmonary disease and associated co-morbid conditions. Members may call 24 hours a day, seven days a week for coaching on any medical topic. Blues On Call health coaches include registered nurses, respiratory therapists, certified diabetic educators and dieticians.

With the participant's permission, Highmark forwards all reports to each participant's primary care physician, and the summary data are shared with health coaches from Blues on Call to further risk-stratify members for condition management programs.

Bariatric Surgery and Weight Loss Medications

Highmark offers clinical interventions to members who meet defined criteria. Bariatric surgery is available to members; however, it is only provided to those who meet weight criteria and who have sought intervention through an approved weight management program for at least six months prior to the procedure. Prescription weight loss drugs are currently covered for an underlying condition that is related to obesity; however, coverage exclusively for weight loss is not available to members at this time.

Horizon Blue Cross Blue Shield of New Jersey

In the essay he authored for this report, Dr. Eric J. Berman, Medical Director for Horizon Blue Cross Blue Shield of New Jersey writes, "Although several factors contribute to the development of obesity, the key to controlling it from a public health standpoint lies in uniting public and private resources ..." Horizon's response to the complex problem of obesity embodies this philosophy by approaching the issue from two angles – as a chronic health problem affecting the lives of many of its members, and as a major public health crisis, with implications far beyond Horizon's membership.

Enhancing Community Resources

As part of its strategic planning efforts, Horizon developed and launched the World Class Clinical Quality initiative in 2002. Part of this initiative included identifying the key issues affecting the health and well-being of New Jersey residents and developing strategies to address these issues in ways that produced quantifiable, replicable and sustainable results. To address the issues of overweight and obesity, Horizon designed and implemented several programs that focus on education and behavior modification.

Estimates of the cost of low health literacy are approximately \$84 billion, primarily in the form of extra physician visits and longer hospital stays.¹⁴

Horizon's programs also have a special emphasis on health literacy, defined as the ability to read, understand, and act on health information. Horizon's community-based programs include the following:

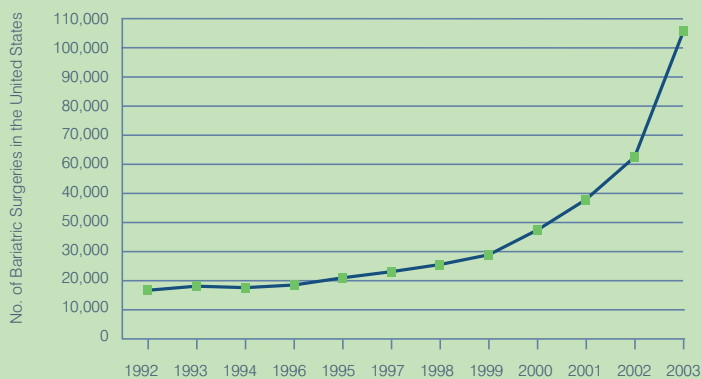
- **Youth Mentoring Program.** Horizon has an ongoing partnership with the New Jersey Boys and Girls Clubs to provide teen mentoring and tutoring on health literacy in the Newark and Atlantic City areas. In these programs, teenagers are trained as mentors to work with younger children to improve their reading skills. An important component of the program is the integration of health-related information.
- Nearly half of adults nationwide are considered to have low levels of health literacy, which directly impacts their ability to understand food labels and nutritional guidelines, as well as understand and follow medical advice related to their own or their children's weight.¹⁵**
- **Horizon Walks for Health Campaign.** This community/corporate wellness program was developed in partnership with the American Heart Association and American Diabetes Association and is designed to encourage daily moderate exercise and portion control by delivering a consistent message at public, corporate and school events.
 - **Horizon Health Kit.** Launched in July 2003, the Horizon Health Kit is designed to educate New Jersey residents about the importance of exercise and healthy eating. The kit includes a BMI chart, a pedometer and a pocket calendar for recording activities. It is being distributed at health-related events throughout the state. The Health Kit is also available in a low literacy version.
 - **Horizon Health Future.** Through a partnership with the New Jersey Network (NJN), a public television and radio network, Horizon provided the necessary hardware and software to link thousands of teens and adults to approximately 400 educational modules through Boys and Girls clubs in several New Jersey communities. The modules included health literacy and other topics. The program also provided funding for participating teens to develop their own videos on health-related topics, including obesity.
 - **Shape It Up Program.** In conjunction with the Ernest Mario School of Pharmacy at Rutgers University, Horizon recently began an initiative to provide obesity intervention workshops in New Jersey public elementary schools. The program and its accompanying materials were designed by state-certified teachers to meet the requirements of the New Jersey Core Health Curriculum. More than 350 schools have requested the program, and it will be presented to 150 schools during its first year. More information is available at www.bcsnj.com/shapeitup/index.asp.

Employers and Health Plans Weigh Benefits and Risks of Weight Loss Surgery

For individuals classified as morbidly obese, generally defined as having a BMI of 40 or greater, non-surgical treatment options have shown little success in achieving substantial or sustained weight loss. Bariatric surgery has long been viewed as a last resort for the morbidly obese, as well as moderately obese individuals (BMI of 35 or greater) who have one or more co-morbid conditions, but it is becoming an increasingly popular procedure.

Over the last decade, the number of weight loss surgeries performed has skyrocketed from less than 20,000 in 1992 to over 100,000 in 2003. The growing popularity of bariatric surgery has many concerned about the procedure, its effectiveness, costs and risks.

Figure 5. Trend in Bariatric Surgery Use (1992-2003)



Source: American Society for Bariatric Surgery, www.asbs.org

Background, Efficacy and Risks

The National Institutes of Health (NIH) guidelines for bariatric surgery were published in 1991 and have remained unchanged since then. The guidelines state that surgery should be considered for individuals with a BMI of 40 or greater (or greater than 35 with a co-morbid condition), who have failed under other treatments and are motivated to lose weight.

A large number of studies have demonstrated that bariatric surgery is effective in helping morbidly obese individuals achieve substantial weight loss. For example, a recent evidence review by the Blue Cross and Blue Shield Association Technology Evaluation Center (TEC) found that "the evidence is sufficient to conclude that surgery improves health outcomes for patients with morbid obesity as compared to non-surgical treatment."

It is important to note that the TEC evaluation draws heavily from a single study that included over 1,000 patients, the majority of whom

were followed for at least five years post-surgery. The other studies in the evaluation were smaller but corroborate the findings from the larger study. However, given these data limitations, TEC cautions that "it is not possible to draw conclusions as to the relation of increment of weight loss to increment of improvement in health outcome measures," nor is it possible to identify a weight threshold for success of the surgical procedure. Some of the concern over the impact of weight loss surgery on co-morbid conditions may be alleviated by a recent review in the *Journal of the American Medical Association*, which found effective weight loss and significant improvement in co-morbid conditions, including diabetes and hypertension, among morbidly obese patients undergoing bariatric surgery.

There is somewhat conflicting evidence over the risks faced by individuals who undergo bariatric surgery. One recent study found that one in 50 surgery patients died within 30 days of surgery, while other studies have reported rates of one in 200 or one in 300. Additional risks from surgery include pneumonia, infection, anemia and other nutritional deficiencies.

Employer and Health Plan Response

While uncertainty remains about the relative risks and benefits of weight loss surgery, most plans do cover the procedure for members meeting the NIH criteria, but this may be changing. Within the last year, two major health plans — Blue Cross and Blue Shield of Florida and Nebraska — have announced that they are dropping coverage for bariatric surgery and some have speculated that other plans may follow suit. With an average cost of \$30,000 and extensive follow-up care required, employers and health plans are questioning whether the cost is in line with the benefits.

If the Medicare Coverage Advisory Commission gives its approval for weight loss surgery, there may be growing pressure on commercial insurers to cover the procedure. But regardless of Medicare's decision, health plans, providers and employers are continuing to develop evidence-based policies that maximize the potential benefits of weight loss surgery while minimizing the risks. One increasingly popular approach is designating Centers of Excellence — typically facilities that have high weight loss surgery volumes or can otherwise demonstrate high quality. Another approach was recently taken by a consortium of New York health plans and providers who developed a set of consensus guidelines for selecting the most appropriate patients, the most experienced surgeons and the best-equipped facilities across the state.

Sources:

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See, for example, Pope GD, Birkmeyer JD, Finlayson SR. *National trends in utilization and in-hospital outcomes of bariatric surgery*. J Gastrointest Surg 2002;6:855-860;discussion 861 or Commonwealth of Massachusetts Betsy Lehman Center for Patient Safety and Medical Error Reduction Expert Panel on *Weight Loss Surgery Executive Report August 4, 2004*.
Medicare Coverage Advisory Commission "Summary of Evidence - Bariatric Surgery - November 4, 2004" Available at: www.cms.hhs.gov/lmcacl/1371.pdf

- **Poster and Brochure Campaign.** These award-winning materials were created in partnership with the American Heart Association and the American Diabetes Association and are targeted toward families and children. They are also available in a low literacy version.

Improving Employee Health

After learning that almost half of its employees had at least one chronic disease risk factor, Horizon launched an employee wellness program with its joint venture partner, Atlanticare, in southern New Jersey. The program gives employees time to engage in physical activity and provides incentives and places for them to do so. The program also includes regular testing of blood pressure, blood sugar and cholesterol.

Shaping the Policy Agenda

Consistent with its philosophy of addressing obesity by joining public and private resources, Horizon has taken a leadership role in focusing the health policy agenda in New Jersey on the growing epidemic of obesity. Horizon sponsors an annual Health Policy Forum each October, which gathers policymakers, clinical experts and health leaders to discuss health policy, obesity and health literacy, as well as other important issues. At last year's forum, Horizon launched the New Jersey Health Policy Consortium, which it hopes will bring together diverse expertise and influence the health policy agenda in New Jersey.

Resources for Horizon Members

Horizon has also implemented weight management tools and programs designed specifically for its own members and is continuing to develop and expand these programs as part of its World Class Clinical Quality initiative. In spring 2004, Horizon launched a pilot Weight Management Health and Wellness Education Program. The program is currently available to fully-insured HMO members who are identified through medical and pharmaceutical claims analysis. Identified members are further classified into high- and low-risk groups by a predictive modeling tool that looks at past costs and utilization.

All identified members are notified of their eligibility for the Weight Management Health and Wellness Education Program by mail and are given the opportunity to opt out. Those who remain in the program receive quarterly mailings containing educational materials and weight loss tools such as a pedometer, a food diary and a tape measure. The materials promote weight management by encouraging healthy eating behaviors combined with a moderate exercise regimen. Participants learn how to measure BMI, choose healthier meals, control blood pressure and reduce cholesterol. All identified members also have free 24-hour access to health professionals via a telephone counseling line to help them create and follow through on a customized treatment strategy. Horizon plans to add group educational seminars to the program in 2005.

Members identified as high risk receive additional services. These members are contacted by a registered dietician and

While the Horizon/Alliance program is voluntary, almost all employees participated in the pilot, and the feedback and results have been encouraging. Out of 48 employees with a BMI of 25 or more, 25 reduced their BMI over a one year period. The employee wellness program has since been expanded to two additional sites, with plans to expand enterprise-wide and eventually introduce the program to Horizon's employer groups.



complete a comprehensive health assessment over the phone. The assessment is used to develop an individual weight loss plan for the member. These members are then contacted by the dietician every one to three weeks to assess progress.

Horizon is also currently implementing a small pilot study of the Weigh to Live program, a comprehensive, medically supervised 16-week commercial weight loss program. The pilot, which is being limited to 100 members (members receive a discount on the program and a rebate upon completion), includes one-on-one and group counseling, regular lab tests, healthy meals, and a gym membership with access to a personal trainer. The pilot will be evaluated in late 2005. If successful, Horizon may offer larger discounts for the program across its membership.

Bariatric Surgery and Weight Loss Medications

Horizon covers bariatric surgery for members with a BMI greater than 35 with one or more co-morbidities, or greater than 40 with no co-morbidities. Candidates must also complete a behavioral evaluation and must demonstrate that other meaningful attempts at weight loss have failed. Weight loss drugs are covered when prescribed by a physician.

Additional Efforts

With funding from Shape-Up America, Horizon has developed and distributed a web-based pediatric assessment tool to measure overweight and obesity risk in children, for whom adult BMI standards are not appropriate. The assessment tool is available to all physicians both inside and outside of Horizon's network. Horizon believes this is the first web-based tool of its kind.

Horizon's ongoing efforts to address overweight and obesity are coordinated through the Horizon Health Council, an internal body that includes representatives from across the organization. The Council is currently looking at ways to expand the employee health program to additional sites and to Horizon employer groups and is also evaluating reimbursement and incentive models for both network physicians and Horizon members to encourage weight management and weight loss.

Kaiser Permanente

With an estimated 4.4 million overweight or obese adult members out of 7 million total adult members and data showing that the total cost of care for obese members was 44 percent higher than for healthy weight members, Kaiser Permanente (KP) knew it had to take a broad, public health approach to combat this problem. In January 2002, the Care Management Institute (CMI) of Kaiser Permanente launched the Weight Management and Obesity (WMO) initiative to address the growing epidemic of overweight and obesity. The WMO initiative includes five related components:

- Establishing appropriate clinical management tools,
- Disseminating successful practice strategies,
- Building community partnerships,
- Establishing a research network, and
- Influencing legislation and public policy.

The short-term goals of the initiative are to document the existing programs in place across KP, implement weight management strategies in the primary care setting, and begin to review and identify additional interventions. Longer-term goals include developing metrics to quantify the effectiveness of interventions, standardizing programs and enhancing physician and member skills through tools and education. Additional longer-term goals include the institution of effective public policy targeting prevention of overweight and obesity and fostering the development of community based weight management programs.

Kaiser Permanente's integrated delivery system and information technology systems provide a clear advantage in implementing and evaluating clinical approaches to weight management, and Kaiser's regional structure provides a natural laboratory for testing a wide range of approaches to this epidemic.

Weight Management and Obesity Initiative

Clinical Management

KP's multi-tiered approach to the obesity epidemic was created with the clear intention of refraining from "over-medicalizing" a problem that has causes and implications far beyond the medical. Nevertheless, clinical management is the glue that holds KP's Weight Management and Obesity Initiative together.

To ensure that KP clinicians and administrators are knowledgeable about obesity and the KP programs available for overweight and obese members, KP-CMI has developed the *CMI Weight Management Source Book*, which outlines key elements of KP's weight management and bariatric surgery programs. KP has collaborated with HealthPartners to complete an update of the literature and is now translating that evidence for clinicians and members. This information will guide program design and the creation of practice recommendations.

KP's weight management efforts are closely tied to system-wide data initiatives, especially an initiative to implement electronic medical records (EMR) in all regions over the next three years. KP hopes to institute near universal BMI measurement of all KP enrollees, especially children, to assess trends over time in order to intervene early and move toward effective prevention strategies. In addition, the availability of BMI measures supports conversations between clinicians and patients about weight and health. Some regions have been moving rapidly to implement BMI as a vital sign, with rates exceeding 50 percent, while other regions have been proceeding more cautiously. It is expected that the implementation of the EMR will accelerate adoption of BMI as a vital sign.

Successful Practice Dissemination

Practice dissemination is accomplished through several strategies, including workshops and motivational interviewing training for clinicians. Dr. Scott Gee, Medical Director for Prevention and Health Information in KP's Northern California Region, has developed a training program for clinicians on how to help patients change behavior based on the Stages-of-Change Model.¹⁶ He has used the program to train clinicians in several KP regions. To help physicians communicate with their patients about weight management, KP has also created and disseminated a template to guide communications and prioritize discussion based on the amount of time available (one-minute, three-minute and ten-minute periods).

Building Community Partnerships

KP's Community Benefit Program works with community clinics and safety net providers to help them address overweight and obesity among their patients by providing training for clinicians and tools, such as BMI wheels, tip

sheets and charting forms to support care delivery and effective conversations with patients and families. Weight management messages have been incorporated into KP's Educational Theatre production, *Zip's Great Day*, and weight management posters are distributed to schools where Educational Theatre productions are staged.

Establishing a Research Network

A research network comprised of 30 KP scientists has been established to create and disseminate new knowledge and make KP's weight management programs more effective. In addition, the Kaiser Permanente Garfield Memorial Fund has selected 15 KP existing and proposed interventions for funding as part of its Weight Management Research Initiative. Published results of these initiatives will be available in the future.

Influencing Legislation and Public Policy

A key component of the public health model involves collaborating with a variety of public and private partners to address societal issues that contribute to the obesity epidemic. As part of this effort, KP's Care Management Institute (www.kpcmi.org) has forged a strong relationship with the Division of Nutrition and Physical Activity of the Centers for Disease Control (CDC) to identify practical solutions that can be applied in the primary care setting and translate research into clinical recommendations. The Care Management Institute was also one of the sponsors of a major national roundtable discussion in August 2003 titled "Prevention and Treatment of Overweight and Obesity: Toward a Roadmap for Advocacy and Action" which brought together researchers, health plans, community organizations and others to identify priorities for advocacy and action.

Kaiser Permanente's integrated delivery system and information technology systems provide a clear advantage in implementing and evaluating clinical approaches to weight management, and Kaiser's regional structure provides a natural laboratory for testing a wide range of approaches to this epidemic.

Regional Weight Management Programs

Complementing the CMI's model, KP continues to initiate and test interventions for various populations regionally with the goal of improving these programs as the knowledge base increases. Many of KP's programs have been in place for several years, and a number of evaluations are underway to assess their effectiveness. All regions include bariatric surgery as a covered benefit for members who meet specific criteria. The programs are described below.

KP Colorado

KP Colorado offers multiple programs including Weight Connections, a six-week group visit model for adults that can be supplemented by small group booster sessions during weight maintenance. The program has enrolled 360 participants during its eight-month existence. An evaluation framework is currently being developed. Additional programs include Family Connections, a multi-session group visit program for parents of children under 12 years old, and Bariatric Connections, a twelve-session pre-bariatric surgery preparation course. KP Colorado is currently piloting a telephone-based triage and weight management system with encouraging early results.

KP Mid-Atlantic States

KP's Mid-Atlantic region has offered dietician-led classes in weight management for over six years. Class topics include dietary change, factors that influence eating and exercise, and beliefs and attitudes about weight. The program has not been formally evaluated.

KP Northwest

KP Northwest offers three weight management programs: a self-study program titled Weight Loss Basics, a five-week educational program, and a twelve-week program. The five- and twelve-week programs provide information on behavioral modification, diet and exercise. Participants in these programs lose a mean of 1.1 pounds per week.

KP Northern California

KP Northern California adult members have access to several programs, ranging from web-based educational programs to the *Lifestyle and Weight Management Program*, a multi-session class led by a team consisting of a dietician, a counselor, and a health educator and/or an exercise physiologist. KP Northern California also offers

single-session classes on physical activity and another on weight management, which are intended to help the member understand the KP and non-KP resources that are available to them and develop personalized weight management and exercise programs. These programs are available at no additional charge.

Lower-risk children are enrolled in the national KidShape® program while high-risk children and those with co-morbid conditions are enrolled in a Kaiser program that combines a multi-session educational program with a low-calorie diet.

KP Northern California's Health Education Department has also developed counseling protocols to clinical health educators in counseling patients about weight loss and weight management issues. KP Northern California is nearing completion of multiple evaluations of its adult and pediatric obesity programs.

KP Southern California

KP Southern California offers several weight management programs, ranging in length from one session to six months or longer. In addition, KP Southern California operates a freestanding fee-for-service metabolic obesity center. KP also offers weight management programs for adolescents and their caregivers, which consist of one or two sessions and address reasons for weight gain and strategies for healthy eating and increasing physical activity.

KP Ohio

KP Ohio members can access discount programs, such as Weight Watchers™ that offer member discounts for group and online programs. The KP Fitness program offers discounted memberships to fitness centers and gyms.

KP Georgia

KP Georgia members have access to a variety of weight management resources and programs. These include classes such as Managing Your Weight (adult six-session class), Operation Zero (eight-session class for children age 11-17), The Art of Cooking Healthy, and Working Towards Wellness. Other resources include the Behavioral Health Eating Disorder program, discounted rates for health clubs and commercial weight loss programs, as well as a variety of online resources.

KP Hawaii

Members have access to a variety of programs including Fitter Me, which is an individual or group-based intervention available since 1990 that enrolls 128-337 members per year. In addition, Weight Watchers™ has been available since 2002 with approximately 75-100 enrollees per year. KP Hawaii is also currently piloting FitZone, a pediatric program for children ages 9 to 15.

Group Health Cooperative

Group Health Cooperative members have access to several weight management programs that can be tailored to meet individual needs. The programs include meal replacement, weekly classes, individual contact with a health educator (by phone or in person), or a combination of these components.



Premera Blue Cross

Employers bear a significant portion of the costs associated with obesity and obesity-related conditions in the form of reduced productivity and higher health and disability insurance costs. In 1994, obesity-related health problems cost U.S. businesses almost \$13 billion, including \$10 billion in health and life insurance expenditures, \$2 billion for sick leave and \$1 billion for disability insurance.¹⁷ The 2001 Surgeon General's report on obesity indicates that the overall costs of obesity totaled \$117 billion, including both direct costs for prevention, diagnosis and treatment as well as indirect costs associated with lost wages and future earnings. Not surprisingly, employers are increasingly looking to health plans for answers.

Concerned about employee health and rising healthcare costs, Microsoft, one of the nation's largest companies, took action. Even though employees of this large software company tend to be younger and healthier than average for large U.S. corporations, the company was not immune to the larger national trend. As a result, Microsoft developed a pilot weight management program in 1999. After reviewing the pilot results and implementing several plan design modifications, a comprehensive weight management program was rolled out to all U.S. employees on January 1, 2002.

Premera was awarded the Microsoft account in part because of its approach that supported employee wellness and comprehensive weight and obesity management programs.

One year later, Premera Blue Cross joined Microsoft in its efforts to manage rising healthcare costs by assuming responsibility for healthcare claims management for all U.S. Microsoft employees. Based on their commitment to supporting wellness programs, Premera was able to further support Microsoft's efforts to offer a comprehensive weight management program to achieve positive results for its participants as well as for Microsoft.

Premera's Approach: A Collaborative, Physician-Driven Model

Roki Chauhan, M.D., Premera's Vice President for Medical Services and Medical Director for Quality, describes the

Microsoft program as a medical and surgical benefit that is “physician driven” but also uses a team approach. Employees and their covered spouses/same-sex domestic partners are eligible for the weight management program if their BMI is greater than or equal to 30 or if they have a BMI of 27 with two or more of the following conditions:

- Congestive Heart Failure
- Coronary Heart Disease
- Diabetes
- Hyperlipidemia
- Hypertension

Participation is voluntary, and members must be assessed by their primary care physicians to determine if they qualify.

Members meeting the criteria are enrolled in approved weight management programs that provide services for at least 24 weeks and sometimes longer. To meet Premera’s and Microsoft’s standards, a weight management program must provide medically supervised care in the areas of nutrition, behavioral therapy and personal fitness training. Once a member qualifies for a weight management program, the member is assessed and a comprehensive program is developed by the weight management team. The programs typically involve an intensive phase, which includes a minimum of ten sessions with a physician, a personal fitness trainer, a dietician and a behavioral health therapist. Following the completion of the intensive phase, a three-month maintenance phase begins, which focuses on follow-up with professionals on exercise, nutrition and medical oversight on a less rigorous but still regular schedule.

Early Challenges and Results

With an enrollee base dispersed throughout the U.S., one initial challenge for Premera was building and maintaining a network of qualified weight management programs, especially outside of its home state of Washington. Programs meeting all of the criteria were sometimes difficult to find, and some of the programs that did exist were often unprepared to handle the administrative complexities of insurance reimbursement. To address this issue, Premera worked to design simplified claims and reporting requirements for these programs. As of December 2004, sixteen programs in twelve states have been approved and contracted to provide weight management for Microsoft employees.

Tiered Approach to Weight Management

Spurred by the success of the Microsoft program, growing interest from other employer groups and disturbing national trends, Premera brought together a task force to address overweight and obesity issues. In early 2004, under the leadership of Shelly Smith, M.N., Director of Quality, and Corinne Bell, D.O., Western Washington Medical Director, Premera formed a Comprehensive Obesity Strategy Team to define, develop and implement a strategy for members and employers. Team members represented medical directors, clinical quality, disease management, benefit design, actuarial and product strategy development. The team addressed the impact of obesity, related quality of life issues, and the impact on medical costs. The result is a product that responds to employer requests for obesity strategies for their overweight and obese employees.

A five-tier program was designed to balance coverage with choice and to respond to varying levels of employer interest in obesity and weight management. The components of the five tiers range from basic tools and incentives targeted toward prevention and encouraging healthy lifestyles to a comprehensive obesity benefit offering medical, nutritional, behavioral and surgical services specific to obesity. Bariatric surgery is only offered at the highest level, and then only under strict criteria and with intensive behavioral modification counseling. Weight loss drugs are not covered at any level.

Tier 0 – Basic Benefit

This level is offered to all fully-insured members at no additional cost and includes online health information on fitness, weight loss, and men’s and women’s health, as well as discounted memberships for weight loss programs and fitness clubs.

Tier 1 – Health Management Benefit

The next level adds a Health Management Benefit, which provides limited coverage for community wellness classes such as weight management and smoking cessation.

Tier 2 – Health Risk Management

Tier 2 offers a more targeted approach to addressing overweight and obesity through Premera’s vendor Summex. Employees who work for employers that purchase this

option will be provided with a Health Risk Assessment (HRA) tool for the identification of health risk factors including obesity. Those determined to be at-risk will receive further assessment as well as telephonic coaching and other targeted interventions.

Tier 3 – Intensive Weight Management

For employer groups who desire a specific BMI-focused program, the intensive weight management option identifies overweight or obese members through a health risk assessment tool. Identified members receive condition-specific telephonic counseling and coaching along with tools to support their weight loss goals.

Tier 4 – Obesity Benefit

For employers such as Microsoft that desire a comprehensive obesity benefit, Premera has created a template to provide physician-directed obesity and weight management services that may include medical visits, nutritional counseling, physical therapy and surgical interventions. Candidates for bariatric surgery, a covered benefit at this level, must meet specific criteria and undergo significant behavior modification counseling.

Premera Comprehensive Obesity Strategy

Tier 4 – Obesity Benefit	
Tier 3 – Intensive Weight Management	
Tier 2 – Health Risk Management	
Tier 1 – Health Management Benefit	
Tier 0 – Basic Benefit	

Toward the Future

Based on the success of Microsoft’s program, Premera was able to develop a Comprehensive Obesity Strategy to meet the needs of other employer groups and their employees. This work demonstrates that collaborative approaches are critical in shaping clinically-based benefit packages and ensuring that the right care is provided to employees who need treatment for overweight and obesity. Continual assessment, monitoring and improvement of the programs will occur so that positive outcomes can be achieved.

Expert Panels’ Recommendations Set Important Standards

By establishing review panels to evaluate research studies on health interventions, the federal government provides leadership and direction in disseminating evidence-based practices. The U.S. Preventive Services Task Force (USPSTF) is an independent panel of experts in primary care and prevention, convened by the government and housed at the Agency for Healthcare Research and Quality, to review systematically the evidence of effectiveness and develop recommendations for clinical preventive services. The Task Force on Community Preventive Services (TFPCS) is also an expert panel, appointed by the government and housed at the Centers for Disease Control and Prevention, whose mission is to provide leadership in the evaluation of community, population and healthcare system strategies to address a variety of public health and health promotion topics. The USPSTF evaluates studies on clinical interventions while the TFPCS evaluates interventions that occur outside the clinical setting, are delivered to groups rather than individuals, or are delivered by persons other than healthcare providers.

U.S. Preventive Services Task Force: Recommendations on Screening and Counseling for Obesity in Adults

In a December 2003 *Annals of Internal Medicine* article, the USPSTF recommended that physicians screen all adults for obesity and offer intensive counseling and behavioral interventions to all obese adults.

USPSTF members conducted a thorough review of the literature and concluded:

- There is fair to good evidence that high-intensity counseling produces modest but sustained weight loss in obese adults. High intensity interventions yielded an overall mean sustained (18 month) weight loss of three to five kilograms. In one of the studies the panel deemed reliable, 30 percent of participants lost at least 5 percent of their body weight and kept it off for a year. In another, 38 percent of people in the intervention group lost an average 7 percent of body weight;
- There is no direct evidence that intensive diet and nutrition counseling and behavior modification lowered mortality or morbidity, but there is strong indirect evidence of impact based on intermediate outcome assessments (improved glucose metabolism, lower lipid levels, etc.);
- There is insufficient evidence that moderate- or low-intensity counseling, together with behavioral intervention, yielded sustained weight loss; and
- There is insufficient evidence to indicate whether people who are overweight but not obese benefit from high intensity weight loss programs.

The group defined obese adults as those with a BMI of 30 or above.² For screening adults, it viewed the BMI measure as “easy...highly reliable, and closely correlated with adult body fat.” It also recommended that clinicians measure waist circumference and waist-to-hip ratio. Both screening measures capture increased cardiovascular risk

associated with central adiposity (concentration of body fat in the mid-section) and metabolic syndrome (a cluster of risk factors including hypertension, high triglycerides, blood clots, glucose intolerance and insulin resistance).

The expert panel defined counseling intensity by the frequency and the type, modes and mix of interventions. More than one person-to-person (individual or group) session per month for at least the first three months of treatment constitutes a high intensity intervention. One session per month was defined as a moderate-intensity intervention.

Successful interventions typically included at least two and preferably three of the core components of treatment — diet, exercise and behavioral therapy. Consistently across the studies the panel evaluated, diet combined with physical activity counseling resulted in greater reduction of weight and abdominal fat than either approach used alone. More information on the USPSTF and its obesity screening and counseling recommendations is available at <http://www.ahrq.gov/clinic/uspstfix.htm>.

Task Force on Community Preventive Services: Recommendations for Promoting Physical Activity

The TFCPS issued recommendations on interventions to promote physical activity in the *American Journal of Preventive Medicine* in 2002. Physical activity is associated with longer, healthier life as well as reduced incidence of certain diseases, particularly high blood pressure, diabetes, heart disease and obesity. However, despite the benefits of regular physical activity, many Americans lead a sedentary lifestyle: only 25 percent of adults and 27 percent of high school students get moderate exercise regularly.

To better understand what strategies work best in promoting physical activity, the Task Force examined research on effectiveness of informational approaches, behavioral and social approaches, and environmental and policy approaches to increasing physical activity. They classified the evidence of effectiveness as either “strong,” “sufficient,” or “insufficient.”

The Task Force found strong evidence in support of:

- Community-wide informational campaigns, which yielded a 5 percent increase in the proportion of people who are physically active and a 16 percent increase in energy expenditure;
- Individually-adapted health behavior change (e.g., individual goal-setting and tailored behavioral reinforcement), which generated a median 35 percent increase in physical activity;
- School-based physical education, which generated an 8 percent increase in aerobic fitness;
- Non-family social support (e.g., walking groups), which resulted in as much as a 44 percent increase in time spent being physically active; and

- Increased access to places for physical activity, which yielded as much as a 25 percent increase in the number of people who exercise three or more times a week.

The Task Force is currently evaluating the effectiveness of transportation policy and infrastructure changes on increasing physical activity as well as urban planning approaches.

In many cases, the TFCPS found multi-component strategies to be effective. The Task Force’s findings are summarized below. More information on their recommendations is available at www.thecommunityguide.org.

Table 2. Recommendations for Promoting Physical Activity

Intervention	Recommendation
Information Approaches	
Community-wide campaigns	Recommended – Strong evidence
“Point of Decision” prompts	Recommended – Sufficient evidence
Classroom- based health education	Insufficient evidence to determine effectiveness
Mass media campaigns	Insufficient evidence to determine effectiveness
Behavioral and Social Approaches	
Individually-adapted health behavior change	Recommended – Strong evidence
Health education with TV/Video game turnoff component	Insufficient evidence to determine effectiveness
College-age physical/health education	Insufficient evidence to determine effectiveness
Family-based social support	Insufficient evidence to determine effectiveness
School-based physical education	Recommended – Strong evidence
Non-family social support	Recommended – Strong evidence
Environmental and Policy Approaches	
Creation and/or enhanced access to places for physical activity combined with informational outreach activities	Recommended – Strong evidence
Transportation policy and infrastructure changes to promote non-motorized transit	In progress
Urban planning approaches – zoning and land use	In progress

Sources:

McTigue et al. *Screening and Interventions for Obesity in Adults: Summary of the Evidence for the US Preventive Services Task Force. Annals of Internal Medicine* Dec. 2003;139:933-949
 Task Force on Community Preventive Services. *Recommendations to Increase Physical Activity in Communities. American Journal of Preventive Medicine* 2002;22(4S):67-72

WellPoint Health Networks

In July 2002, the American Academy of Pediatrics published a study in the journal *Pediatrics* that reported a high interest among pediatric primary care practitioners in additional training on childhood overweight and obesity, especially in the areas of patient counseling and assessment of risk. To help address these issues, WellPoint launched a project to create a comprehensive web-based CME program. When completed, the CME program will form an important component of WellPoint's multi-faceted approach to addressing childhood overweight and obesity.

While most providers routinely evaluated blood pressure, a minority of those surveyed routinely looked for orthopedic problems, insulin resistance or sleep disorders, and less than 10 percent followed all recommendations for medical history and physical examination.

Childhood Obesity CME Program

The 2002 *Pediatrics* study found that physicians, pediatric nurse practitioners and other providers fell short of recommended practice guidelines for evaluation of overweight children and adolescents. While most providers routinely evaluated blood pressure, a minority of those surveyed routinely looked for orthopedic problems, insulin resistance or sleep disorders, and less than 10 percent followed all recommendations for medical history and physical examination. In response to these findings and the recent growth in web-based CME programs, WellPoint partnered with Dr. Slusser, Assistant Clinical Professor of Pediatrics at UCLA and a nationally recognized expert on childhood nutrition, the American Academy of Pediatrics, the California Medical Association and other family physicians and pediatricians to develop a CME program to provide health care practitioners, including family physicians, pediatricians and pediatric and family nurse practitioners, with the knowledge, attitude and skills necessary to help them prevent, detect, assess and manage overweight and obese children and adolescents.

In addition to helping practitioners expand their knowledge of obesity, evidence-based preventive interventions and the medical and psychosocial conditions associated with overweight and obesity, specific skills covered in the program include:

- The medical interview, focusing on the family, psychosocial history, diet and physical activity/inactivity as well as a focused review of symptoms for medical conditions associated with overweight;

- The physical examination including: BMI measurement and plotting on graph, assessment and interpretation of growth patterns, physical conditions associated with overweight and breastfeeding observation;
- Management and/or referral of children/adolescents with a medical condition related to overweight;
- Basic dietary and physical activity counseling to promote healthy lifestyles;
- Development of systems that assist in the utilization of appropriate members of the health care team to ensure comprehensive care of the patient and the family;
- Assessment and utilization of community resources to help prevent and support treatment plans for overweight children and adolescents;
- Community-oriented care with focus on the health needs of all children within a community, particularly underserved populations;
- Psychosocial and developmental screening techniques;
- Behavioral counseling and referral;
- Health promotion, disease prevention, and anticipatory guidance of adolescents; and
- Psychosocial issues, such as peer and family relations, depression, eating disorders, substance abuse, suicide and school performance.

In addition, the CME program is designed to help practitioners develop cultural sensitivity toward the patient population they serve and understand their own personal biases and prejudices related to weight, food, breastfeeding and physical activity.

The American Academy of Pediatrics, the American Academy of Family Physicians, and the California Medical Association have approved the Childhood Obesity program for 1.5 hours of CME credit. These organizations provided valuable input into the content development of the program. WellPoint will initially pilot the program – free of charge – with its network physicians starting in Georgia and California by the first quarter of 2005. WellPoint will then test the user-friendliness of the program and measure its impact on physician knowledge and attitudes. The results of the evaluation will inform revisions in the content as needed before the program is rolled out nationwide later in 2005.

Other Resources Targeting Pediatric Obesity

Over the past two years, WellPoint has developed and distributed several tools to help physicians and families address childhood obesity, including:

- **Healthy Habits for Healthy Kids.** This bilingual print and web-based guide was developed in collaboration with the American Dietetic Association to help doctors, nurses and other health care professionals communicate with parents and families about childhood obesity. The guide stresses family participation and provides practical strategies for engaging the family in healthy eating and physical activity.
- **Get Up and Get Moving.** This multilingual program includes resources for both parents (available in Spanish, Vietnamese and Russian) and providers and is targeted at California Medicaid and SCHIP members and the providers who serve them. The provider toolkit includes a BMI chart, Expert Committee Recommendations for assessing and treating overweight children, and a Community Resource Center contact sheet. The parent toolkit is written at a low literacy level and includes tips on healthy eating and exercise, a food guide pyramid and a Community Resource Center contact sheet.
- **Physician Desk Reference Tool.** WellPoint collaborated with Dr. Slusser to develop this resource to give physicians quick access to current data from the scientific literature and expert work groups related to childhood obesity. Like the CME program, the desk reference tool was created to help providers better evaluate, treat and communicate with children who are overweight, obese or at-risk.
- **The Hungry Red Planet.** WellPoint has distributed over 2000 CD ROMs of this award-winning computer game to participating physicians for distribution to patients. This game, developed with support from an NIH grant, teaches children important nutrition information while they attempt to help build a colony on the Hungry Red Planet. More information is available at: www.hungryplanet.com

Health Improvement Resources for Adult Members

WellPoint's disease management programs and prevention and wellness initiatives are developed centrally by the Health Improvement Resources division and include telephone-based programs for individuals with diabetes, congestive heart failure, asthma and other chronic conditions. All of these programs are available to WellPoint's fully-insured

members and are available for purchase by self-insured groups. Currently, there is no free-standing health improvement program for obesity. However, many of the health improvement programs include significant weight management modules.

WellPoint's health improvement programs are led by health coaches that include RNs, dietitians, social workers, exercise physiologists and other health professionals. As part of the initial session, the health coach calculates the member's BMI based on self-reported height and weight. The frequency of follow-up phone contact with the member varies based on the individual's BMI and their motivation to change as assessed by the health coach. Individuals with a BMI below 40 receive ongoing coaching and counseling to help them develop and carry out a strategic diet and exercise plan. WellPoint is currently testing a new "healthy weight module" for individuals with a BMI of 40 or greater. The module includes more extensive information on diet and exercise and more frequent follow-up by the health coaches. An evaluation of the healthy weight module is currently underway.

All of the content for WellPoint's health improvement programs, as well as web-based and printed materials, is developed centrally and approved by a team of physicians and other providers. Educational materials include an assessment tool for the health coaches to measure risk factors and readiness to change, and over 50 "teaching sheets" on topics ranging from healthy eating to exercise and behavior modification. The teaching sheets are used by health coaches to help guide their sessions with members.

Members have access to discounts for weight loss programs, vitamins and other health resources (specific discount programs vary by market). In addition, employer groups can access WellPoint's Healthy Weight and Nutrition program, a fee-based worksite wellness program led by a registered dietician.

Bariatric Surgery and Weight Loss Medications

Coverage of weight loss surgery and medications varies across WellPoint's markets. However, WellPoint is currently in the process of identifying and designating Centers of Excellence for weight loss surgery that meet specific criteria for quality. WellPoint's Blue Cross of California plan has already identified centers in California that meet its criteria and have been available to certain accounts since January 2005. WellPoint is currently evaluating facilities in Georgia (Blue Cross and Blue Shield of Georgia) and expects to start evaluating facilities in Wisconsin (Blue Cross and Blue Shield of Wisconsin) to launch Centers of Excellence programs in these states shortly.

GUEST ESSAYS



Combating Obesity Will Require New Models of Care

By William H. Dietz, MD, PhD, Director, Division of Nutrition and Physical Activity, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Our health care system evolved over many decades to address acute medical problems like infectious diseases or injuries, and it has not yet adapted to the care of patients with chronic diseases like diabetes, heart disease and obesity that are the principle causes of death and human suffering today.

Perhaps the most important strides in addressing the obesity epidemic over the next decade will come from the dramatic improvements we must make in caring for people with chronic disease. We need new and reengineered systems to deliver such care. Such systems will have to be more effective and efficient.

In many clinical settings, the co-morbidities of obesity – such as diabetes, cardiovascular disease, or osteoarthritis – are managed in different clinics. The need for integration and shared information is essential. Therefore, one avenue to improve care for obesity will be the electronic health record (EHR). For example, incorporation of the body mass index (BMI) as a vital sign in an EHR could lead to prompts for care linked to the severity of obesity.

We may also have to move away from a physician-centric model of care for some chronic diseases, including obesity. Doctors are likely to continue to oversee the care of obese patients. But physicians may not be the most appropriate providers to deliver care on an ongoing basis. Physicians have little time, are expensive, and are poorly trained in behavior change strategies. Care is likely to be delivered more efficiently and effectively by nutritionists, nurse practitioners, or social workers trained in strategies to change behavior, like motivational interviewing.

The model of care must move toward helping overweight and obese patients develop the skills for self-management of their condition and enable and empower families to manage their child's weight.

Environmental changes in schools, worksites, or communities represent another element critical to patient self-management. For example, overweight children and adolescents will not make more healthful food choices in schools if those choices are not available. Obese adults may not be able to initiate a walking program unless their neighborhood has sidewalks or safe areas to walk.

The need for complementary medical and environmental systems to help obese patients manage their weight offers novel opportunities for alliances between medical and public health systems. Some models already exist. Blue Cross Blue Shield of Massachusetts, for example, has partnered with the CDC-funded state nutrition, physical activity and obesity program to develop the “5-2-1” campaign for public schools. This campaign promotes daily intake of five fruits and vegetables, two hours or less of television viewing, and one hour of physical activity. Kaiser Permanente has partnered with the Steps to a Healthier US program in several communities to control obesity, diabetes, and asthma through tobacco control, nutrition, and physical activity.



We Must Attack Childhood Obesity

By Kenneth R. Melani, MD
President & CEO, Highmark Inc., Pennsylvania

I belong to a generation of physicians that was trained at a time when domestic disease epidemics commanded a relatively minor focus. Unlike the physicians who taught us, and who as young men and women had worked tirelessly to combat the ravages of polio, smallpox and diphtheria, we came of age with a more proactive and optimistic view of the contribution we could make to improve the community's health.

Because health professionals and the lay public alike continue to define the word "epidemic" in the context of diseases with well-defined, specific causes and manifestations – polio, for example – we have allowed ourselves to become immersed in a much more insidious type of epidemic – chronic diseases spawned by unhealthy lifestyles. To appreciate the scope of the situation, consider this: fully half of the two million premature deaths that occur in this country each year result from modifiable behaviors. Moreover, because 70 percent of the burden of illness today is related to lifestyle, it is in fact *preventable*.

Obesity, particularly *childhood* obesity, contributes significantly to the toll exacted by preventable illnesses. In fact, given that about a third of American kids are overweight, obesity among children and adolescents clearly qualifies as an epidemic.

Both as a physician and as the CEO of one of the nation's largest health insurance companies, I am greatly concerned about the downstream ramifications of the epidemic of childhood obesity. Overweight children are at substantially greater risk of developing serious medical problems, including heart disease, diabetes and certain types of cancers.

In addition to the price these children eventually will pay in terms of their health, there also will be a substantial financial price to be paid – a price the nation simply may not be able to afford.

I believe strongly that we can forestall much of this suffering and cost by dealing with the problems of childhood obesity in the same way we dealt with earlier epidemics – through education, awareness and prevention. It has long been Highmark's focus to create a healthier community in Pennsylvania. Through developing and sponsoring innovative programs, we are building bridges for health care professionals and community-oriented groups to work together.



Countering Obesity: Our Culture Needs A Shock

By David Katz, MD, MPH, Associate Clinical Professor of Public Health and Director of the Prevention Research Center, Yale University School of Medicine

When pondering the ever-worsening toll of epidemic obesity, it is increasingly common to note that our genes have changed little in nearly 100,000 years, and are thus woefully out of place in an environment of fast food restaurants, satellite dishes, and DVDs. In large measure, it is the incompatibility of slow moving genes with accelerating environmental change that renders both Nature and Nurture the parents of obesity.

These reflections can be discouraging, because revising the environment is hard to do and reengineering genes even more so, if possible at all. There is thus something hopeful in identifying obesity's "third" parent: cultural inertia. The blistering pace of change – going from horseless carriage to Mars rover and from rickets to prevailing caloric overload in the span of a single century – has left our cultural norms, as well as our genes, in the proverbial dust.

Throughout human history, food has been a fundamental and often rate-limiting influence on survival. So naturally almost every culture reveres food as a precious commodity. Of course a lavish display, a shared feast, is a time-honored demonstration of friendship, love, hospitality. No wonder food marches through our very lexicon as a measure of prosperity and status: we speak of "making dough," being the "bread winner," and "bringing home the bacon." No wonder we cringe at waste, encourage plate-cleaning, and revere the "all you can eat" buffet.

These attitudes are anachronisms, cultural imperatives that no longer apply. Consider the false bargain in saving money by "supersizing" or "chowing down" at all-you-can-eat buffets, then writing checks for lotions, potions, or programs to help lose all the excess weight we gained for free!

But that is the hopeful element in cultural inertia: at some point, it just gets too silly to overlook. And once we recognize the ridiculous in ourselves, we can change it. Unlike our genes, culture is a medium we can alter and control. Culture is where the danger in the obesity crisis meets opportunity.

As a nation of parents informed of the threat epidemic obesity poses to our children, we can abandon hand-me-down admonitions about "starving children in Europe..." and surrender our preoccupations with plate-cleaning. We can, instead, put less food on our children's plates, and pat them on the back if they have the good sense to stop eating when full.

We can recognize that nutrition and physical activity belong on the short list of things to talk over with our kids, along with sex, drugs, tobacco, and alcohol. And we can recognize that talking the talk is not enough; we need to walk the walk, literally-setting an example of physical activity, as well as good nutrition, for our children to follow.

We should insist that schools be safe nutritional environments. We can clamor for buildings in which stairs are prominent and inviting, elevators, perhaps, less so. We can accept that in the modern age, stuffing food into friends and family is not an act of hospitality and devotion, but the propagation of a public health threat! Going for a walk could become a holiday tradition.

Culture is our collective pond. Its complacent surface reflects our outdated attitudes back at us. Anyone of us could be the first to shock those images away – just by tossing a pebble.



Health Plans “Positioned to Lead” on Obesity

By Eric J. Berman, DO, MS

Medical Director, Horizon Blue Cross Blue Shield, New Jersey

The overwhelming burden that obesity places on the quality of life and the cost of health care is irrefutable. Unchecked, this epidemic will ensure that the life expectancy of our children’s generation both fails to surpass that of our own and continues to swell the ranks of uninsured Americans for whom health care has become an unaffordable luxury. Health plans have historically been reluctant to address health policy concerns that were considered to be within the domains of government, academia or society at large. They also have been hesitant to invest in programs whose potential return on investment could be jeopardized by the migration of members to competitors.

Given the gravity, rapid escalation, and broad impact of obesity, that position must change quickly if we are to have any real hope of reversing this deadly trend. Horizon Blue Cross Blue Shield of New Jersey, for one, has recently initiated a multiyear plan to address critical health issues, including obesity, that adversely effect the health and well being of *all* residents in our geographic region, regardless of whether they are Horizon enrollees.

Many forces contribute to the American obesity epidemic. Economic and cultural drivers reinforce behaviors that promote obesity. Our nation’s cultural diversity creates disparities in the delivery of care to the overweight and obese members of minority populations. Furthermore, a plethora of “treatments” exist with weak evidence of effectiveness. As a result, it has been unclear for many years what medical interventions work and how best physicians and health plans can help people lose excess pounds and/or maintain a healthy body weight. Most plans therefore have not reimbursed providers for identifying and treating obesity as the primary diagnosis.

Not surprisingly, patients frequently have failed to receive adequate education on the important role prevention and lifestyle changes play in reversing the medical consequences of obesity. That too is about to change. The Centers for Medicare and Medicaid Services (CMS) recently removed language suggesting that obesity was not a disease. This shift will effectively allow treatments with a proven track record to be considered for reimbursement.

Although several factors contribute to the development of obesity, the key to controlling it from a public health standpoint lies in uniting public and private sector resources behind the message that healthy weight is critical to long-term health and that healthier weight can generally be achieved and maintained through moderate daily exercise with a well-balanced, portion-controlled diet.

Health plans are well positioned to lead this effort by initiating and sponsoring educational initiatives, developing care coordination programs for weight management, and designing innovative products that create economic incentives for providers to manage, and members to sustain, healthy lifestyle choices. Together with like-minded organizations and government agencies, we can and must exchange our national metabolic energy imbalance for an epidemic of health.





The Obesity Epidemic

By Helen Darling
President, The National Business Group on Health, Washington, DC

Who would have guessed ten years ago that one of the largest threats to the well-being of our country and the quality and productivity of our workforce would be the huge number of Americans who are seriously overweight or obese? A frightening proportion of this group already has major health problems, such as diabetes and heart disease.

It will be hard to make the kind of dramatic social and behavioral changes needed to reverse this epidemic anytime soon, especially given the growing number of children, adolescents and young adults who are already obese. Improvement will be slow in coming and progress may be measured in inches.

But that cannot be an excuse for inaction. Indeed, it means we must redouble our efforts. America's employers and companies increasingly recognize the challenge. They are motivated in no small measure by the threat of being swamped financially by the costs (estimated at \$117 billion in 2003) of obesity and its impact on health and productivity. In addition, they understand that obesity and serious overweight have a tragic effect on the quality of life and safety of their employees and family members.

In 2003, the National Business Group on Health concluded obesity was in fact the most urgent health crisis facing American business and its workers. We also concluded that we had to move as fast as possible to develop a strategy, related tactics and solutions that employers could use immediately. We founded an Institute on the Costs and Health Effects of Obesity.

The Institute's major goals are to identify the most effective programs and best practices to promote healthy weight and healthy lifestyles – and then to disseminate this knowledge, with specific recommendations, in a proactive manner. We have already begun to urge employers to do the following:

- Encourage health plans to develop effective healthy weight and weight reduction programs
- Select health plans that help physicians make weight reduction and management a high priority in all patient encounters
- Develop a comprehensive, corporate-wide health improvement program and food policy (e.g., eliminate mindless unhealthy snacking at meetings)
- Contract with food and snack service vendors to increase healthy options and label all food
- Offer on-site or near-site programs, such as Weight Watchers at Work
- Create safe, attractive opportunities to walk, use stairs, and get moving
- Subsidize the use of health risk appraisals, risk status personal counselors, and other tools to motivate healthy weight
- Work with federal agencies to evaluate weight management programs. Medicare will have to fund studies that demonstrate what programs or treatments will be effective in helping the millions of obese Medicare beneficiaries (18%) lose weight and become more active. Otherwise, Medicare will be bankrupt by paying for the terrible consequences of obesity among disabled and elderly beneficiaries.

Obesity is preventable. We must implement programs aimed at helping overweight employees and their dependents lose those pounds, increase activity, become healthier and enjoy a higher quality of life. Employers have no choice. Corporate America must act in their own best interest to tackle this issue, but that interest is in every way also the interest of their employees and communities.

Obesity: Integrated Medical-Public Health Approach Needed

By George Isham, MD, Medical Director and Chief Health Officer, HealthPartners, Minnesota

The health plan community in the U.S. must become a leader in the social and cultural struggle now underway to prevent and manage obesity and overweight. There is simply no more important problem affecting the health of our enrollees and the broader U.S. population right now. We need to begin to build programs and a benefit structure that supports healthy living and eating and results in reducing behavioral risk factors.

Collaboration between the private and public health sectors is essential in this effort. CDC and other public health agencies must exhibit clear leadership in laying out an evidence-based overall strategy. That process is underway, and it needs full support for effective implementation and dissemination. Health plans will then be in a position to actively deploy those public policy and public health approaches for their members. Both sectors must also join forces to foster and support community-based initiatives and organizations that will help people be active and live healthier lives.

Together with the public sector, we then need to conduct rigorous evaluations of medical, surgical and behavioral interventions for obesity, including counseling and weight loss programs. We must ask the hard questions about what really works, and we must generate hard evidence. Evaluating the cost-benefit ratio has to be a part of that process.

Most interventions that are covered under insurance are now at the end of the obesity spectrum – that is, surgical interventions for the morbidly obese. Some plans also cover some drugs known to be safe and effective. But for the most part behavioral interventions and counseling are not covered services. To have a meaningful impact on obesity in our populations, health plans should be prepared to extend coverage to medical, behavioral and counseling interventions that are proven effective and safe. Health plans should deploy these evidence-based interventions for the overweight as well as the obese and morbidly obese.

Implementing new coverage for non-surgical approaches will require mechanisms to ensure that non-evidence based and ineffective approaches are not encouraged. In an environment with a plethora of products and services for the overweight and obese that are ineffective or in some cases quackery, this will be a challenge.

The reason is cost. Cost pressures in health care are powerful and growing. While obesity is costing us billions, neither employers nor health plans are in a position to broadly expand this area of treatment without solid proof of a long term return on the investment. In Minnesota, for example, if 50% of our 600,000 or so enrollees are overweight or obese, as is the case, and all might be eligible for intensive behavioral therapy or dietary approaches, that would be a tremendous increase in costs on an already strained system.

There are some things we ought to do right away. One is to promote the measurement of Body Mass Index (BMI) as a vital sign. Another is to begin to help physicians to feel more competent in advising patients on weight loss, eating and activity. We know that many doctors are quite frustrated trying to provide this help. And we know they see it as one more thing they *have* to do in the 10 minutes or so they spend with a patient.

A third action is to tighten the criteria for bariatric surgery and to expand the screening of candidates. This is a complex and invasive procedure that has a huge physical and physiological impact and a sizable potential for complications. Not everyone benefits.

Many people have begun to draw analogies between preventing obesity and smoking cessation. Clearly, both are broad public health problems that require an integrated medical and public health approach. I'm certain there are lessons as we attempt to promote changes in people's behavior to reduce overweight. But obesity also has its own unique set of issues. The sooner we begin to define those issues and start effectively helping people achieve a healthy body weight, the better.



The Physician's Dilemma

By Robert F. Kushner, MD

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Editor, The American Medical Association's Brochure Series on Obesity Management

Today's physician is faced with an enormous dilemma. Statistically, two out of three adult patients and nearly two out of every ten children are overweight or obese and at risk for developing multiple chronic diseases that will need life long treatment. Although physicians are trained to treat the consequences of obesity – diabetes, high blood pressure, and elevated blood lipid levels, among others – they are woefully unprepared to treat or prevent the underlying causes.

Medicine, including its system of delivery and reimbursement structure, is geared toward addressing acute care problems that can be tended to in single ten minute office visits with provision of a prescription. Unfortunately, this structure is inconsistent with the delivery of care needed for the treatment of overweight and obesity. Herein lies the dilemma of healthcare for the most preventable cause of death over the coming decades.

At a time when government agencies, national medical organizations, and the media are increasingly focusing their attention on obesity, physicians and insurers have responded with – so far – unproductive answers. Whether due to lack of training, confidence, interest, time or knowledge, physicians do not often view their patients' obesity as a medical problem that they need to address. The prevailing view, sadly, is that it's the patients' fault or responsibility that they are gaining weight and therefore, the patient needs to take responsibility and do something about it.

Even though the recently released U.S. Preventive Services Task Force recommended that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults, it is difficult to appreciate how this recommendation will be implemented given current attitudes, practice behaviors and time constraints among primary care physicians.

For the insurers' part, obesity still remains an 'excluded benefit' for many patients, forcing individuals to pay out of pocket for treatments and solutions that are guided by fad diets, commercial programs and internet support groups. If a physician chose to become involved in the patient's obesity care, the insurance company would not likely cover the visits and the anti-obesity medication prescribed. One of the most frustrating barriers for some patients is obtaining coverage for bariatric surgery. Due to an avalanche of surgical requests, many insurance companies are either denying coverage entirely or putting up roadblocks in the approval process.

There are no easy solutions. Physicians must become engaged in the delivery of obesity care and insurers must provide better benefits. This will require creative changes for both groups. A recently released Primer for Physicians on the Assessment and Management of Adult Obesity by the American Medical Association (www.ama-assn.org/ama/pub/category/10931.html) is a step forward. It provides physicians with the strategies, skills and tools needed to offer obesity care. For their part, insurers and health plans need to partner with employers, patients and physicians to develop incentives to prevent and treat obesity. Working together, physicians and insurers must build the care systems needed to promote integrative services for obese individuals, incorporating dietitians, health psychologists and exercise specialists. Nothing short of a team approach will meet the challenges this population presents.

Many people have begun to draw analogies between preventing obesity and smoking cessation. Clearly, both are broad public health problems that require an integrated medical and public health approach. I'm certain there are lessons as we attempt to promote changes in people's behavior to reduce overweight. But obesity also has its own unique set of issues. The sooner we begin to define those issues and start effectively helping people achieve a healthy body weight, the better.



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