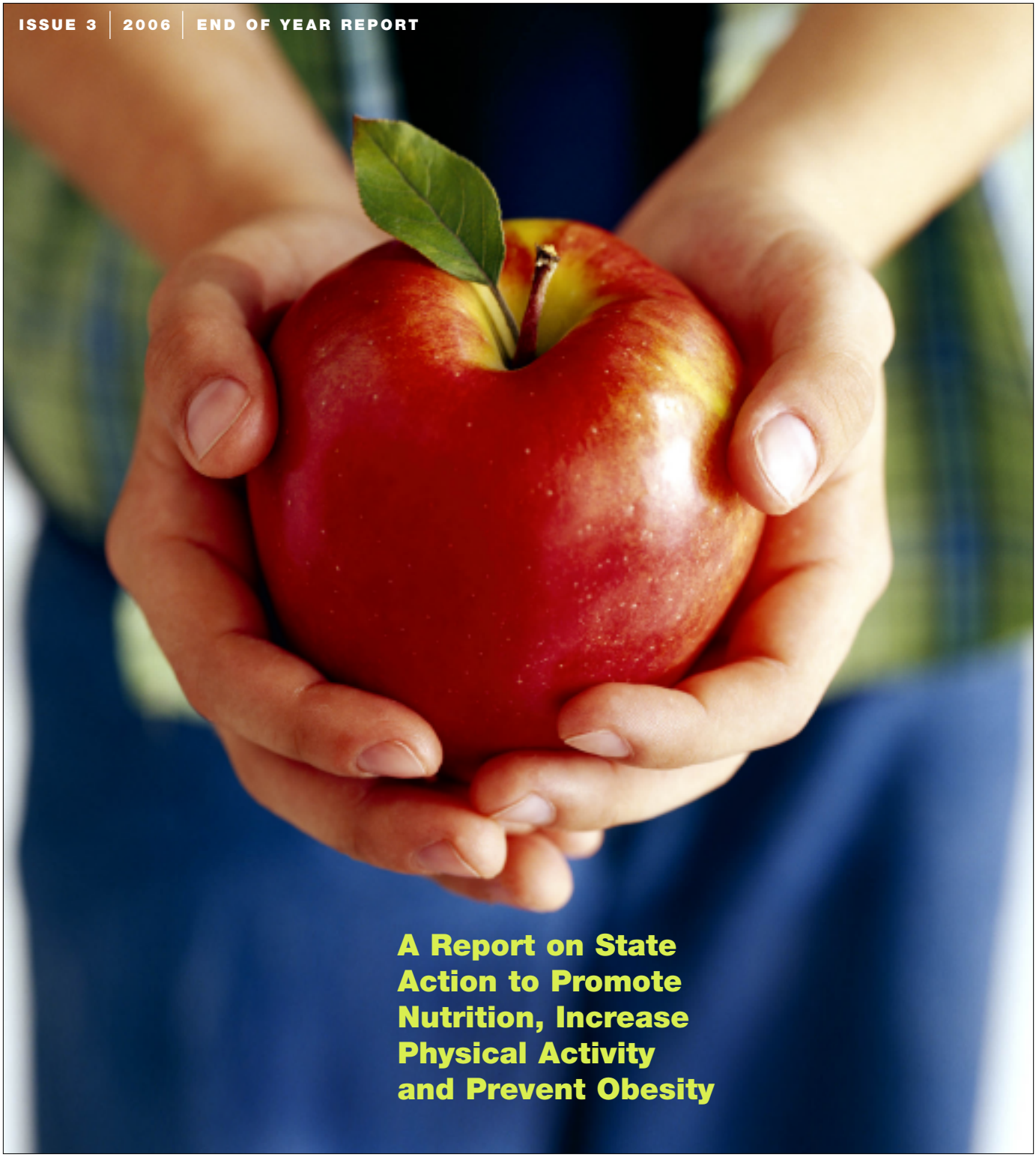
Robert Wood Johnson Foundation

BALANCE

ISSUE 3 | 2006 | END OF YEAR REPORT



A Report on State Action to Promote Nutrition, Increase Physical Activity and Prevent Obesity

Produced by Health Policy Tracking Service, a service of Thomson West.

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CONTENTS

Introduction

In the past three decades, the prevalence of overweight and obesity has soared to epidemic proportions. Today 66 percent of U.S. adults and more than 33 percent of children and adolescents fall into the top two weight categories as defined by the Centers for Disease Control and Prevention (CDC). Those categories are defined as "obese" and "overweight" for adults, and as "overweight" and "at risk of overweight" for children. Since 1976 the percentage of overweight children ages 6 to 11 has nearly tripled and the percentage of overweight adolescents ages 12 to 19 has more than tripled (see table on page 5).[1,2]

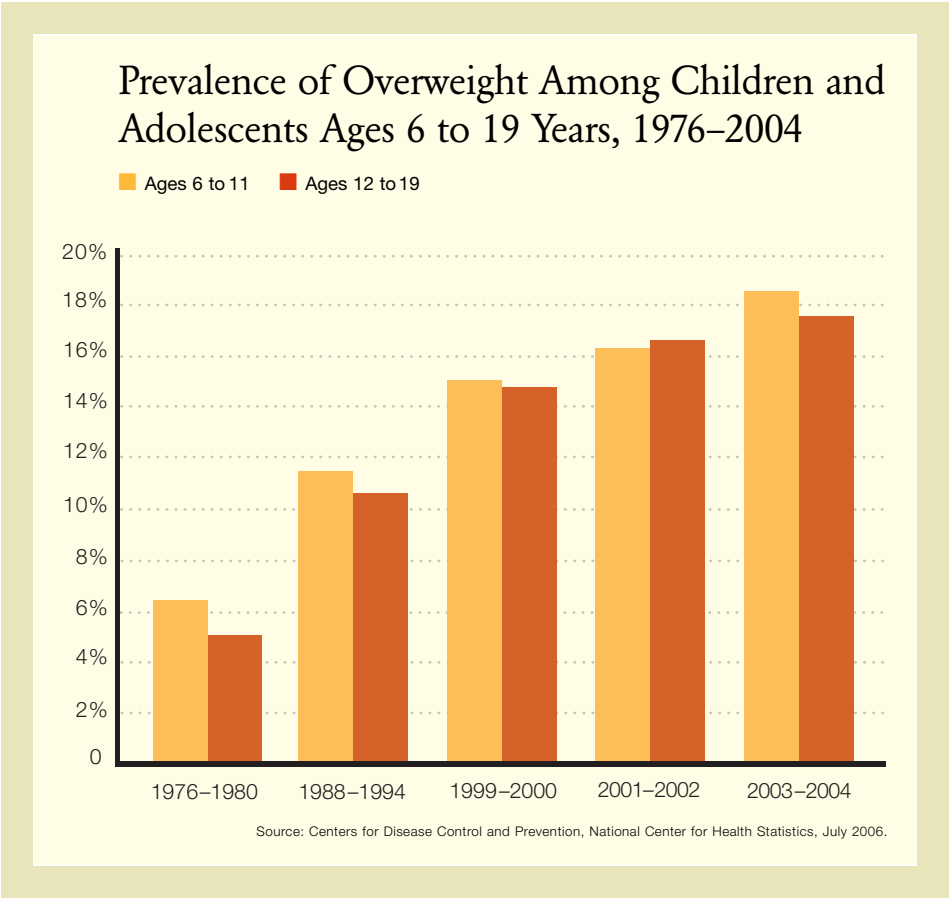
Overweight children and adolescents are 70 to 80 percent more likely to become overweight or obese in adulthood. The health risks associated with overweight and obesity are serious, and include chronic diseases such as high blood pressure, high cholesterol, type 2 diabetes and heart disease. The incidence of type 2 diabetes, once considered adult-onset diabetes, has dramatically increased among children in recent years. Other health consequences include a greater risk of low self-esteem, depression and asthma.[3]

There is also concern that the childhood obesity epidemic could further contribute to rising health care costs. The annual health care costs (direct and indirect) associated with overweight and obesity have put additional strain on state and federal government budgets:

1 National Center for Health Statistics. *Prevalence of Overweight and Obesity Among Adults: United States, 2003–2004* (2006), available at *http://www.cdc.gov/nchs/products/pubs/pubd/hestats/obese03_04/overwght_adult_03.htm.*

2 National Center for Health Statistics. *Prevalence of Overweight Among Children and Adolescents: United States, 2003–2004* (2006), available at *http://www.cdc.gov/nchs/products/pubs/pubd/hestats/obese03_04/overwght_child_03.htm.*

3 Office of the Surgeon General. *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity* (2001), available at *http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_adolescents.htm.*



- The annual hospital costs related to treating childhood obesity from 1979 to 1981 were $35 million, calculated in 2001 dollars. That number increased to $127 million from 1997 through 1999.[4]
- The total cost of obesity in the United States in 2000 was estimated at $117 billion. This amount includes $61 billion for direct medical costs and $56 billion for indirect costs such as loss of productivity, absenteeism and income lost due to related morbidity or premature mortality.[5]
- Annually $33 billion in medical costs and $9 billion in lost productivity due to heart disease, cancer, stroke and diabetes are attributed to diet.[6]
- Estimates indicate that providing medical treatment to obese Americans has cost the country $75 billion, of which taxpayers pay more than half through the nation's Medicare and Medicaid programs.[7]

[4] Office of the Surgeon General. *Preventing Obesity and Chronic Diseases Through Good Nutrition and Physical Activity* (2005), available at *http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/obesity.htm.*

[5] *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity.* Washington: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General (2001), available at *http://www.surgeongeneral.gov/topics/obesity/calltoaction/toc.htm.*

[6] National Center for Chronic Disease Prevention and Health Promotion. *Overweight and Obesity: Economic Consequences* (2004), available at *http://www.cdc.gov/nccdphp/dnpa/obesity/economic_consequences.htm.*

[7] Finkelstein EA, Fiebelkorn IC and Wang G. "State-Level Estimates of Annual Medical Expenditures Attributable to Obesity." *Obesity Research*, 12: 18–24 (2004).

The alarming health and economic implications of the obesity epidemic have ignited government intervention on the state and federal level during the past four years. Between 2003–2005, the main focus of state legislation and policies was on nutrition and physical education in schools. Although this approach continued to be a central theme of obesity prevention efforts, in 2006 the state focus moved toward more comprehensive, multidimensional strategies that are in line with the recommendations of leading public health advocates. While 2005 was a sentinel year for state initiatives targeting childhood obesity, 2006 was a significant year for industry and local initiatives. This end-of-year edition of *BALANCE* summarizes both the key legislative and non-legislative actions and trends of 2006.

School Nutrition

Overview

Because of nutrition's proven impact on weight, health and academics, many lawmakers continue to focus on instilling lifelong healthy behaviors in children by encouraging or mandating improved nutrition in state public school systems. Studies show that soft drink and fat consumption among adolescents has increased since the 1970s. Advocates contend that this is due in part to an increase in the availability of competitive foods and beverages in schools that tend to be high in fat and added sugar and low in nutrients. They stress that the availability of such products also contradicts health and nutrition education classes.[1]

Studies demonstrate that the presence of à la carte foods and vending machines in schools, common venues for competitive foods and foods of minimal nutritional value (FMNV), are associated with less fruit and vegetable consumption.[2, 3] As students spend a significant amount of time in school, advocates emphasize the important role of schools in promoting, facilitating and teaching lifelong healthy eating habits. Although the American Dietetic Association promotes a balanced healthy diet that includes eating all foods in moderation, they also advocate for ensuring that all foods available and consumed by children in schools are consistent with Recommended Daily Allowances (RDA) and Dietary Guidelines for Americans, and contribute to the development of lifelong healthy eating habits.[1]

1 American Dietetic Association. *Local Support for Nutrition Integrity in Schools* (2000), available at *http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/advocacy_3779_ENU_HTML.htm.*

2 Kubik MY, Lytle LA, Hannan PJ, et al. "The Association of the School Food Environment with Dietary Behaviors of Young Adolescents." *American Journal of Public Health*, 93(7): 1168–1173 (2003).

3 St-Onge MP, Keller KL, Heymsfield SB. "Changes in Childhood Food Consumption Patterns: A Cause for Concern in Light of Increasing Body Weights." *American Journal of Clinical Nutrition*, 78: 1068-1073 (2003).

The food and beverage industries historically have opposed state school nutrition legislation that restricts access to or the sale of certain foods and beverages, emphasizing that a healthy diet can include all foods and beverages in moderation. However, in the past year many associations and companies have altered their positions and taken initiatives of their own to reduce and prevent obesity. Many industry leaders and local school officials still maintain that school nutrition decisions should be made at the local, not state level. Without the additional revenue generated from partnerships between food and beverage companies and schools, funding for certain school activities such as physical education, athletics, art and music classes, may be in jeopardy.

Some lawmakers argue that school nutrition is a local issue to be overseen by local school administrators, school boards and parents. Others maintain that the government, which incurs a significant portion of the rising health care costs, should intervene in the obesity crisis by facilitating healthy lifestyles, particularly in schools. Despite the controversial debate over school nutrition, the Health Policy Tracking Service (HPTS) has seen significant federal and state activity in the past several years.

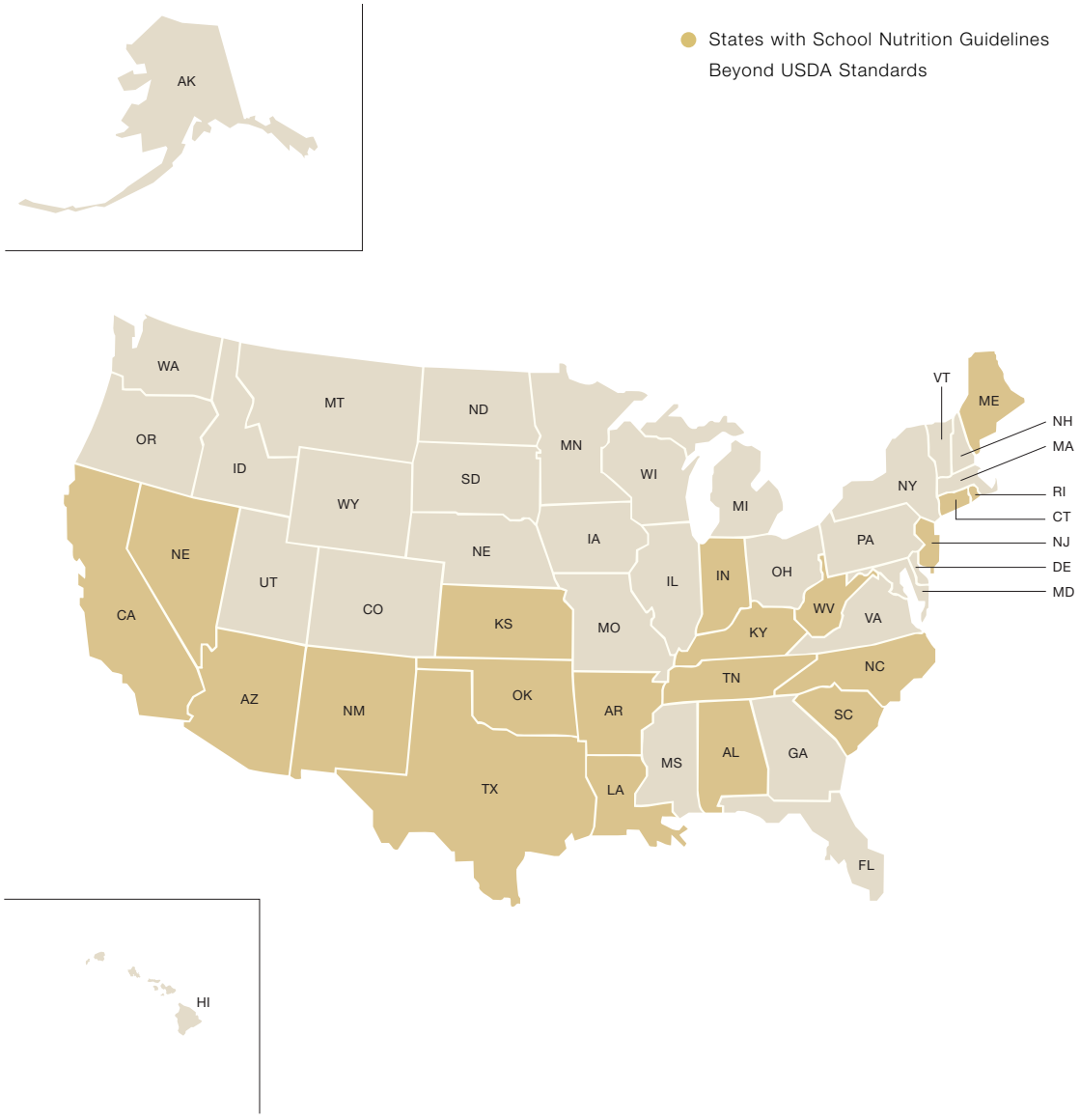
Since 2003 at least 20 states–**Alabama, Arizona, Arkansas, California, Connecticut, Indiana, Kansas, Kentucky, Louisiana, Maine, Nevada, New Jersey, New Mexico, North Carolina, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas** and **West Virginia**–have adopted school nutrition guidelines beyond those required by the USDA through legislative bills, executive orders, rules and regulations (see next page).

The leading policy initiatives to improve nutrition among children include the following elements:

- Establishing nutritional standards for foods and beverages sold in schools.
- Restricting access to and sales of competitive foods and beverages.
- Increasing and promoting access to fresh produce in schools.
- Developing model policies and programs.
- Establishing school wellness committees, councils or task forces.
- Encouraging state and local education officials to take action.

In the past three years more and more school districts across the country are beginning to restrict the sales of less nutritious food and beverage items and replace them with healthier options.

States with School Nutrition Guidelines Beyond USDA Standards



Source: Health Policy Tracking Service, a service of Thomson West, Nov. 2006

Memorandum of Understanding

While in recent years legislative action has dominated efforts to prevent childhood obesity, perhaps the most significant actions taken in 2006 were two non-legislative agreements between public health advocates and the food and beverage industry.

In May the Alliance for a Healthier Generation–a joint initiative of the William J. Clinton Foundation and the American Heart Association–reached a monumental agreement–a Memorandum of Understanding (MOU) with the American Beverage Association; Cadbury Schweppes Americas Beverages; The Coca-Cola Company; and PepsiCo, Inc., to set a new school beverage policy nationwide. In October the Alliance reached another agreement with Campbell Soup Company; The Dannon Company, Inc.; Kraft Foods Global, Inc.; Masterfoods USA (a division of Mars, Inc.); and PepsiCo, Inc., to establish nutrition guidelines for competitive foods sold in schools.[4,5,6]

The policies strive to provide schoolchildren with healthier foods and beverages. However, the implementation of the guidelines is voluntary and relies on all involved parties–bottlers, independent food and beverage companies, manufacturers and distributors, contract operators, vending brokers, vending service companies, schools and school districts–to support and adopt the guidelines, and when applicable, to amend existing contracts or sign new agreements.

Parties who adopt the beverage guidelines agree to only supply schools with beverages as follows:

- *Elementary schools:* Only bottled water, low- and nonfat milk and milk alternatives (not to exceed 150 calories per 8-ounce serving) and 100 percent juice with no added sweeteners (not to exceed 120 calories per 8-ounce serving).
- *Middle schools:* Same guidelines as elementary schools except serving sizes must not exceed 10 ounces.
- *High schools:* Bottled water, low- or no- calorie beverages (not to exceed 10 calories per 8-ounce serving), low- and nonfat milk and milk alternatives (not to exceed 150 calories per 8-ounce serving), 100 percent juice with no added sweeteners (not to exceed 120 calories per 8-ounce serving) and light juices and sports drinks (not to exceed 66 calories per 8-ounce serving). Serving sizes for milk, juices and sports drinks must not exceed 12 ounces, and at least 50 percent of beverages available for sale must be water and low- or no-calorie options.[7]

4 William J. Clinton Foundation, Alliance for a Healthier Generation. "Clinton Foundation and American Heart Association and Industry Leaders Set Healthy School Beverage Guidelines for U.S. Schools" (Press Release, May 3, 2006), available at *http://www.clintonfoundation.org/050306-nr-cf-hs-hk-usa-pr-healthy-school-beverage-guidelines-set-for-united-statesschools.htm.*

5 President Clinton and American Heart Association Announce Joint Agreement Between Alliance for a Healthier Generation and Food Industry Leaders to Set Healthy Standards for Snacking in School" (Press Release, Oct. 6, 2006), available at *http://www.healthiergeneration.org/docs/snack-press-release.pdf.*

6 Alliance for a Healthier Generation. *Memorandum of Understanding* (2006), available at *http://www.healthiergeneration.org/docs/MOU-snack-food.pdf.*

7 William J. Clinton Foundation. *School Beverage Policy* (2006), available at *http://www.clintonfoundation.org/cf-pgm-hs-hk-work1.htm.*

Parties who adopt the competitive food guidelines agree to only supply schools with competitive foods that meet one of the following criteria:

1. Any fruit with no added sweeteners or vegetables that are non-fried.
2. Any reduced-fat cheese less than or equal to 1.5 ounces.
3. Any one egg or equal egg equivalent with no added fat.
4. Any other food that meets all of the following criteria:
    a. No more than 35 percent of calories from fat except nuts, nut butters and seeds;
    b. No more than 10 percent of calories from or one gram of saturated fat;
    c. No trans fat;
    d. No more than 35 percent sugar by weight;
    e. No more than 230 mg of sodium;
    f. If a dairy product, must be low- or nonfat dairy; and
    g. No more than 100 calories for all grade levels except for foods that contain essential nutrients (as defined by minimum amounts of certain vitamins, minerals, fiber, protein, fruits or vegetables). Those foods may contain up to 150 calories in elementary schools, 180 calories in middle schools, and 200 calories in high schools.

The MOU also provides certain special exemptions and requirements for fat and sodium content of various items.[8]

The guidelines are intended to apply to all foods and beverages sold on school grounds during the regular and extended school day. However, they do not apply to school-related events where parents and adults are a significant part of the audience or are selling food and beverages as boosters during intermission or immediately before or after such school-related events (e.g., sporting events, school plays and band concerts).

8 Alliance for a Healthier Generation. *Guidelines for Competitive Foods Sold in Schools to Students* (2006), available at *http://www.healthiergeneration.org/docs/snack-food-guidelines.pdf.*

The goal for the beverage guidelines is implementation in 75 percent of schools by the 2008–2009 school year, and in all schools by the 2009–2010 school year. The goal for implementation of competitive food guidelines is to work together toward ensuring that all schools adopt the policy and offer students only competitive foods that meet the guidelines. To achieve these goals, the Alliance and all signatories are working together to encourage all involved parties to support and adopt the policy. In addition to supporting the guidelines, the five food industry signatories have agreed to product reformulation and new product development to meet the guidelines and, in doing so, to facilitate compliance with the policy.

To monitor progress of the beverage policy implementation, an independent third-party, Dr. Robert Wescott, will conduct an annual analysis. The first report will be published in August 2007 and will include analyses of all beverage sales to students and the percentages of school and school district contracts that comply with the policy.

For competitive foods, the Alliance and signatory companies will create a baseline report with an analysis of the types and availability of competitive foods offered for sale to students by December 2007. It is not yet determined who will conduct the analysis, or how the data will be collected. The Alliance will conduct a similar biennial analysis and comparison through December 2011 on the impact and implementation of the guidelines. In the future, the Alliance plans to develop guidelines targeting à la carte entree items and reimbursable meals.

Although the policy is not mandated and relies on involved parties to comply voluntarily, the majority of the reactions to these efforts have been positive and supportive. Both the Institute of Medicine and the CDC lauded the parties for their efforts and for developing sound evaluation procedures.[9] The agreement also has motivated the food and beverage industry to develop new snack items that meet the guidelines and healthier beverage alternatives to soft drinks, such as flavored waters, fruit drinks and sports drinks. Many school districts have already implemented stringent nutritional guidelines as a result of statewide policies or federally-mandated local school wellness policies. The guidelines and the strong partnership between leading public health advocates and industry leaders demonstrate further national support for school-based policies that provide healthier options for children.

[9] Alliance for a Healthier Generation, Centers for Disease Control and Prevention. "Statement on Action by U.S. Beverage Distributors to Restrict Soft Drink Marketing in Schools" (Press Release, May 3, 2006), available at *http://www.healthiergeneration.org/docs/afhg_cdc_beverage_press_release_05-03-06.pdf.*

2006 State Legislative Activity

The past year was marked by considerable legislative activity on school nutrition, with many states preparing to comply with the provisions of the Child Nutrition and WIC Reauthorization Act of 2004, which requires every school district that participates in the National School Lunch Program to have adopted a local school wellness policy that promotes healthy nutrition and physical activity by July 1, 2006.[10, 11]

- Thirty-one states introduced or carried over school nutrition legislation.
- Eleven states adopted legislation.
- Two states vetoed legislation (see map on following page).

Setting Nutrition Standards

Of the 31 states, at least 23 introduced or carried over legislation that would establish or amend school nutrition standards. The states include **Alaska, Arizona, California, Colorado, Connecticut, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Maryland, Massachusetts, Mississippi, Missouri, New Jersey, Pennsylvania, New York, Rhode Island, Vermont, Virginia, West Virginia** and **Wisconsin**. A brief description of each state effort is provided below:

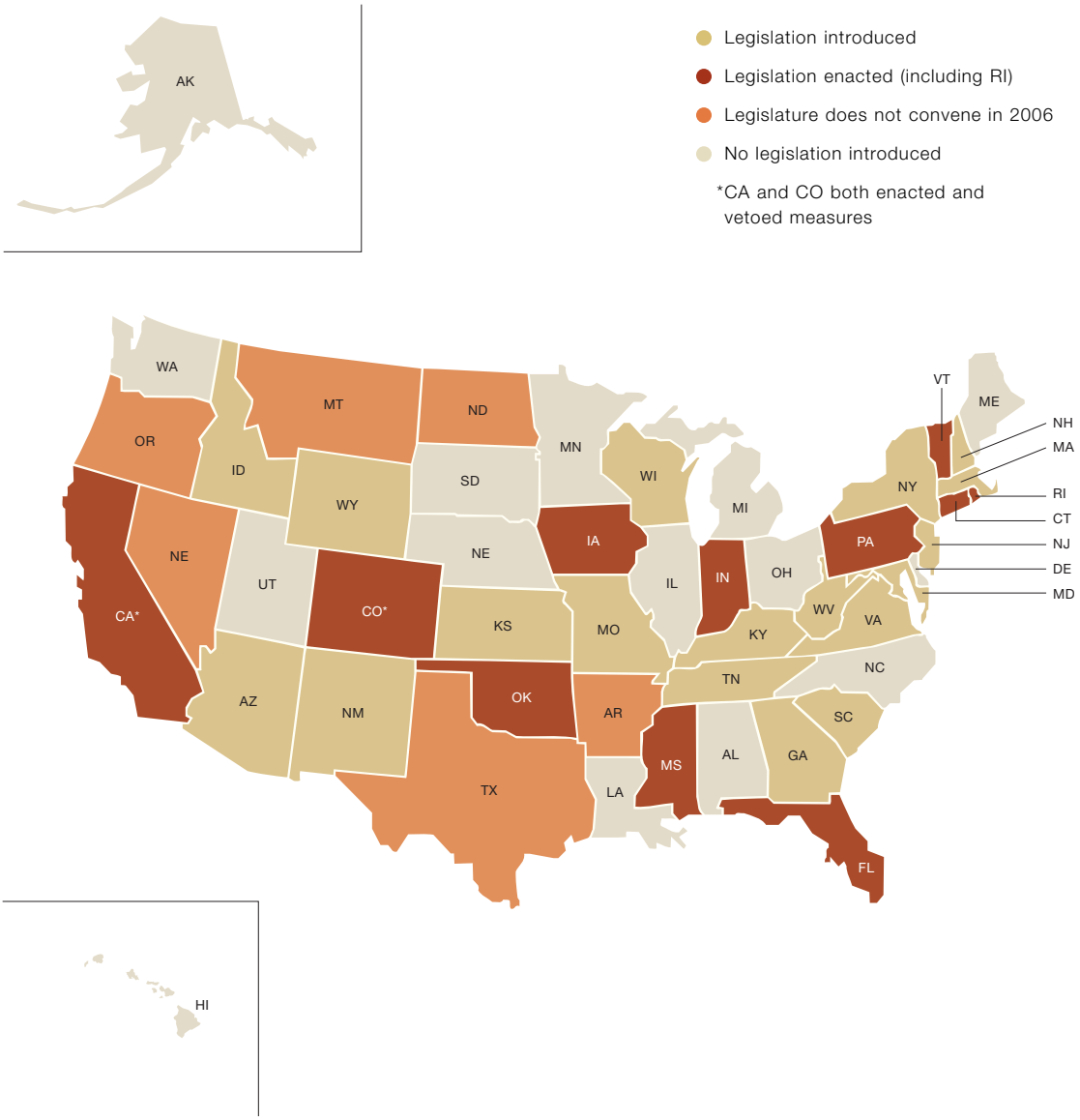
Early in 2006 **Indiana** Gov. Mitch Daniels (R) signed a school wellness bill, S.B. 111. The measure prohibits elementary school students from having access to vending machines and requires that at least 50 percent of competitive foods and beverages sold in schools qualify as "better choice foods" and "better choice beverages," as defined in the bill language, by Sept. 1, 2007.

In 2005 **Connecticut** Gov. M. Jodi Rell (R) vetoed a controversial bill with sweeping school nutrition and physical activity mandates, citing her strong support for local control of schools and parental participation. After a year-long debate, the governor, the state Senate and the state Department of Education (D.O.E.) reached an agreement in February on a legislative proposal for school nutrition, S.B. 373. In May Gov. Rell signed the bill, An Act Concerning Healthy Food and Beverages in Schools. The new law contains the following beverage provisions, which are among the country's most stringent because it applies the same guidelines to all school levels:

[10] U.S. House of Representatives Committee on Education and the Workforce. *The Child Nutrition and WIC Reauthorization Act Update* (July 2004), available at *http://edworkforce.house.gov/democrats/hr3873cnupdate.html.*

[11] USDA's Food and Nutrition Service. *Local School Wellness Policy Requirements*, available at *http://teamnutrition.usda.gov/Healthy/wellness_policyrequirements.html.*

2006 School Nutrition Legislation



Source: Health Policy Tracking Service, a service of Thomson West, Nov. 2006

- Restricts beverage sales to students from any source (e.g., school stores, cafeterias, vending machines or fundraising activities on school premises) to only low- and nonfat milk, nondairy milk, 100 percent fruit and vegetable juices and water.
- Allows local boards of education to permit the sale of other beverages to students as long as the sale takes place after school or during weekend school-sponsored events.

While lawmakers continue to allow for local control over food sold in schools, they provide a unique financial incentive for schools to offer healthy foods. The state D.O.E. was required to publish nutrition standards for food items, and those were released in August. School districts participating in the National School Lunch Program must report to the Department each year on whether they will offer only food items that meet the new standards. Districts that do so will receive from the state an additional 10 cents per lunch– a substantial increase from the current rate of 5 cents per lunch.

In **Rhode Island**, Gov. Donald Carcieri (R) signed two identical bills to establish school nutrition guidelines on food and beverages, S.B. 2696 and H.B. 6968. The new law requires all state elementary, middle and junior high schools that sell or distribute beverages and snacks on school grounds to offer healthier beverages, effective Jan. 1, 2007, and healthier snacks, effective Jan. 1, 2008. The new law defines healthier beverages as the following:

- Water, including carbonated water, flavored or sweetened with 100 percent fruit juice and containing no added sweetener.
- Low- and nonfat milk and milk alternatives with no more than four grams of sugar per ounce.
- 100 percent fruit juice and fruit- and vegetable-based drinks with no less than 50 percent fruit or vegetable juice and no added sweetener.

Healthier snacks are defined as the following:

- Individually sold portions of nuts, nut butters, seeds, eggs, cheese packaged for individual sale, fruit, vegetables that have not been deep-fried and legumes.

- Individually sold portions of low-fat yogurt with no more than four grams of total carbohydrates (natural and added) per ounce and reduced fat or low-fat cheese packaged for individual sale.
- Individually sold enriched grain products or whole grain food items that contain no more than 30 percent of total calories from fat, no more than 10 percent of total calories from saturated fat, and no more than seven grams of total sugar per ounce.

The standards will not apply to items sold by students at least one hour after the end of the school day or off school grounds or to items sold during a school-sponsored activity after school.

Among its many provisions, **Pennsylvania** H.B. 185 imposes restrictions on competitive food and beverage contracts. The bill also would have required every local education agency that participates in the National School Lunch Program to review the nutritional value of and adopt nutritional guidelines for all foods and beverages available during the school day, but that provision was removed at the last minute. Gov. Edward Rendell (D) signed the bill on July 11.

Developing Local Wellness Policies

The Child Nutrition and WIC Reauthorization Act of 2004, which requires the establishment of local school wellness councils and policies, leaves considerable authority to the states and localities to determine what should be included in each policy.

In the past two years many states considered legislation to help guide school districts in their efforts to comply. Some states considered legislation to add state requirements in conjunction with the federal requirements. This year lawmakers in at least eight states–**Florida, Georgia, Indiana, Massachusetts, Mississippi, New York, Oklahoma** and **Pennsylvania**–introduced legislation to assist or set requirements for school districts in establishing wellness councils and policies. Much of the legislation provides guidance for both nutrition and physical activity. Florida, Indiana, Mississippi, Oklahoma and Pennsylvania enacted bills. The table below details the bills that were enacted. While the **New Mexico** Legislature did not consider such legislation, Gov. Bill Richardson (D) approved the statewide school nutrition and wellness rules that included guidelines for local school wellness policies.

2006 Enacted Legislation to Develop Local School Wellness Policies

Florida

FL SB 772

Requires each school district to submit to the Department of Education (D.O.E.) a copy of its school wellness policy and its physical education policy by Sept. 1, 2006.

Requires the D.O.E. to post Web site links to each district's policies by Dec. 1, 2006.

Requires the D.O.E. to provide Web site links to examples of school wellness policies.

STATUS: 06/26/2006—Signed.

Indiana

IN SB 111

Requires each school board to establish a coordinated school advisory council to develop a local wellness policy that complies with federal requirements.

Directs the D.O.E. to provide information concerning health, nutrition and physical activity to the councils.

STATUS: 03/15/2006—Signed.

Mississippi

MS HB 319

Directs local school districts to establish local school health councils and wellness policies in accordance with the federal requirements.

STATUS: 03/15/2006—Signed.

Oklahoma

OK SB 1459

Requires the state departments of Education and Health to assist the Healthy and Fit School Advisory Committees by making information and technical assistance available to schools for use in establishing healthy school nutrition environments, reducing childhood obesity, developing physical education and activity programs, preventing diet-related chronic diseases and establishing school wellness policies.

STATUS: 04/24/2006—Signed.

Pennsylvania

PA HB 185

Requires each local education agency to establish a local wellness policy by June 30, 2006.

Establishes an interagency coordinating council for child health and nutrition to annually review and revise the Pennsylvania nutrition and activity plan to prevent obesity and related chronic disease. The plan must include recommendations regarding local wellness policies.

Establishes local advisory health councils to provide recommendations on the development of local wellness policies.

STATUS: 07/11/2006—Signed.

Source: Health Policy Tracking Service, a Thomson West Business, Nov. 2006

Establishing Committees, Councils and Task Forces

Instead of mandating school nutrition standards, several states considered legislation to appoint statewide or local committees, councils or task forces to study the issues and formulate recommendations. In 2006 at least 10 states– **California, Iowa, Maryland, Massachusetts, Missouri, New Hampshire, New Mexico, Oklahoma, Pennsylvania** and **Tennessee**–introduced or carried over such legislation. Iowa, Oklahoma, Pennsylvania and Tennessee enacted bills.

In **Iowa**, Gov. Thomas Vilsack (D) signed S.B. 2251, directing the departments of Education and Public Health to establish a 24-member healthy children taskforce. The taskforce will assess current policies affecting the health of children, particularly those pertaining to physical activity and nutrition, and will develop and submit policy recommendations by Jan. 1, 2007.

Oklahoma lawmakers approved H.B. 2655 calling for a 15-member Farm-to-School Taskforce to study the barriers of implementing a Farm-to-School Program and to recommend resolutions in a report to state lawmakers by Dec. 31, 2006.

In June **Tennessee** lawmakers enacted a carry-over measure, the Child Nutrition and Wellness Act of 2005. The law directs the commissioner of health to appoint an advisory council to advise him and the Office of Child Nutrition and Wellness on child nutrition and wellness issues. The council will meet quarterly and is responsible for the following:

- Advocating for the wellness of children and recommending forums, programs and initiatives to educate the public regarding child nutrition and wellness.
- Developing nutrition and physical activity standards for children.
- Gathering data on child nutrition and wellness.
- Developing a comprehensive long-term strategy to promote child nutrition and wellness in various settings, including schools, child-care centers, health care facilities and community settings.

Pennsylvania H.B. 185, enacted in July, contains a provision for the establishment of an interagency coordinating council for child health and nutrition to annually review and revise the state's nutrition and activity plan to prevent obesity and related chronic diseases. The plan will include recommendations regarding physical education and nutrition guidelines for food and beverages sold in schools. The bill also calls for the secretary of education to establish an advisory committee to offer recommendations to the council.

Increasing Access to Fresh Produce

In 2006 there was an increase in the number of bills aimed at promoting access to fresh fruits and vegetables in schools, rather than restricting access to certain foods. At least eight states introduced such legislation, including **Arizona, California, Colorado, Connecticut, Iowa, Oklahoma, Pennsylvania** and **Vermont**. In **Colorado**, for instance, Gov. Bill Owens (R) signed a bill in May to implement a pilot program to increase students' access to fresh fruits and vegetables in participating schools. **Vermont** and **Oklahoma** lawmakers enacted bills that create farm-to-school programs to support farms and to promote healthy eating and nutrition education in schools. The table that follows highlights the enacted legislation.

2006 Enacted Legislation to Increase Access to Fresh Produce

California

CA HB 1535

Amends law on the Instructional School Garden Program.

STATUS: 09/25/2006—Signed.

Colorado

CO SB 127

Creates a pilot program to make free fruits and vegetables available to students throughout the school day in participating schools.

STATUS: 05/25/2006—Signed.

Oklahoma

OK HB 2655

Establishes the Oklahoma Farm-to-School Program Act.

STATUS: 05/26/2006—Signed.

Vermont

VT HB 456

Establishes a mini-grant program for schools to develop farm-to-school connections and to teach nutrition education.

STATUS: 05/15/2006—Signed.

Source: Health Policy Tracking Service, a Thomson West Business, Nov. 2006

Promoting School Nutrition

Rather than mandating action, lawmakers in several states introduced legislation to promote school nutrition. Examples include urging education officials to establish nutrition policies, providing incentives to promote school nutrition, developing model policies to serve as local guidance, etc. In 2006 **Connecticut, Florida, Georgia, Hawaii, Iowa, Massachusetts** and **New Hampshire** considered such legislation. Bills were enacted in Connecticut and Florida.

Instead of mandating schools to offer healthy foods, **Connecticut** S.B. 373 will provide a financial incentive for school districts that choose to offer only food items that meet the state D.O.E.'s nutrition guidelines.

In **Florida** lawmakers approved H.R. 9095, designating the 2006–2007 school year as Healthy School Lunch Year. The bill urges all school districts and parents of schoolchildren to emphasize the importance of healthy eating, and provide daily diets consisting of fruits, vegetables, whole grains and legumes.

Vetoed Legislation

Current law in **Colorado** encourages school districts to ensure that at least 50 percent of items available for sale in school vending machines meet acceptable nutritional standards. House Bill 1056 would have mandated the 50 percent threshold for vending machine items. However, Gov. Bill Owens (R) vetoed the bill, saying, "Though I am in favor of efforts to improve the physical and nutritional lifestyles of Colorado's children, I cannot support legislation that micromanages school districts and their policies. Currently 12 percent of school districts have already voluntarily adopted those recommendations. As current contracts for vending machine contents expire, I trust that school boards will continue to provide increased healthy options to students. It is, however, a decision that is best left to local school districts to make."

California Gov. Arnold Schwarzenegger (R), a strong proponent for health and wellness initiatives who signed a major school nutrition legislative package in 2005, vetoed H.B. 469. The bill would have required the state D.O.E. to maintain the existing nutritional guidelines for all schools and to add guidelines for sugar and sodium. In his veto message, the governor said, "Simply revising state-level guidelines without any implementation or enforcement mechanism does not address the proliferation of unhealthy foods in any effective or timely manner… I would welcome a bill next year that attempts to increase the quality of food served on California school campuses by eliminating meals with unhealthy trans fats and those foods fried in unhealthy oils, as much as practically possible." He vetoed a similar bill in 2005 for the same reason.

Pending Legislation

New Jersey and **Virginia** will carry over legislation to the 2007 session. Bills of interest include one in New Jersey to codify the Department of Agriculture's model school nutrition policy, S.B. 1218. The bill passed the Senate and remains in the House for further consideration. The Virginia Legislature, which has been reluctant to make such decisions at a state level, will carry over two identical bills that would establish school nutrition guidelines and require superintendents to receive instruction in childhood obesity and prevention.

Rules and Regulations

In addition to legislative initiatives, **Arizona's** and **New Mexico's** D.O.E.s finalized their school nutrition rules, while the **Illinois** Legislature blocked the state Board of Education's adopted rules. In accordance with the law passed last year, the **Arizona** D.O.E. released the finalized version of *The Arizona Nutrition Standards*, which include restrictions on the fat, sugar and caloric content of foods; beverages available for sale; and maximum portion sizes for food and beverage items.

New Mexico Gov. Bill Richardson (D) approved the final version of school nutrition and wellness rules, proposed by himself and the Public Education Department as part of his Healthy Kids initiative. The final nutrition rules prohibit food vending machines in elementary schools, set strict nutritional content standards for food vending machines and fundraisers in middle and high schools, limit à la carte food items and establish stringent beverage regulations for all school levels.

Despite a defeated proposal in the 2004 legislative session, **Illinois** Gov. Rod Blagojevich (D) renewed his efforts in late 2005 to restrict the sale of unhealthy foods and beverages in schools by urging the state board of education to take action. In March the board adopted rules to ban junk food and soft drinks during the school day in elementary and middle schools effective for the 2006–2007 school year. However, upon receiving notice of the adopted rules, the state's Joint Committee on Administrative Rules took the unusual action of blocking the plan. The legislative committee explained that they support the proposal but that the rules should address the nutrition of cafeteria items and meals, not just that of competitive foods and beverages. The board hopes to revise and adopt a new proposal.[12,13]

[12] The Associated Press. "Legislators Block Illinois Junk Food Ban from Taking Effect." *The Washington Post*, April 11, 2006.

[13] Illinois State Board of Education. "ISBE Adopts Gov. Blagojevich's Proposal to Ban Junk Food in Illinois Elementary and Middle Schools" (Press Release, Mar. 16, 2006), available at *http://www.isbe.net/news/2006/mar16a.htm.*

Conclusion

Given the impact of nutrition on wellness and academics, many states have proposed legislation supporting improved nutrition in public schools. Legislation has typically proposed one of the following: establishing nutritional standards for foods and beverages sold in schools; restricting access to and sales of competitive foods and beverages; increasing and promoting access to fresh produce in schools; developing model policies and programs; establishing school wellness committees, councils or task forces; or encouraging state and local education officials to take action.

Perhaps the most significant actions taken on this front in 2006 were non-legislative agreements between public health advocates and the food and beverage industry that set a new school beverage policy nationwide and established nutrition guidelines for competitive foods sold in schools. These policies are intended to provide schoolchildren with healthier foods and beverages. However, the implementation of the guidelines is not mandatory and relies on all involved parties, including schools, to voluntarily support and adopt the policies. In concert, these agreements and new legislative proposals could lead to significant changes in school nutrition policies.

Health and Physical Education

Overview

Routine physical activity is just as important to children's weight, health and academic performance as good nutrition. Over the past two decades, children have become less physically active, in part because they engage in more sedentary activities. In recent years we have also witnessed a decreased emphasis on physical education in schools. Both factors contribute to the nation's rising obesity rate, and lawmakers have recently pushed legislation to address health and physical education in public schools.

Leading health advocates, including the CDC, Action for Healthy Kids and the National Association of State Boards of Education, recommend providing all children from pre-kindergarten through grade 12 with daily physical activity in schools and co-curricular physical activity programs.[1,2,3] In addition to enhancing physical education instruction, some lawmakers have sought to ensure that health education curricula includes nutrition and physical education instruction and teaches the importance of lifelong healthy eating habits and physical fitness.

1 National Center for Chronic Disease Prevention and Health Promotion. *Overweight and Obesity: Contributing Factors* (March 2006), available at *http://www.cdc.gov/nccdphp/dnpa/obesity/contributing_factors.htm*.

2 Action for Healthy Kids. *An Action for Healthy Kids Report: Criteria for Evaluating School-Based Approaches to Increasing Good Nutrition and Physical Activity* (Fall 2004), available at *http://www.actionforhealthykids.org/pdf/report_small.pdf.*

3 National Association of State Boards of Education. *Sample Policies to Encourage Physical Activity*, available at *http://www.nasbe.org/HealthySchools/Sample_Policies/physical_activity.html.*

Although most states require health and physical education to be provided as part of the public school curriculum, student participation may not be required, and enforcement of education requirements often remains at the local level. Facing annual budget constraints and pressure to meet academic standards, local and state education officials, school administrators and educators often express concern about legislative measures with health and physical education mandates. Such bills often do not provide for the increased funding needed to support the proposed enhancements, making them unpopular, unfunded mandates. School administrators and teachers also express concern that allotting more time for physical education and activity takes away from the time spent teaching core academic subjects. On the other hand, students and parents tend to support opportunities for increased physical education and activity in schools. On occasion, students have even lobbied state lawmakers in support of such measures.

Because the food and beverage industries, including the Grocery Manufacturers of America and the American Beverage Association, have been impacted by school nutrition legislation, they strongly support initiatives that focus on physical activity in efforts to reduce childhood obesity.[4,5]

During the past several years lawmakers have introduced a growing number of legislative proposals on childhood obesity and physical education. Given the July 2006 deadline for school districts to comply with the requirements of the Child Nutrition and WIC Reauthorization Act of 2004, more and more school districts across the country will begin to enhance physical education and increase opportunities for physical activity during school.

2006 State Legislative Activity

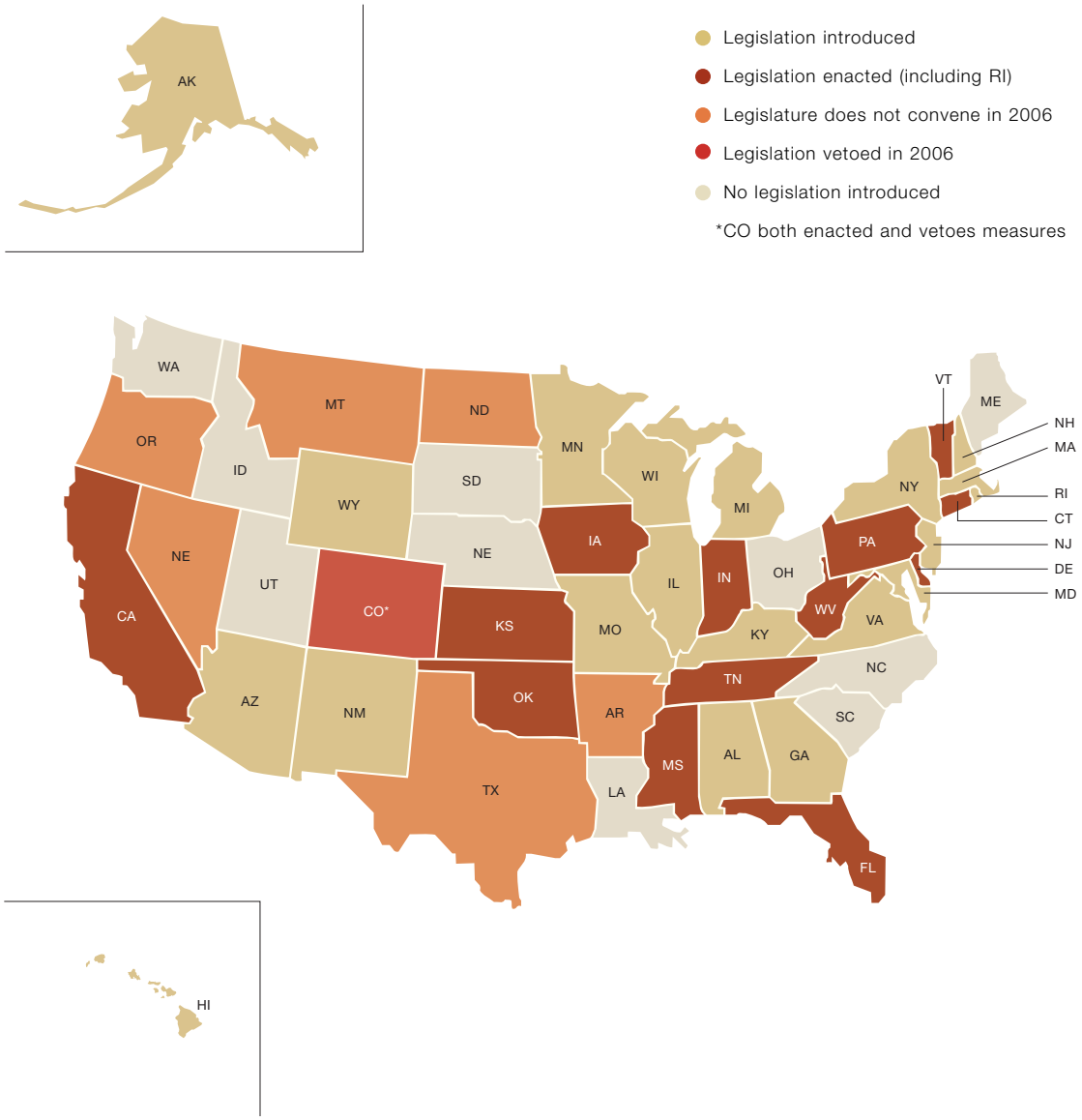
Lawmakers continue to introduce legislation that sets standards for health and physical education. In 2006 at least 34 states introduced or carried over legislation. Of those, 11 states have adopted legislation and one state has vetoed legislation (see map on next page).

- Thirty-four states introduced or carried over legislation.
- Thirteen states adopted legislation.
- One state vetoed legislation.

[4] Grocery Manufacturers of America. Public *Policy Priority Programs: Obesity*, available at *http://www.gmabrands.com/publicpolicy/obesity.cfm.*

[5] American Beverage Association. *School Partnerships: Are There Health Concerns?* Available at *http://www.ameribev.org/schools/health.asp.*

2006 Health and Physical Education Legislation



Source: Health Policy Tracking Service, a service of Thomson West, July 2006

Setting Health and Physical Education Standards

Of the 34 states that introduced measures, at least 19 states have considered legislation that sets health and physical education or physical activity standards in schools to help prevent obesity and improve fitness and wellness. The states include **Alabama, California, Connecticut, Florida, Georgia, Hawaii, Indiana, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New York, Oklahoma, Rhode Island, Tennessee** and **Virginia**. The proposed standards, however, vary significantly. While some of the legislation calls for specific duration, frequency and intensity requirements, other bills leave some control and flexibility to state or local education agencies.

Early in the year **Indiana** Gov. Mitch Daniels (R) enacted a school wellness bill, S.B. 111, requiring school districts to provide daily physical activity opportunities for elementary school students.

Florida Gov. Jeb Bush (R) also signed a bill, H.B. 7087, to enhance health and physical education requirements. The new law requires students to fulfill one credit of health and physical education to graduate from high school.

In **Tennessee**, lawmakers enacted H.B. 3750, a bill that requires each local education agency to integrate 90 minutes of physical activity per week into the school day for elementary and secondary school students. The bill also authorizes each agency to implement a coordinated school health program by the 2007–2008 school year, and creates the positions of school health coordinator and physical education specialist within the D.O.E. to assist with coordinated school health programs. Gov. Phil Bredesen (D) signed the measure on June 27.

In **West Virginia**, S.B. 785 and H.B. 4848 proposed minor amendments to the West Virginia Healthy Act of 2005 that set physical education and fitness requirements for public school students by grade levels. The companion bills proposed that the physical education grouping requirements be amended to programmatic levels (e.g., elementary, middle and high school), rather than to grade levels in order to accommodate variance in grade levels within each school. Gov. Joe Manchin III (D) signed S.B. 785 into law April 4, mandating the following physical education participation requirements:

- *Elementary school students:* At least 30 minutes of physical education, including physical exercise, at least three days a week.
- *Middle school students:* At least one full period of physical education, including physical exercise, every day for one semester of the academic year.

- *High school students:* At least one full course of physical education, including physical exercise, for high school graduation and the opportunity to enroll in an elective lifetime physical education course.

Developing Local Wellness Policies

Two years ago Congress enacted The Child Nutrition and WIC Reauthorization Act of 2004. The law required every school district that participates in the National School Lunch Program to have adopted a local school wellness policy that promotes healthy nutrition and physical activity by July 1, 2006. However, the Act left much authority to the states and localities in determining what should be included in each policy.[6, 7]

In the past two years, many states considered legislation to help guide school districts in their efforts to comply. Some states considered legislation to add state requirements in conjunction with the federal requirements. This year lawmakers in at least eight states–**Connecticut, Florida, Georgia, Indiana, Massachusetts, Mississippi, Oklahoma** and **Pennsylvania**–introduced legislation to assist or set requirements for school districts in establishing wellness councils and policies. Much of the legislation provides guidance for both nutrition and physical activity. Florida, Indiana, Mississippi, Oklahoma and Pennsylvania enacted bills. While the **New Mexico** Legislature did not consider such legislation, Gov. Bill Richardson (D) approved the statewide school nutrition and wellness rules that included guidelines for local school wellness policies as well as health and physical education performance standards. The following table details bills that were enacted in 2006.

6 U.S. House of Representatives Committee on Education and the Workforce. *The Child Nutrition and WIC Reauthorization Act Update* (July 2004), available at *http://edworkforce.house.gov/democrats/hr3873cnupdate.html.*

7 USDA's Food and Nutrition Service. *Local School Wellness Policy Requirements*, available at *http://teamnutrition.usda.gov/Healthy/wellness_policy requirements.html.*

2006 Enacted Legislation to Develop Local School Wellness Policies

Florida

FL SB 772

Requires each school district to submit to the Department of Education (D.O.E.) a copy of its school wellness policy and its physical education policy by Sept. 1, 2006.

Requires the D.O.E. to post Web site links to each district's policies by Dec. 1, 2006.

Requires the D.O.E. to provide Web site links to examples of school wellness policies.

STATUS: 06/26/2006—Signed.

Indiana

IN SB 111

Requires each school board to establish a coordinated school advisory council to develop a local wellness policy that complies with federal requirements.

Directs the D.O.E. to provide information concerning health, nutrition and physical activity to the councils.

STATUS: 03/15/2006—Signed.

Mississippi

MS HB 319

Directs local school districts to establish local school health councils and wellness policies in accordance with the federal requirements.

STATUS: 03/15/2006—Signed.

Oklahoma

OK SB 1459

Requires the state departments of Education and Health to assist the Healthy and Fit School Advisory Committees by making information and technical assistance available to schools for use in establishing healthy school nutrition environments, reducing childhood obesity, developing physical education and activity programs, preventing diet-related chronic diseases and establishing school wellness policies.

STATUS: 04/24/2006—Signed.

Pennsylvania

PA HB 185

Requires each local education agency to establish a local wellness policy by June 30, 2006.

Establishes an interagency coordinating council for child health and nutrition to annually review and revise the Pennsylvania nutrition and activity plan to prevent obesity and related chronic disease. The plan must include recommendations regarding local wellness policies.

Establishes local advisory health councils to provide recommendations on the development of local wellness policies.

STATUS: 07/11/2006—Signed.

Source: Health Policy Tracking Service, a Thomson West Business, Nov. 2006

Promoting Physical Activity

Legislators seeking to increase physical activity in schools without imposing mandates have pushed measures to encourage education officials to enhance physical education in schools and provide them with guidance (i.e., guidelines, model policies) to do so. Eleven states introduced such measures this year– **Connecticut, Delaware, Florida, Georgia, Hawaii, Iowa, Kansas, Massachusetts, Missouri, New Hampshire** and **Tennessee**. The following table details the bills that were enacted.

2006 Enacted Legislation to Promote Physical Activity

Connecticut

CT SB 204

Requires the state Department of Education (D.O.E.) to develop guidelines to address the physical health of students and provide them to local boards of education by Jan. 1, 2007.

The guidelines must include plans for promoting daily physical exercise before, during and after school hours.

Local boards of education may establish and implement, based on the guidelines, plans to address physical health of students by the 2007–2008 school year.

STATUS: 05/08/2006—Signed.

Delaware

DE HB 471

Establishes a physical education/physical activity pilot program to provide at least 150 minutes of physical education and physical activity for each student in at least six schools.

STATUS: 07/10/2006—Signed.

Florida

FL SB 772

Encourages each school district to provide 150 minutes of physical education each week for students in kindergarten through grade 5 and 225 minutes each week for students in grades 6 through 8.

STATUS: 06/26/2006—Signed.

Kansas

KS HR 6011-6

Urges the state Board of Education to require some type of physical education instruction for students in kindergarten through grade 12.

STATUS: 03/10/2006—Signed.

Source: Health Policy Tracking Service, a Thomson West Business, Nov. 2006

Establishing Committees, Councils and Task Forces

Instead of mandating physical education and activity standards, several states are considering legislation to appoint committees, councils or task forces to study the issues and formulate recommendations. This year lawmakers in at least 10 states–**California, Delaware, Iowa, Maryland, Massachusetts, Missouri, New Hampshire, Oklahoma, Pennsylvania** and **Tennessee**– introduced or carried over such legislation. California, Delaware, Iowa, Pennsylvania and Tennessee enacted bills.

In 2005 **Delaware** established a Physical Activity and Education Task Force to examine current physical activity and physical education policies and programs and to develop recommendations to improve or create high-quality physical education programs in the state. Its recommendations included the creation of a Statewide Health Advisory Council. In 2006 lawmakers enacted S.B. 289, a measure codifying the 17-member Statewide Health Advisory Council. The Council is responsible for providing ongoing guidance to the state D.O.E. regarding current and future physical education and physical activity programs in public schools. It will convene four times each year and sunset in 2011.

In **Iowa**, Gov. Thomas Vilsack (D) signed S.B. 2251, directing the Departments of Education and Public Health to establish a 24-member healthy children task force. The task force will assess current policies affecting the health of children, particularly those pertaining to physical activity and nutrition, and will develop and submit policy recommendations by Jan. 1, 2007.

In June **Tennessee** lawmakers enacted a carry-over measure, the Child Nutrition and Wellness Act of 2005. The law directs the commissioner of health to appoint an advisory council to advise him and the Office of Child Nutrition and Wellness on child nutrition and wellness issues. The council will meet quarterly and holds the following responsibilities:

- Advocating for the wellness of children and recommending forums, programs and initiatives to educate the public regarding child nutrition and wellness.
- Developing nutrition and physical activity standards for children.
- Gathering data on child nutrition and wellness.

In **California**, lawmakers approved S.C.R. 73, providing for the California Task Force on Youth and Workplace Wellness to continue to promote health and fitness in schools and workplaces. The bill passed the Senate and awaits action in the House.

Pennsylvania H.B. 185, enacted in July, contains a provision for the establishment of an interagency coordinating council for child health and nutrition to annually review and revise the state's nutrition and activity plan to prevent obesity and related chronic diseases. The plan will include recommendations regarding physical education. The bill also calls for the secretary of education to establish an advisory committee to offer recommendations to the council.

Vetoed Legislation

In **Colorado**, Gov. Owens (R) vetoed a bill, H.B. 1021, prohibiting schools from employing physical education teachers who are not endorsed or highly qualified to instruct physical education. He expressed in his veto message that he saw no evidence that current licensure requirements or physical education instruction are inadequate. He also stated that local school districts have the authority to impose stricter hiring standards and that he does not want to impose barriers for current or aspiring physical education teachers. In 2005 he vetoed a bill to establish a physical education recognition program.

Pending Legislation

Virginia lawmakers will carry over to 2007 three introduced bills that propose standards for physical education or physical activity in schools.

Conclusion

In response to the childhood obesity epidemic, lawmakers have proposed legislation to address health and physical education in state public school systems. Efforts within the public school have included modifying school health and physical education standards; providing guidance to schools in developing school wellness policies; and appointing committees to study nutrition and fitness. These legislative proposals are critical to efforts aimed at improving physical activity and nutrition standards in schools.

Body Mass Index Monitoring and Reporting

Overview

Body mass index (BMI) measures an individual's weight in proportion to his or her height and is a simple, widely accepted measurement used to screen for weight categories that are associated with health problems. For children and adolescents, BMI measurements are compared with age- and gender-specific charts developed by the CDC, and commonly referred to as BMI-for-age growth charts. These charts help health care professionals determine whether a child or adolescent is underweight, at a healthy weight, at risk for being overweight or overweight (see table below).

BMI for Age Interpretation

BMI percentile	Child is considered:
Under 5th percentile	Underweight
Between 5th and 15th percentile	At risk for being underweight
Between 15th and 85th percentile	At a healthy weight
Between 85th and 95th percentile	At risk for being overweight
Over 95th percentile	Overweight

Source: Centers for Disease Control and Prevention, 2006

In some states lawmakers have implemented legislation that measures BMI for children and adolescents in an attempt to assess the prevalence of obesity, educate parents and evaluate current policies aimed at curbing obesity rates among children and adolescents. In addition, some lawmakers have supported issuing "health report cards" to increase parental awareness of their child's health status. Despite the good intent behind BMI reporting bills, they have evoked some controversy.

For instance, some parents feel that the assessments are intrusive and could hurt students' self-esteem levels. Recently, researchers in the United Kingdom concluded that the potential psychological damage of BMI reporting could outweigh the benefits. Yet other studies have shown that most parents of overweight children fail to identify their children as such. Health advocates contend that if parents do not perceive a problem, they will not support the necessary lifestyle changes that will help reduce their child's risk for the health problems associated with obesity.

Another argument is that BMI does not always provide a reliable measure of a person's health status. BMI does correlate to direct measures of body fat, but does not consider muscle mass, cardiorespiratory fitness or other health measures. For example, the BMI score for a healthy, athletic child with significant muscle mass may fall into the "at risk for being overweight" or "overweight" category, while a thinner, sedentary child may have a BMI indicating he or she is in the "healthy" or "underweight" category. Thus, BMI serves as more of a guideline than a determinant of healthy weight status.

States Begin to Take Action

Under the mandates of Act 1220 of 2003, **Arkansas** was the first state to require public schools to assess students' BMI and to send both the results and an explanation of possible health effects to parents in an annual health report. In 2004 the Arkansas Center for Health Improvement (ACHI) released its baseline report, showing that 38 percent of Arkansas' public school students were "overweight" or "at risk for being overweight." After three consecutive years of BMI screening, ACHI's 2006 analysis indicated that Arkansas had halted the progression of the obesity epidemic among its public schoolchildren–despite the continued increase among children nationwide. In Arkansas the percentage of students classified as "overweight" decreased from 20.9 percent in 2004 to 20.4 percent in 2006. Data also show that the percentage of students "at risk for being overweight" declined slightly over the same period from 17.2 percent to 17.1 percent.[1] The CDC has praised the state for its efforts.

[1] Data available at *http://www.achi.net/current_initiatives/obesity.asp.*

In 2004 the **Illinois** Department of Health was required by the legislature to collect data measuring obesity as part of the mandatory health examination required for students to attend public schools. Three states–**New York, Tennessee** and **West Virginia**–joined the ranks of those using BMI to monitor childhood obesity in 2005.

2006 State Legislative Activity

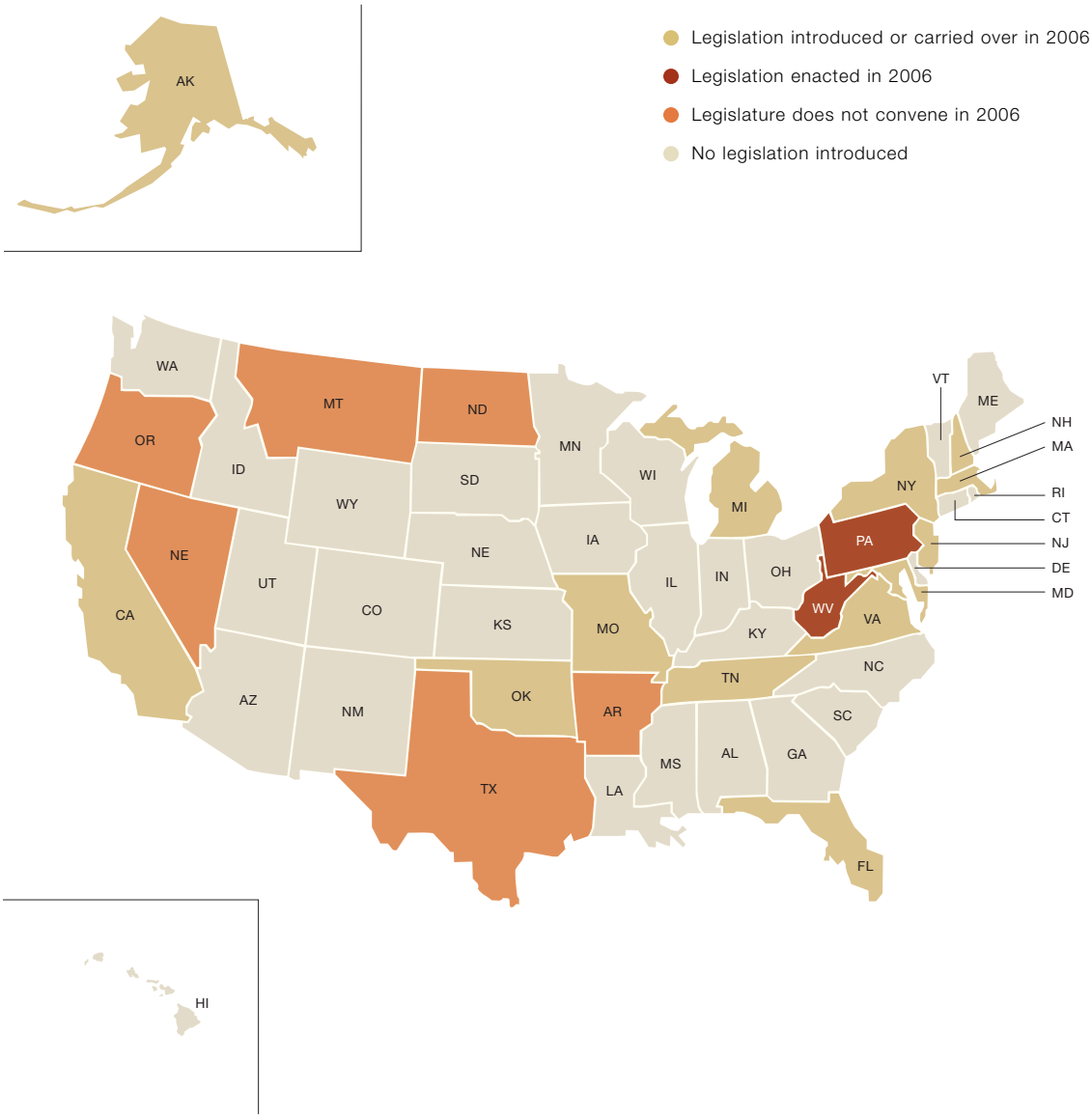
Lawmakers continue to introduce legislation to encourage, require or amend guidelines for schools to monitor and report students' BMI. In 2006 lawmakers in 15 states–**Alaska, California, Florida, Maryland, Massachusetts, Michigan, Missouri, New Hampshire, New Jersey, New York, Oklahoma, Pennsylvania, Tennessee, Virginia** and **West Virginia**–introduced or carried over measures that address BMI measuring and reporting in schools.

Last year **West Virginia** enacted a law requiring schools to report BMI measures in an effort to monitor the effect of school nutrition and physical education policies put into place. The law required BMI measures to be included in kindergarten screening procedures and mandated that students in grades 4 through 12 have their BMI measures taken through routine fitness testing procedures. However, this year lawmakers enacted a bill, S.B. 785, directing the state Board of Education to adopt a rule governing the process and allowing assessment only for a scientifically random sample of students.

While **Pennsylvania** law already requires schoolchildren to have their height and weight measured by a school nurse or teacher as part of established school health tests, H.B. 185, enacted July 11, requires that information be used to generate a weight-to-height ratio.

Only two of the 15 states that introduced or carried over BMI measures in schools actually enacted BMI legislation in 2006, which may indicate some reluctance among state lawmakers to pass legislation that evokes such controversy. However, positive results in states that have enacted laws to measure and report BMI, such as **Arkansas**, may encourage lawmakers in other states to push for similar legislation in the future.

2006 BMI Monitoring Legislation



Source: Health Policy Tracking Service, a service of Thomson West, Nov. 2006

Other Actions

Although **California** has not enacted legislation, Blue Cross of California initiated *Taking Measures for Their Future*, a statewide BMI training and promotion program for clinicians to screen for childhood obesity. The program, part of a three-year, $9-million statewide childhood obesity initiative, will train clinical staff from approximately 9,000 physician offices on BMI screening and their role in fighting childhood obesity. John Monahan, president of Blue Cross State Sponsored Business, said in a press release, "Training thousands of clinical staff on how to identify children at risk for overweight and obesity early is a vital step in the fight against childhood obesity, which is a growing epidemic in our state. Providing the training and resources needed to build obesity screening into regular pediatric care will help foster a medical community more equipped to empower California families and help children lead healthier lives."[2]

Conclusion

A growing number of states are introducing or carrying over BMI-related legislation. Currently BMI measuring and reporting methods vary from state to state, and there is some controversy surrounding the practice of BMI monitoring in public schools. As states continue to collect data and evaluate results, more lawmakers may be encouraged to support school-based BMI initiatives.

[2] Blue Cross of California. "Blue Cross of California Launches BMI Training and Promotion Program to Make Childhood Obesity Screening a Statewide Standard" (Press Release, June 26, 2006), available at *http://www.bluecrossca.com/wps/portal/chpfooter?content_path=shared/noapplication/pressroomwlp/nosecondary/notertiary/pw_a086897.htm&label=BLUE%20CROSS%20OF%20CALIFORNIA%20LAUNCHES%20BMI%20TRAINING%20AND%20PROMOTION%20PROGRAM%20TO%20MAKE%20CHILDHOOD%20OBESITY%20SCREENING%20A%20STATEWIDE%20STANDARD.*

Food and Beverage Advertising and Marketing

Overview

In addition to re-examining the products they sell in schools, the food and beverage industry has faced growing criticism for their advertising and marketing to children. Public health advocates claim these advertisements and marketing strategies are contributing to the rising rate of obesity in children and adolescents. In 2005 the Institute of Medicine released a report on the effect of food and beverage marketing on children and urged the federal government to take action. This year the federal government all but mandated the food, beverage and advertising industries to change their marketing to children.

The Reports

In May the Federal Trade Commission (FTC) and the Department of Health and Human Services (HHS) issued a report, *Perspectives on Marketing, Self-Regulation and Childhood Obesity*, urging the food industry to take specific steps to change its marketing practices aimed at children.

The report included the following recommendations:

- Food companies should develop new products and reformulate existing products to make them more nutritious and appealing to children and to help control portion sizes and intakes.
- Food companies should create labels that make it easier to identify healthier choices.
- Food companies should revise their marketing practices to improve the nutritional profile of food marketed to children and in schools.
- Media and entertainment companies should review their licensing of children's television and movie characters to promote more nutritious foods.
- All involved parties should continue to improve efforts to educate consumers on nutrition and fitness.
- The industry should consider improving self-regulatory efforts, particularly through the Children's Advertising Review Unit (CARU) of the Council of Better Business Bureaus (CBBB).

The FTC and HHS plan to closely monitor the implementation of the recommendations and to issue a follow-up progress report on the industry.[1] The FTC also is conducting a study on the nature and extent of food marketing techniques directed at children and adolescents. No timeline has been set for the follow-up report or the study.

Also released in May was a report funded by the FDA, *Keystone Forum on Away-From-Home Foods: Opportunities for Preventing Weight Gain and Obesity*, which provided valuable recommendations for industry, government, health professionals, consumer representatives and others to help reduce obesity and improve the health of consumers purchasing food outside of the home.

[1] Federal Trade Commission. "FTC, HHS Release Report on Food Marketing and Childhood Obesity" (Press Release, May 2, 2006), available at *http://www.ftc.gov/opa/2006/05/childhoodobesity.htm.*

Several recommendations pertained to consumer marketing and education, especially away-from-home foods:[2,3]

- Shift marketing focus to increase the marketing of lower-calorie and less-calorie-dense foods while decreasing the marketing of higher-calorie and calorie-dense foods and large portions.
- Conduct market research to determine how to best market low-calorie and less-calorie dense menu options and more appropriate portion sizes to different populations and how to shift the prevailing value proposition away from large portions.
- Review and update standards for marketing to children, including the marketing of away-from-home foods.
- Strengthen and create education and promotion programs regarding away-from-home foods that promote the consumption of fruits, vegetables, no- and low-fat milk and milk products, whole grains and foods low in fat.
- Use social marketing campaigns and consumer education programs to provide healthy lifestyle education to help individuals eat more healthfully in today's food environment.

While several agencies including the FTC and Institute of Medicine have focused mainly on print and television advertising, in July, the Kaiser Family Foundation released the first study concentrating on online food advertising, *It's Child's Play: Advergaming and the Online Marketing of Food to Children*.[4] The study analyzed 77 Web sites, which received more than 12.2-million visits from children ages 2 to 12 in the second quarter of 2005, according to Nielsen NetRatings.

2 The Keystone Center. *The Keystone Forum On Away-From-Home Foods: Opportunities for Preventing Weight Gain and Obesity*, May 2006, available at *www.keystone.org/spp/documents/Forum_Report_FINAL_5-30-06.pdf.*

3 U.S. Food and Drug Administration. "FDA Receives Keystone Forum Report on Away-From-Home Foods" (Press Release, June 2, 2006), available at *http://www.fda.gov/bbs/topics/NEWS/2006/NEW01379.html.*

4 Kaiser Family Foundation. *It's Child's Play: Advergaming and the Online Marketing of Food to Children*, July 2006, available at *http://www.kff.org/entmedia/upload/7536.pdf.*

The report listed the following key findings:

- Eighty-five percent of the top food brands that target children through television advertising also use Web sites to market to children.
- Seventy-three percent of the Web sites feature "advergames," online games featuring a company's product or brand characters (e.g., Chips Ahoy Soccer Shootout, the M&M's Trivia Game and the Pop-Tart Slalom).
- Sixty-four percent of the Web sites featured viral marketing, in which children are encouraged to contact their peers about a company's Web site or product.

Whereas print and television advertising generally is limited in space and time, online advertising provides the opportunity for an unlimited amount of marketing to the consumer. The study concluded that future research efforts should examine how children respond to such online marketing messages.[5]

The Response

In response to the FTC and HHS report, the National Advertising Review Council (NARC), the agency that oversees the CBBB National Advertising Division and CARU, underscored the strides CARU has made in achieving several of the recommendations. The CBBB and CARU, which issues and enforces the Self-Regulatory Guidelines for Children's Advertising, established a project to revise the current guidelines and is considering each recommendation of the report.[6]

Some companies have voluntarily reduced the advertising of certain products to children and developed products and campaigns that foster healthy eating habits. Throughout the remainder of this year, Kraft Food, Inc. will continue to implement changes to its advertising in television, radio and print media with a target audience of children ages 6 to 11. The company is phasing in advertising of products that meet its Sensible Solution criteria and phasing out advertising of products that do not meet the criteria.

[5] Kaiser Family Foundation. "First Analysis of Online Food Advertising Targeting Children" (Press Release, July 19, 2006), available at *http://www.kff.org/entmedia/entmedia071906nr.cfm.*

[6] National Advertising Review Council. Prepared Statement of James R. Gunthrie, President and CEO, National Advertising Review Council (NARC), in response to the joint report of the Federal Trade Commission and Department of Health and Human Services: "Perspectives on Marketing, Self-Regulation and Childhood Obesity" (Press Release, May 2, 2006), available at *http://www.caru.org/news/2006/NARCrelease.pdf.*

The product must meet one of two criteria to qualify as a Sensible Solution product:

1. Provides beneficial nutrients such as protein, calcium, fiber or whole grain at nutritionally meaningful levels, or delivers a functional benefit such as heart health or hydration, while staying within specific limits on calories, fat (including saturated and trans fat), sodium and sugar.

2. Meets specifications for "reduced," "low" or "free" in calories, fat, saturated fat, sugar or sodium.

Kraft has also curbed its Oreo and Kool-Aid advertising campaigns to children under the age of 12. PepsiCo ceased advertising its soft drinks to children under 12, and Frito-Lay, PepsiCo's snack unit, no longer advertises Cheetos to children under eight.

Kraft and its divisions have worked to develop and promote more nutritious products that also appeal to children, including DiGiorno Harvest Wheat Crust pizzas, Supermac and Cheese pasta and sauce, and a new line of 100 percent whole grain snacks. In response to the MOU and the growing demand for healthier options, beverage companies have been working and competing to develop new alternatives to soft drinks. The alternatives include a wide array of flavored waters, flavored milks and milk alternatives, new fruit juices and juice smoothies, no calorie, nutrient-enhanced soft drinks, sports drinks, energy drinks, teas and coffees.[7]

With an innovative approach to promoting nutrition to children, companies such as Nickelodeon, Warner Brothers and Walt Disney Co. have signed licensing agreements with produce growers and distributors to help promote fruits and vegetables to parents and children. Walt Disney Co. has partnered with Imagination Farms, LLC, an Indianapolis-based produce distributor, to create a Disney Garden brand featuring Disney cartoon characters on the packaging of fruits and vegetables sold in supermarket chains, such as peaches with Goofy stickers and grapes packaged in Mickey Mouse boxes. At least 100 different Disney Garden produce items are expected in supermarkets by the end of 2006 and another 100 by the end of 2007. Nickelodeon and Warner Brothers have signed similar agreements to market fruits and vegetables using their characters, including SpongeBob Square Pants spinach, Dora the Explorer oranges, Tweety Bird grapes and Tasmanian Devil apples. These actions go along with the Institute of Medicine's and federal government's recommendations to use television and movie characters to market nutritious foods.[8]

[7] Herzog K. "Drink! New Beverages Join the Coke-Pepsi Wars." *Milwaukee Journal Sentinel*, June 7, 2006.

[8] Adelman J. "Entertainment Firms Cultivate Healthy Images." Bucks County Courier Times, Sept. 5, 2006.

Disney took further action in October, announcing its new guidelines for foods and food promotions targeted to children. Under the new policy, Disney will use its name and characters only on kid-focused products that meet specific nutritional guidelines:

- A cap on calories to provide for child-sized portions.
- Total fat may not exceed 30 percent of calories for main and side dishes and 35 percent for snacks.
- Saturated fat may not exceed 10 percent of calories for main dishes, side dishes and snacks.
- Added sugar may not exceed 10 percent of calories for main dishes and side dishes and 25 percent for snacks.

The exception to these guidelines is Disney-licensed special-occasion sweets (i.e., birthday cakes and seasonal candy), but Disney will reduce the percentage of special-occasion sweets in its licensed portfolio to 15 percent by 2010 and will make them available in single-serving portions. Disney plans to eliminate added trans fat from its licensing and promotional products by the end of 2008.

In addition, Disney will phase in and market healthier options at Disney-operated restaurants in its parks and resorts. Starting in October, kids' meals were served with low-fat milk, 100 percent fruit juice or water and side dishes such as apples and carrots instead of soft drinks and French fries. The company also plans to eliminate added trans fat from food served at U.S. parks and resorts by the end of 2007.

President and CEO Robert Iger stated in a press release, "Disney will be providing healthier options for families that seek them, whether at our parks or through our broad array of licensed foods. The Disney brand and characters are in a unique position to market food that kids will want and parents will feel good about giving them." [9]

9 The Walt Disney Company. "The Walt Disney Company Introduces New Food Guidelines to Promote Healthier Kids' Diets" (Press Release, Oct. 16, 2006), available at *http://corporate.disney.go.com/news/corporate/2006/2006_1016_food_guidelines.html.*

2006 State and Federal Legislative Activity

Because consumer advertising and marketing is generally regulated at a federal level, state legislators have introduced very few bills limiting or regulating the advertising and marketing of foods and beverages to children. This year **California, Illinois, Indiana, Massachusetts** and **New York** introduced or carried over legislation that pertains to food and beverage marketing and advertising to children. None of the measures was enacted.

At least three federal bills proposing greater regulation of the food and beverage marketing industry were introduced, but no action was taken on them:

- Federal House Bill 5737 and S.B. 1074 proposed to restore the authority of the FTC to issue regulations that restrict the marketing or advertising of foods and beverages to children under age 18 if there is evidence that consumption of certain foods and beverages is detrimental to the health of children.
- In addition to authorizing FTC regulations, Federal S.B. 799 would have prohibited advertisements and marketing in schools and on school grounds for foods of poor or minimal nutritional value, proposed that the Institute of Medicine conduct a study and make recommendations on guidelines for food and physical activity advertising and marketing. The bill also called for a Federal Leadership Commission to Prevent Childhood Obesity and a National Summit to Implement Food and Physical Activity Advertising and Marketing Guidelines to Prevent Childhood Obesity.

Conclusion

The food and beverage industry is beginning to take steps to change the way their products are marketed to children, but so far it is doing so on a voluntary basis. No action has been taken on federal legislation mandating greater regulation of the industry.

Industry Liability Lawsuits

Overview

The number of state legislatures moving to limit an individual's ability to sue food and beverage companies continues to grow. Commonly referred to as Commonsense Consumption Acts, these measures limit the civil liability of manufacturers, distributors, advertisers, trade associations and sellers or retailers of food or beverages for damages resulting from weight gain, obesity or obesity-related conditions.

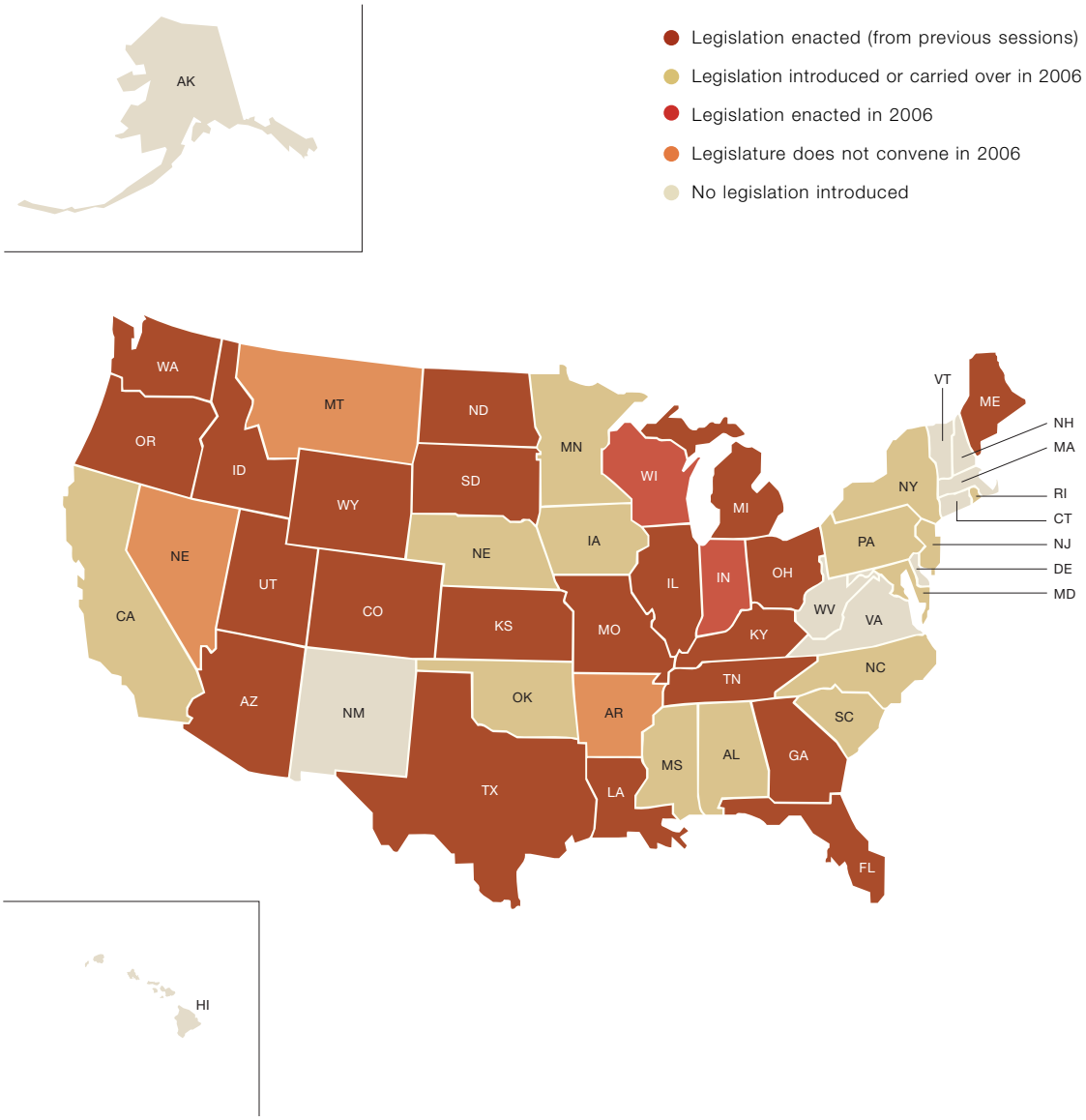
Those in favor of limiting, if not banning, such lawsuits wanted the Senate to pass the Commonsense Consumption Act of 2005, S.B. 908. In 2005 the House passed its version of the bill, Personal Responsibility in Food Consumption Act, H.B. 554. Enactment of the legislation would have "…wiped out all court cases–new and pending."[1] However, Congress adjourned without the Senate having acted.

2006 State Legislative Activity

While Congress has not acted, state legislatures are taking the lead in preventing obesity-related lawsuits from being filed in their jurisdictions. During 2006 lawmakers in **Indiana** and **Wisconsin** enacted H.B. 1113 and S.B. 161, respectively. Legislative action in 2006 is highlighted in the following map.

[1] Grier C. "Advocacy Group Files Obesity-Related Lawsuit as Senate Weighs Banning Such Actions." *Bestwire Services*, June 16, 2006.

2006 Legislation Limiting Obesity-Related Lawsuits



Source: Health Policy Tracking Service, a service of Thomson West, July 2006

Supporters of these bills, including the National Restaurant Association, believe that restaurant and food manufacturers should not be held liable for personal decisions made by individuals. However, opponents of such legislation, including the American Heart Association and the National Trial Lawyers Association, fear that these bills will encourage restaurants to continue to provide menu options that are high in fat and calories.

Arguments offered by food industry and the public health advocates with regard to such legislation include:

- *Industry:* Frivolous lawsuits blaming the restaurant industry for obesity in America deny the role that personal responsibility plays in dietary choices that individuals make on a daily basis.
- *Public Health Advocates:* Keeping litigation available does not deny the role of individual dietary decisions and choices; it merely represents one potential tool to address the problem.
- *Industry:* Healthy eating and physical activity should be promoted through education, not lawsuits.
- *Public Health Advocates:* The restaurant industry should not object to nutrition labeling on menus and message boards in large chain restaurants.
- *Industry:* The food and restaurant industries need protection from abusive, frivolous litigation.
- *Public Health Advocates:* These laws are unnecessary because courts can dismiss cases they deem "frivolous" by way of Rule 11, a federal act that sanctions attorneys who bring such cases to court.

Other Legal Activities

In June the Center for Science in the Public Interest (CSPI) filed a class action lawsuit against Kentucky Fried Chicken (KFC) in the District of Columbia Superior Court. CSPI filed the suit to prohibit KFC from preparing food with partially hydrogenated oils that contain trans fat.

In late October KFC, a unit of Yum Brands Inc., announced that it will switch to trans fat-free cooking oil in its U.S. restaurants by spring 2007. However, certain KFC offerings, such as its biscuits, will continue to be made using trans fat cooking oil while it looks for a suitable alternative for these products. The move is considered to be one of the most significant actions by a U.S. fast-food chain.

During summer 2006 Wendy's International began converting to trans fat-free cooking oil and more recently the Walt Disney Company announced that food sold at its theme parks and resorts will be trans fat-free by the end of 2007.

As a result of KFC's announcement, CSPI withdrew its lawsuit.

The Public Health Law Project (PHLP) of the Public Health Institute in California is working to assist nutrition and health advocates with changing county and city policies related to land use–with a special focus on General Plans and Zoning Ordinances–that set standards for future development of the built environment within community settings. The Project believes these actions will lead to improved environments for healthy eating and physical activity.

PHLP is also providing legal and technical assistance to nutrition and public health advocates, parents, students and other interested persons to enable them to participate in schools' contracting decisions for foods and beverages. The assistance includes consultation regarding how to negotiate new contracts and amend existing contracts to maximize economic benefits to the school while promoting healthy food choices.

Conclusion

While no action has been taken on the federal level, numerous state legislatures have moved to limit an individual's ability to sue food and beverage companies for damages resulting from weight gain, obesity or obesity-related conditions.

Snack and Soda Taxes

Overview

According to a Yale study released in 2000, a one-cent tax on soft drinks, candy, chips and other snack items could raise more than $1.8 billion–money that public health advocates hope will be appropriated to fund obesity research, as well as national or state efforts to prevent and reduce obesity. The study estimates that the one-cent tax would generate $1.5 billion from soft drinks, $70 million from candy, $54 million from potato chips and an additional $190 million from other snack items.[1]

In the early- to mid-1990s several states and jurisdictions enacted legislation to tax sodas and snacks at a higher rate than other food products. However, due to the complexity involved in the collection and administration of the tax, most of the measures were repealed in states such as **California, Louisiana, Maryland, Mississippi, North Carolina, Ohio** and **South Carolina**. Opponents, including the Grocery Manufacturers of America and the Snack Food Association, have helped defeat these measures. They argue that taxing sodas and snack foods leads to consumer and retailer confusion, establishes government-imposed preferences and creates competitive disadvantages for retailers whose businesses operate near state borders.

[1] Yale. "Soda and Snack Tax Could Raise $1.8 Billion for Health Promotion Programs, Yale Study Shows" (News Release, June 1, 2000), available at *http://www.yale.edu/opa/newsr/00-06-01-03.all.html.*

In 2006 legislation to either tax soda or snack foods at higher rates than other food products was introduced in **California, Indiana, Kansas, Maryland, New Mexico** and **Wisconsin**. None of the legislation was considered or acted upon. In fact, no new snack or soda tax legislation has been enacted in the past two years. With the exception of tobacco products, increasing the sales tax on beer, wine, alcohol, soda and snacks is very difficult. Such taxes are seen as regressive and having a negative effect on low-income and working-class families. Furthermore, any proposal to increase taxes, no matter what the product or purpose, faces a difficult legislative future in the current political climate.

The following table indicates the states and jurisdictions that have statutes governing taxes on soda and/or snack food.

Conclusion

No new snack or soda tax legislation has been enacted in the past two years, and new legislation on the issue is unlikely in the near future.

Current Soft Drink and Food Taxes–State and Locality

Arkansas

1992 $.21 per gal. of liquid soft drink; $2 per gal. of soft drink syrups.
DEDICATED USE: Medicaid

California

1993 7.25% sales tax on soft drinks.
DEDICATED USE: General Funds

Chicago

1993 3% on sales of containers by distributors; 9% on sales of syrups.
DEDICATED USE: General Funds

District of columbia

1993 5.75% on sales of snack foods and soft drinks.
DEDICATED USE: General Funds

Illinois

1985 6.25% sales tax on soft drinks [Other food products taxed at 1% to 2%].
DEDICATED USE: General Funds

Indiana

1963 5% sales tax on candy, gum, soft drinks, bottled water, dietary supplements.
DEDICATED USE: General Funds

Kentucky

1972 6% sales tax on candy, gum and soft drinks.
DEDICATED USE: General Funds

Maine

1991 5.5% sales tax on snack foods, soft drinks, carbonated water, ice cream, toaster pastries.
DEDICATED USE: General Funds

Source: State Tax Handbook (Chicago, Ill: Commerce Clearing House) and Center for Science in the Public Interest.

Minnesota

1982 6.5% sales tax on candy, carbonated drinks, fruit drinks (not containing fruit juice), chewing gum, single serve ice cream.

DEDICATED USE: General Funds

Missouri

1962 $.003 per gal. of soft drinks produced.

DEDICATED USE: General Funds

New Jersey

1966 6% sales tax on candy and carbonated soft drinks.

DEDICATED USE: General Funds

New York

1965 7.5% sales tax on soft drinks, candy, confectionary, fruit juices with less than 70 percent natural fruit juice.

DEDICATED USE: General Funds

North Dakota

1985 5% sales tax on candy, chewing gum, carbonated beverages, soft drinks with less than 70 percent fruit juice, powdered drink mixes.

DEDICATED USE: General Funds

Rhode Island

1984 $.04 per case (24–12 ounce cans) of soft drinks, soda water, mineral water, beer paid by wholesaler.

DEDICATED USE: General Funds [Originally earmarked for environmental management]

Tennessee

1963 1.9% of gross receipts from soft drinks, and soft drink ingredients, paid by manufacturers and bottlers.

DEDICATED USE: 21 percent for highway litter control

Texas

1961 6.25% on carbonated and noncarbonated packaged soft drinks, diluted juices, candy.

DEDICATED USE: General Funds

Virginia

1977 Excise tax on wholesalers and distributors based on total sales of carbonated soft drinks.

DEDICATED USE: Litter control and recycling fund

Source: State Tax Handbook (Chicago, Ill: Commerce Clearing House) and Center for Science in the Public Interest.

Washington

1989 $1 per gallon of syrup.

DEDICATED USE: Violence prevention and drug enforcement

West Virginia

1951 $.001 per half-liter of carbonated and non-carbonated soft drinks, fruit drinks and chocolate milk; $.8 per gal. of syrups paid by manufacturers or wholesalers.

DEDICATED USE: West Virginia University medical, dental and nursing schools

Source: State Tax Handbook (Chicago, Ill: Commerce Clearing House) and Center for Science in the Public Interest.

Insurance Coverage for Obesity Treatment

Overview

The annual health care costs (direct and indirect) associated with overweight and obesity have put an additional strain on state and federal government budgets. The total cost of obesity in the United States in 2000 was estimated at $117 billion. This amount includes $61 billion for direct medical costs and $56 billion for indirect costs such as loss of productivity, absenteeism and income lost due to related morbidity or premature mortality.[1,2] As the prevalence of obesity and resulting health care costs continue to rise, both the state and federal governments have considered actions to treat and reduce obesity among those already affected.

State lawmakers continue to debate measures mandating that health insurance companies provide coverage for obesity treatment, specifically morbid obesity (bariatric) surgery. As with all mandates for health care benefits, proponents contend that these requirements are necessary to ensure adequate health care for consumers by providing needed coverage for a particular disease, treatment or service. Proponents also maintain that the long-term health and economic benefits of obesity treatment outweigh the short-term costs. Opponents of mandated benefit legislation believe that any additional requirements placed on insurers contribute to the rising costs of health insurance policies, which, in turn, is a factor in the rising number of uninsured.

1 National Center for Chronic Disease Prevention and Health Promotion. *Overweight and Obesity: Economic Consequences* (2004), available at *http://www.cdc.gov/nccdphp/dnpa/obesity/economic_consequences.htm.*

2 National Center for Chronic Disease Prevention and Health Promotion. *Preventing Chronic Diseases: Investing Wisely in Health and Preventing Obesity and Chronic Diseases Through Good Nutrition and Physical Activity* (August 2003), available at *http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/obesity.htm.*

Georgia, Indiana and **Virginia** mandate health insurers to offer the coverage, while **Maryland** mandates health insurers to cover the treatment.

In February the Centers for Medicare and Medicaid Services (CMS) expanded Medicare's coverage of bariatric surgery to all Medicare beneficiaries, including coverage for three types of bariatric surgeries. Due to complications experienced by some seniors, a proposal last year recommended coverage only for beneficiaries younger than age 65. However, after reviewing findings that show that more experienced surgeons have similar outcomes with patients of all ages, CMS decided to expand the coverage to beneficiaries older than age 65. To help prevent complications among beneficiaries older than age 65, Medicare will cover the procedure only in centers certified by the American College of Surgeons and the American Society for Bariatric Surgery.

Until now CMS has covered only one type of bariatric surgery–gastric bypass surgery. Medicare will now cover three types of surgeries, including open and laparoscopic gastric bypass, laparoscopic adjustable gastric banding and open and laparoscopic biliopancreatic diversion with duodenal switch. The procedures will be covered only for those beneficiaries who have been diagnosed with obesity as well as an obesity-related illness or disease such as hypertension, type 2 diabetes, heart disease, stroke, osteoarthritis or sleep apnea.[3]

This decision may impact the national health insurance community as private health insurers and Medicaid programs are under increased pressure to cover obesity treatment procedures. It also may encourage state lawmakers to consider further legislation for health insurance coverage for obesity treatment and prevention.

2006 State Legislative Activity

In 2006 lawmakers introduced or carried over 15 bills in **Alaska, Connecticut, Georgia, Louisiana, Missouri, New Jersey, Oklahoma, South Carolina, Tennessee** and **Virginia** addressing health insurance coverage for morbid obesity treatment. Of the 10 bills that would have required insurers to offer or cover some surgical or non-surgical services for obesity treatment, nine failed when state legislatures adjourned. One in New Jersey will be carried over to the 2007 session (H.B. 1613). Five resolutions to study the issue were introduced; one failed in Georgia (H.R. 1159), while four were adopted in South Carolina and Louisiana, demonstrating that states may want to see more evidence on the costs and benefits of obesity treatment before considering further legislation.

[3] Centers for Medicare and Medicaid Services. "Medicare Expands National Coverage for Bariatric Surgery Procedures" (Press Release, Feb. 21, 2006), available at *http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1786.*

In May lawmakers in **South Carolina** adopted S.C.R. 1379 requesting that the state's Department of Health and Human Services and Department of Insurance conduct a joint study of individual cases of obesity and the effectiveness of bariatric surgery. They will examine the short- and long-term complications and mortality rates of bariatric surgery and the cost-effectiveness of the surgery in relation to long-term treatment. The results of the study and recommendations are to be submitted to the General Assembly before Jan. 16, 2011.

The **Louisiana** legislature adopted three resolutions in June. Senate Resolution 120 directs the Senate Committee on Insurance to study the feasibility of requiring insurance companies to cover surgical treatment for morbid obesity and to deliver a report to the Legislature prior to the 2007 session. Senate Concurrent Resolution 101 requests the state's Office of Group Benefits to conduct a second phase of an ongoing study for gastric bypass surgery. The study, which began two years ago, pays for the surgery for selected eligible state employees and tracks the patients for several years to determine whether the surgery reduces obesity-related health problems and health care costs. House Concurrent Resolution 244 commends the Office of Group Benefits for its study on the effects of obesity on health insurance.

The preliminary results of the first phase of the Office of Group Benefits study, released in April, indicate that the 40 state employees that underwent gastric bypass surgery could save the state money in the long run. Participants filled 30 percent fewer prescription drugs in the 18 months following their surgery–a drop from 809 prescriptions in the 18 months before their surgery to 563. Total spending on pharmaceuticals decreased by $75,000–from $167,000 to $92,000. An additional $11,000 was saved on other medical spending. If the $1-million program generates sufficient savings in the long-term to cover the $25,000 surgery, the Office of Group Benefits will likely recommend providing the benefit to the 250,000 state employees, public schoolteachers and dependents the agency insures.[4]

[4] Griggs T. "Obesity Surgery Beneficial: Agency Says Patients Cut Drug Needs." *Baton Rouge Advocate*, April 27, 2006.

The Office of Group Benefits is also sponsoring a study of non-surgical medical treatments for severe obesity (defined as a body mass index of 40 to 60) begun in July 2005 and to be completed in March 2011. The Louisiana Obese Subjects Study (LOSS), conducted by the Pennington Biomedical Research Center, is aimed at observing the effects of an intensive medical management program on weight loss, medical costs and weight-loss-related health risks such as blood pressure, blood glucose and blood lipids in comparison to usual medical care including access to a weight management Web site. LOSS researchers are performing clinical trials on 480 Office of Group Benefits insurance enrollees who would otherwise qualify as candidates for obesity surgery. Participants will receive three years of active treatment followed by two years of observation. They are expected to lose more than 20 percent of their body weight due to intensive treatment, an amount greater than that achieved with usual medical care.

Similarly Blue Cross Blue Shield (BCBS) of Western New York is commissioning a study on obesity treatment. The insurer has contracted a $5-million, five-year study with the University at Buffalo of 280 people who are 100 or more pounds overweight. The study aims to develop a non-surgical, gold standard model of the most effective combination of diet, exercise and medication. The participants will be divided into four groups. Two groups will consume 800 calories a day and two groups will consume 1,200 to 1,500 calories a day, mostly from a nutritionally-dense powder to be mixed into shakes, soups and other foods. Only half of the participants will be given an FDA-approved appetite suppressant or fat-blocker. All participants will be provided education and will be encouraged to walk daily, increasing the distance to up to three miles a day. Researchers expect to find that participants who take medication and consume 800 calories a day for 12 weeks and then increase to 1,200 to 1,500 calories a day will lose at least 20 percent of their body weight.[5]

[5] "Doctors Search for Alternative to Gastric Bypass." *The Associated Press*, March 9, 2006.

Insurer Wellness Policies

While lawmakers in few states introduced legislation that mandates coverage of overweight and obesity treatment, some insurance carriers are promoting wellness programs to help enrollees live healthier lifestyles. These programs aim to reduce the millions of dollars insurers incur for medical expenses for obesity-related conditions such as high blood pressure, heart disease and diabetes. BCBS of North Carolina, BCBS of South Carolina and Aetna are among the insurers with wellness initiatives.

BCBS of North Carolina offers eligible members its *Healthy Lifestyle Choices* program at no additional charge. Enrollees in the program are given enhanced insurance benefits including up to four doctor's visits to assess and monitor their weight, up to six visits with a dietitian for nutrition counseling and weight loss medications for long-term weight management with prior authorization. They also receive a personalized report with suggestions for lifestyle changes, a food and physical activity diary, a pedometer, other educational resources and access to online programs that focus on fitness, nutrition and weight management. The program is intended to lower obesity-related medical expenses that cost the insurer about $83.1 million in 2003. BCBS of North Carolina has 3.4 million members; 1.3 million are eligible for the program and 13,000 are enrolled.

In September BCBS of North Carolina released the results of a test phase of the program conducted from August through December 2004, with a follow-up six months later. Of the 1,956 participants, 46 percent of respondents to a survey lost an average of nine pounds and trimmed their waistlines by 0.86 inches. Another 46 percent reported exercising more and 76 percent of respondents with high blood pressure reported a decrease in the severity of their condition.[6]

BCBS of South Carolina's *WalkingWorks* campaign teaches enrollees the health benefits of increasing physical activity through walking. WalkingWorks adheres to the recommendation of the President's Council on Physical Fitness and Sports that walking briskly 30 minutes a day, five or more days a week, or 10,000 steps daily tends to improve people's health in the long-term. While WalkingWorks has education tools for everyone, BCBS offers a special program for employers to implement in the workplace. The program includes a planning guide and CD toolkit used to educate employees and track their participation. BCBS provides these tools free of charge for benefits administrators of insurance accounts and offers pedometers for a discount.

[6] Krishnan A. "Blue Cross Test Shows Progress in Health." *The News and Observer*, Sept. 7, 2006.

In 2007 Aetna plans to finish launching a variety of health and wellness programs as part of the Aetna Health Connections medical management strategy launched in April. Aetna Health Connections educates members and helps them attain better health by looking at their health status, plan benefits, demographics, personal preferences and other information. The insurer will offer online resources that provide educational resources and health assessment tools, including *Simple Steps to a Healthier Life*, *Aetna InteliHealth*, the *Healthwise Knowledgebase* and *Women's Health Online*. Aetna will offer discounts on health, wellness and weight loss products and services such as discounts to eDiets, an online resource for weight-loss literature, diet foods, exercise equipment and other accessories. The *Weight Management Discount Program* will offer discounts on Jenny Craig weight-loss programs and products and the Fitness Program will offer discounts on select fitness club memberships and GlobalFit home exercise equipment. Aetna will also launch wellness outreach programs including *Aetna Healthy Body, Healthy Weight Program*, a smoking cessation program, wellness counseling and the Informed Health Line, a 24-hour nurse information line. Finally, Aetna will offer workplace programs such as on-site health screenings and educational resources in various mediums including workshops, CD-ROMs and mailings.[7]

Conclusion

The high health care costs associated with overweight and obesity have significantly impacted state and federal government budgets, and surgical treatment for morbid obesity is a major concern. A few states mandate such coverage, while others continue to study the issue. In February Medicare coverage was expanded to include three types of bariatric surgeries for CMS beneficiaries of all ages.

[7] Aetna. "Aetna Health Connections Programs for Wellness Encourage Members to Engage in Maintaining Health" (Press Release, Oct. 7, 2006), available at *http://www.aetna. com/news/2006/pr_20060912.htm.*

Medicaid Benefits and Services to Treat Overweight and Obese Individuals

Overview

Providing health care services to Medicaid beneficiaries who are obese or overweight costs state governments upwards of $21 billion annually, according to the 2004 study, *State-Level Estimates of Annual Medical Expenditures Attributable to Obesity*. The estimated financial impact of obesity on state budgets ranges from $87 million in Wyoming to $7.7 billion in California.[1] These numbers show the devastating economic impact of obesity on state Medicaid budgets. As state legislators and executives look for ways to reduce short- and long-term health care costs, it is clear that preventing and reducing obesity can help control Medicaid expenditures.

Currently the federal government does not require states to reimburse for the treatment of obesity under Medicaid. However, in 2006 governors and legislatures in several states reviewed their options and considered legislation that encouraged healthy behaviors and placed a premium on behaviors that are detrimental to one's health.

[1] Finkelstein EA, Fiebelkorn IC and Wang G. "State-Level Estimates of Annual Medical Expenditures Attributable to Obesity." Obesity Research, 12: 18–24 (2004).

In addition, the federal Deficit Reduction Act of 2005 authorized the Department of Health and Human Services to select 10 states to conduct demonstration programs to implement Health Opportunity Accounts. The demonstration programs will focus on encouraging preventive services, enabling patients to take responsibility for health outcomes and providing ongoing educational activities. The Centers for Medicare & Medicaid Services (CMS) is developing more specific guidelines for program implementation.

Medicaid Reform and Incentives for Healthy Behaviors

During his tenure as chairman of the National Governors' Association, **Arkansas** Gov. Mike Huckabee (R) spearheaded efforts in his state and nationwide to encourage fellow governors and state lawmakers to develop strategies and adopt policies that promoted healthy behaviors. Gov. Huckabee launched *Healthy America: Wellness Where We Live, Work and Learn*, a year-long initiative. The *Healthy America* Task Force, a bipartisan group comprised of Huckabee and five other governors, worked with health professionals, business leaders, policy-makers and the public to identify strategies governors can use to improve the health of Americans.

Governors are turning to Medicaid waivers and the provisions in the "Deficit Reduction Act of 2005," to revamp their Medicaid programs and control costs. In doing so, they are creating programs that offer incentives to Medicaid beneficiaries to lead healthier lives. **Idaho, Kentucky, Rhode Island, South Carolina** and **West Virginia** are a few of the states that set plans in motion to promote healthy behaviors as they overhauled their respective Medicaid programs.

In late 2005 former **Idaho** Gov. Dirk Kempthorne (R) established a plan that would reform his state's Medicaid program by dividing Medicaid into three separate parts based on eligibility, type and health risk. The Medicaid Simplification Act was signed into law in March 2006 and authorizes the director of the Department of Health and Welfare to restructure the state's Medicaid program in order to improve health outcomes for Medicaid participants and slow the rate of growth in Medicaid costs.

Kentucky's new Medicaid program will offer enrollees special disease management programs and *Get Healthy* benefits to promote healthy behaviors through services including nutritional counseling, dental, vision and smoking cessation programs. More importantly, the new Get Healthy benefits will provide incentives to enrollees practicing healthy behaviors. Enrollees will be eligible to receive additional services after one year of successful participation in a disease management program.[2]

Earlier this year **South Carolina** Gov. Mark Sanford (R) directed the state Department of Health and Human Services to implement his Medicaid reform plan, South Carolina Healthy Connections. The governor's plan will transform the state's Medicaid program from a one-size-fits-all model into one in which beneficiaries may tailor their plans to best fit their needs. The state is also applying to be one of the 10 states selected by CMS to implement a *Healthy Opportunity Account* pilot project. Each Medicaid beneficiary would have an individual health benefit account that is intended to help create patient awareness of the high cost of medical care, provide incentives for patients to seek preventive care and reduce inappropriate use of health care services. The general wellness concept behind the health accounts is to reward beneficiaries with additional monies for health services when they engage in behaviors and services intended to improve their health. **Florida, Idaho** and **Iowa** also passed bills that will establish similar personal health accounts.

Gov. James Douglas (R) and the **Vermont** Legislature agreed on a major health care reform bill to provide health insurance coverage for 25,000 uninsured residents. The 2006 Health Care Affordability Act, H.B. 861, creates a health insurance program called Catamount Health in which everyone who has been without health insurance for 12 months will have access to–and help in paying for–a comprehensive health insurance package. A key aspect of the Catamount Health insurance program is that, unlike high-deductible catastrophic plans, the coverage will pay for primary and preventive care. This coverage is expected to lower the amount of money spent on treatment of people who are unable to afford medical care at the onset of an illness. The law also directs the Department of Banking Insurance Securities and Health Care Administration to adopt rules to permit health insurance companies to offer premium discounts or other incentives (e.g., Healthy Choices Discounts) to people who participate in health promotion or disease prevention programs such as smoking cessation.

[2] United States Department of Health and Human Services. "HHS Approves Historic Medicaid Reform Plans in Kentucky" (Press Release, May 3, 2006), available at *http://www.hhs.gov/news/press/2006pres/20060503a.html.*

In **West Virginia**, the state is offering Medicaid enrollees a choice of two benefits packages: a basic plan based on the current services offered or an enhanced package that includes benefits not usually offered under Medicaid. To be eligible for the enhanced package, enrollees must sign an agreement to comply with all recommended medical treatment and wellness behaviors. The state initially will market the enhanced benefit package to healthy children and adult enrollees. The enhanced package will include nutritional education, substance abuse and mental health services, diabetes care and tobacco cessation assistance. The state will track medical outcomes and compliance with the agreement using several indicators including adherence to health improvement programs and recommended screenings. Enrollees failing to comply with their agreements may lose access to the enhanced package.[3]

2006 State Legislative Activity

Lawmakers in **Virginia** and **Minnesota** introduced legislation to treat obesity either through surgery or drug treatment. In **New York**, legislation was proposed to require Medicaid to cover medically prescribed nutrition therapy for obese children under the age of 18. None of the bills were acted upon; however, Virginia will carry over its legislation into 2007. Bills were adopted in **Colorado, Iowa** and **Massachusetts**.

In 2005 **Colorado's** Gov. Bill Owens (R) signed H.B. 1066. The measure creates the *Obesity Treatment Pilot Program* designed to treat Medicaid beneficiaries through the use of behavior modification, self-management training and medication. Eligible participants must be over the age of 15, have a BMI equal to or greater than 30, and suffer from a coexisting medical condition, such as diabetes, hypertension or coronary heart disease. According to the fiscal report prepared by the state, 7,815 fee-for-service beneficiaries over the age of 15 have a BMI equal to or greater than 30.

Of those, it is estimated that 10 percent will participate in the pilot program at a total cost of $290,000 for the first year, which will be financed through federal funds and other revenue sources such as private donations. However, the law explicitly prohibits the allocation of general funds in fiscal years 2006 and 2007 to support the pilot program. If an independent study is conducted demonstrating that the program provides cost savings to the state, general funds may be appropriated for the program after June 30, 2007. The Obesity Treatment Pilot Program is scheduled to sunset July 1, 2010.

[3] United States Department of Health and Human Services. "HHS Approves Innovative Medicaid Reform in West Virginia" (Press Release, May 3, 2006), available at *http://www.hhs.gov/ news/press/2006pres/20060503.html.*

Also in 2005 **Iowa** Gov. Tom Vilsack (D) signed into law H.B. 841. Among the several provisions of the Medicaid Reform Act is language requiring the Medicaid program to develop a strategy for providing dietary counseling and support services to Medicaid enrollees, and helping enrollees create personal weight loss programs by July 1, 2006.

Although not specifically targeting obesity, **Massachusetts** Gov. Mitt Romney (R) approved legislation in 2006 that requires the state Medicaid program to develop a wellness program that will offer incentives to encourage beneficiaries to achieve desired health outcomes. If outcomes are achieved, enrollees will benefit from reductions in premiums or copayments. The provision is included in H.B. 4850, a comprehensive bill that requires individuals to obtain health insurance coverage by July 1, 2007.

Conclusion

Providing health care services to Medicaid beneficiaries who are obese or overweight places a significant burden on state governments, leaving states to look for ways to reduce the associated short- and long-term health care costs. In response, a number of states considered legislation this past year that would modify Medicaid provisions, support healthy behaviors and discourage unhealthy behaviors. States looked to Medicaid waivers and the provisions in the federal Deficit Reduction Act of 2005 to improve Medicaid programs, curb expenditures and create programs that offer incentives for Medicaid beneficiaries to lead healthier lives.

Menu-Labeling Requirements for Restaurants

Overview

In an attempt to educate consumers on their food selections and in response to growing consumer demand for nutritional information, there has been a push for food establishments to provide nutritional information on their food offerings.

In May the Keystone Center, a nonprofit policy and dispute resolution organization, released the report, *Keystone Forum on Away-From-Home Foods: Opportunities for Preventing Weight Gain and Obesity*. The report provides recommendations to the food and beverage industry, government, health professionals, consumer representatives and others to help reduce obesity and inform consumers about purchasing away-from-home foods and improving their health. The U.S. Food and Drug Administration (FDA) funded the report in response to the growing percentage of meals being consumed outside of the home. According to the report, 32 percent of calories consumed by Americans come from foods prepared outside of the home.

The recommendations pertaining to providing consumers with nutrition information are as follows:

- Food establishments should provide consumers with caloric information in a standard, easily accessible and understandable format.
- Food establishments should increase the availability of lower-calorie menu items.
- Research should be conducted on how consumers use nutrition information for away-from-home foods, how this information affects their caloric intake, and how nutrition information affects food service operators.

The report recognized that nutritional information is voluntarily provided to consumers by at least 150 of the country's 300 largest chain restaurants in many formats, including menus, Web sites and kiosks. The group, however, pointed out that there is no standard format for providing this information to consumers.

The decision to provide nutritional information and the type of information provided varies from business to business. Regardless, the report highlights four national polls that indicate that consumers would like to see nutritional information posted on menus or menu boards. However, not enough data is available to determine how consumers process this information and if it affects an individual's decision regarding what to eat.[1, 2]

Because the FDA report focused on away-from-home foods, many of the recommendations targeted the restaurant industry. The National Restaurant Association announced that it would not formally support the final report, noting that many of the recommendations are already in place and the report unfairly targeted the restaurant industry. According to the National Restaurant Association, "Our industry has made great strides to promote nutrition and healthy lifestyles to our guests and to educate them on the foods that we offer. Efforts to restrict or place mandates on our industry are not solutions. In fact, they risk setting up additional roadblocks for consumers to enjoy the foods they wish to consume. The restaurant industry seeks to provide a wide variety of food options to accommodate the diverse dietary needs of consumers. Restaurants will continue to help consumers meet those needs through consistent positive messages that promote healthier thinking and balanced lifestyles."[3]

1 The Keystone Center. *The Keystone Forum On Away-From-Home Foods: Opportunities for Preventing Weight Gain and Obesity*, May 2006, available at *www.keystone. org/spp/documents/Forum_Report_FINAL_5-30-06.pdf.*

2 U.S. Food and Drug Administration. "FDA Receives Keystone Forum Report on Away-From-Home Foods" (Press Release, June 2, 2006), available at *http://www.fda.gov/bbs/topics/NEWS/2006/NEW01379.html.*

3 National Restaurant Association. "National Restaurant Association Statement in Response to FDA Report on Away-From-Home Foods" (Press Release, June 2, 2006), available at *http://www.restaurant.org/pressroom/pressrelease.cfm?ID=1273.*

Showcasing their independent efforts to promote healthy messages to consumers, the National Restaurant Association and the Healthy Dining Program partnered to launch a new Web site in August. The Healthy Dining Finder is a free resource that allows consumers to identify healthier dining options by searching for restaurants based on specific criteria and for nutrition information on each menu item. The Healthy Dining Program will heavily market the Web site and participating restaurants to health and fitness professionals, employers and consumers.[4]

Providing nutritional content to consumers in restaurants is not currently required under any federal or state laws. The provision of such information is voluntary. However, to help reduce obesity, individual states and the federal government have considered legislation mandating that food service establishments provide this information. Public health advocates, particularly the Center for Science in the Public Interest (CSPI), fully support such measures that require establishments to provide information about the amount of calories, sodium and fat contained in food.

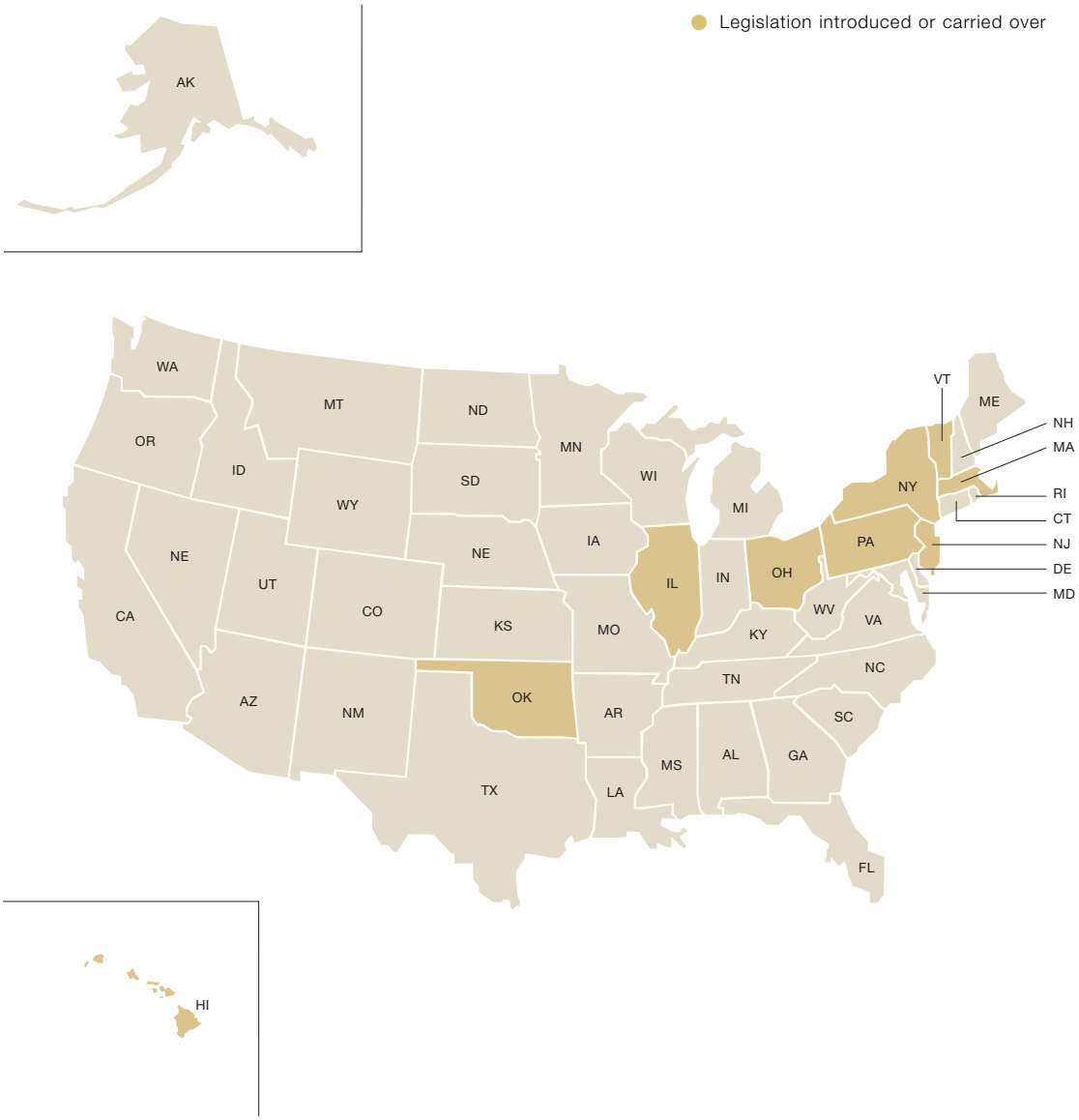
The majority of menu-labeling legislation that has been introduced models CSPI's recommendations, and has targeted chain restaurants and franchises. The legislation would require food service chains with 10 or more units to list the calorie, sodium and saturated and trans fat contents of standard menu items on their menus or menu boards. These bills have faced major opposition from the National Restaurant Association and restaurant owners who claim that nutritional information is already available to the consumer by request or online. Restaurant owners argue that such a legislative mandate would be very expensive and would force small business owners to pass additional costs on to consumers.

2006 Legislative Activity

State menu-labeling legislation was first introduced in **Maine** in 2003. Since then lawmakers in several states have introduced similar requirements, but none has been enacted into law. This year legislators in **New Jersey, Oklahoma, Pennsylvania** and **Vermont** introduced menu-labeling bills, and measures were carried over from **Hawaii, Illinois, Massachusetts, New York, Ohio, Vermont** and the **District of Columbia** (see following map). None of the measures was enacted. Two measures in **New Jersey**, H.B. 1693 and S.B. 2264, will carry over to the 2007 legislative session.

[4] National Restaurant Association. "National Restaurant Association Joins Healthy Dining in Promoting Healthful Menu Choices to Americans" (Press Release, July 17, 2006), available at *http://www.restaurant.org/pressroom/pressrelease.cfm?ID=1284.*

2006 Menu-Labeling Legislation



Source: Health Policy Tracking Service, a service of Thomson West, Nov. 2006

One reason for a lack of state legislation on this issue is that restaurants are typically federally regulated. It would be more difficult to apply state and local regulations to nationally operated chain and franchise restaurants than federal regulations. Congress did introduce and consider companion bills FD HB 5563 and FD SB 3484, Menu Education and Labeling Act, that would have required nutrition labeling of standard menu items at chain restaurants.

On December 5, 2006 on a local level, the **New York City** Board of Health passed a regulation to require some restaurants to post calorie information on menus and menu boards where consumers can easily see the information before ordering.[5] The policy would apply to restaurants that make calorie information for standard menu items publicly available by March 1, 2007, and would go into effect July 1, 2007. Approximately 10 percent of city restaurants would be affected.

The Health Department's assistant commissioner for Chronic Disease Prevention, Dr. Lynn Silver, said in a press release, "By knowing how many calories a food contains before they buy it, New Yorkers can make more informed choices. New Yorkers have this information available to them when they buy their groceries; under this proposal, it would be available to them, where feasible, when they buy food in restaurants."[6]

The Board was expected to vote on the proposal by December 2006 and can make it a regulation without approval from the city council or other city or state agencies.[7]

Conclusion

In an attempt to prevent and reduce obesity by offering consumers more information about their food choices, some argue that food establishments should be required to provide nutritional information. A few states have introduced such legislation, but none has passed. There has been no federal-level legislative action on the issue.

5 The New York City Department of Health and Mental Hygiene. "Board Of Health Votes To Require Calorie Labeling In Some New York City Restaurants" (Press Release, Dec. 5, 2006), available at *http://www.nyc.gov/html/doh/html/pr2006/pr113-06.shtml.*

6 The New York City Department of Health and Mental Hygiene. "Health Department Proposes Two Changes to City's Health Code for Public Comment" (Press Release, Sept. 26, 2006), available at *http://www.nyc. gov/html/doh/html/pr2006/pr093-06.shtml.*

7 Lueck T. "City May Ask Restaurants to List Calories." *The New York Times,* Oct. 30, 2006.

Product Labeling and Claims

In a recent Associated Press-Ipsos survey of 1,000 adults, researchers found that although most Americans read nutritional labels on food products, they usually choose to ignore the information provided. Despite label information indicating that a product is unhealthy, 46 percent of the consumers surveyed chose to purchase those "unhealthy" products. The survey results, released on July 3, 2006, show that women pay closer attention to food labels than do men, and that young adults pay more attention to calorie information than to fat content.[1] This type of consumer data helps inform public health advocates and policymakers as they determine how to address the country's rising obesity rates.

Another 2006 study conducted by Vanderbilt University found that when reading nutrition labels, Americans often fail to account for serving size or misperceive their food intake.[2] According to the study, only a third of participants accurately estimated the grams of carbohydrates in a 20-ounce soft drink, which contains 2.5 servings. Some research and public health advocates suggest that nutrition labels include information on the entire product package in addition to a serving size.[3]

1 Libby Quid. "Label Warnings Often Ignored: Many Food Shoppers Check Information But Still go for the Sugar and Fat." *The Star Ledger*, July 3, 2006.

2 Vanderbilt University Medical Center. *Poor Math Skills Feed Food Label Confusion: Study* (Sept 29, 2006), available at *http://www.mc.vanderbilt.edu/reporter/index.html?ID=5045.*

3 Choi C. "Food Labels Confuse Americans, Study Finds Serving Sizes Often Unnoticed or Miscalculated." *Journal-Gazette*, Sept. 28, 2006.

Because the authority for regulating nutritional information on food products lies with the FDA, only a few state lawmakers have introduced measures to further regulate the nutritional labels of food and beverage products. In 2005 the federal government released sodium standards for items carrying the "healthy" claim. According to the final rules issued, an item can bear the "healthy" claim if the individual serving size does not contain more than 480 milligrams of sodium. Also in 2005 the FDA sought public comment on food label changes, including proposed rules for: 1) voluntary nutrition labeling of raw fruits, vegetables and fish; 2) the prominence of calories on food labels; 3) serving sizes of products reasonably consumed at one time; 4) updating the reference amounts typically consumed; and 5) approaches for recommending smaller portion sizes. In 2003 federal rules were issued that required the inclusion of trans fat information on all packaged products. The mandate became effective on January 1, 2006.[4]

At its 2006 annual meeting, the American Medical Association (AMA) voted to push the federal government to require companies to add warning labels for high-sodium products. The group will also lobby the food industry to cut down on the amount of salt added to processed foods and meals purchased in restaurants by 50 percent in the next decade. The AMA defines high-sodium products as those that contain more than 480 milligrams of sodium per serving. According to an *Associated Press* article, because the AMA is well-respected in Washington, the FDA will probably consider holding hearings on sodium-label warnings.[5]

In 2005 lawmakers in only two states–**California** and **Connecticut**–introduced nutritional labeling legislation. Neither state enacted legislation and no new product labeling measures have been introduced in 2006.

Conclusion

Many Americans either disregard nutritional labels or do not understand them. Only two states have introduced measures to regulate nutritional labeling beyond Food and Drug Administration requirements. The American Medical Association argues that the federal government should mandate warning labels for high-sodium products; the FDA may consider holding hearings on the issue.

[4] Food Labeling; Trans Fatty Acids in Nutrition Labeling. "Consumer Research to Consider Nutrient Content and Health Claims and Possible Footnote or Disclosure Statements." CFR 21: Part 101 (July 11, 2003), available at *http://www.cfsan.fda.gov/~lrd/fr03711a.html.*

[5] Tanner L. "AMA Wants Warning Labels on High-Salt Food." *The Associated Press*, June 14, 2006.

Access to Walking, Biking and Recreation

Today there are fewer opportunities for physical activity than in past decades, which contributes to the nation's rising obesity rates. Health and community advocates and lawmakers are working to create and enhance communities that promote opportunities for physical activity such as walking, biking and other forms of recreation. Some of the non-legislative campaigns to promote safe, accessible physical activity at a community level include the following:

- The Centers for Disease Control and Prevention's (CDC) *Active Community Environments Initiative* (ACES) encourages environmental and policy interventions that promote access to walking, biking and recreational facilities and that will lead to an increase in physical activity. The initiative's activities include:
  - The *KidsWalk-to-School* campaign that encourages kids to walk and bicycle to and from school to increase awareness of the importance of physical activity for children and to promote safe, walkable environments and routes to school.

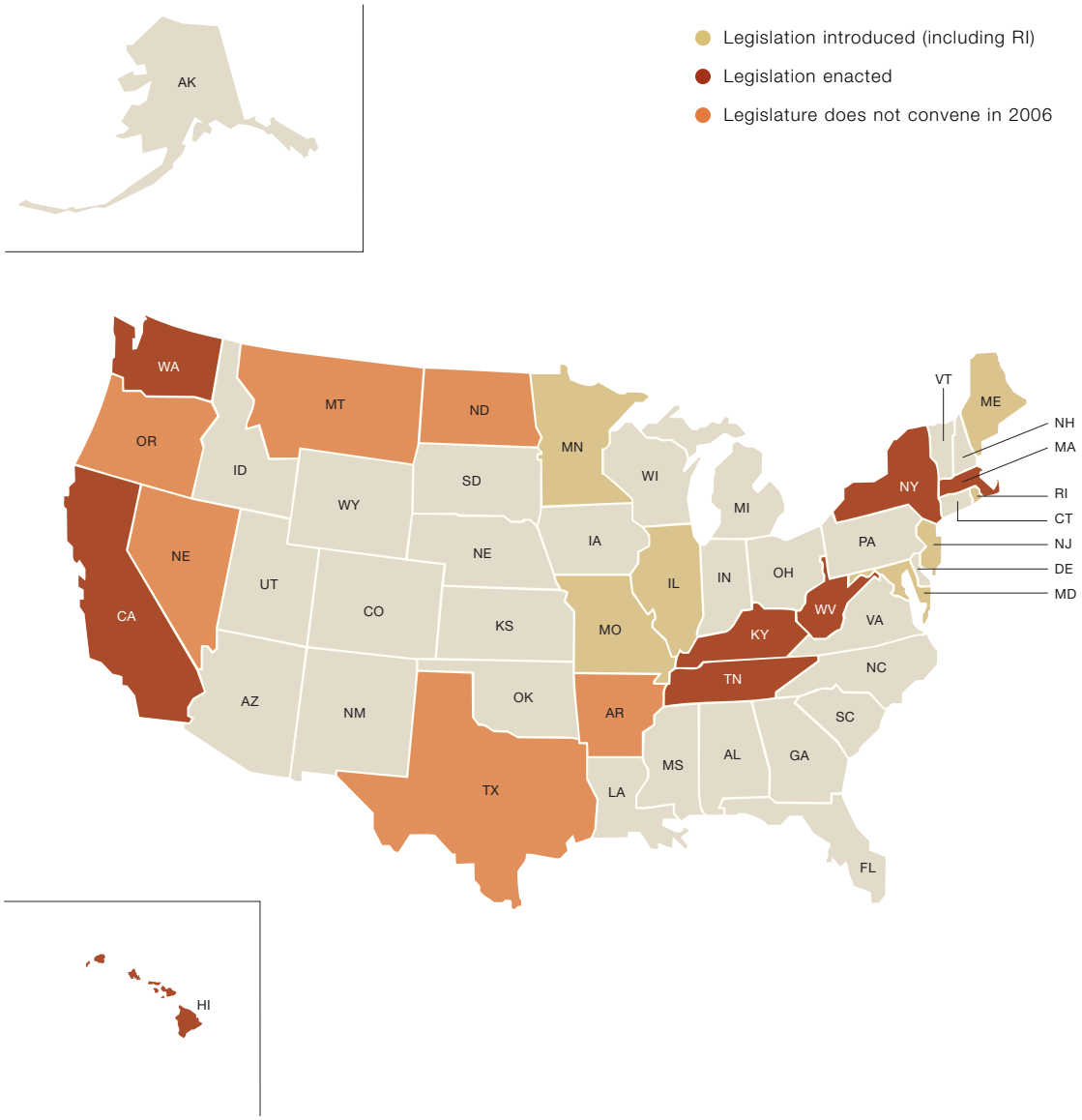
  - A partnership with the National Park Service's *Rivers, Trails and Conservation Assistance Program* to promote the development and use of parks and recreational facilities.
  - A study on the relationships among land use, transportation, air quality and physical activity.

- *Active Living by Design*, a program supported by the Robert Wood Johnson Foundation and the University of North Carolina at Chapel Hill School of Public Health, seeks to increase physical activity through community design, public policies and communication strategies. The program funds 25 community partnerships throughout the country to demonstrate how changing community design impacts physical activity.

2006 State Legislative Activity

To reduce and prevent obesity, promote physical fitness and encourage alternative transportation, some state lawmakers have introduced legislation aimed at creating or improving access to and safety of parks, walking and biking paths, recreational areas and routes to schools. In 2006 Health Policy Tracking Service identified at least 15 states that considered bills addressing these issues. Of those states, eight have adopted a law or resolution. The following figure highlights the states that introduced and enacted legislation. Although the bills vary in their proposed actions, the trend highlights the increased efforts by states to address the obesity epidemic and promote healthier lifestyles.

2006 Legislation to Increase Access to Walking, Biking and Recreation



Source: Health Policy Tracking Service, a service of Thomson West, Nov. 2006

2006 Enacted Legislation to Increase Access to Walking, Biking and Recreation

California

CA HCR 77

Recognizes the importance of local recreation and park agencies in reversing negative trends of physical inactivity, obesity, diabetes and other health problems among Californians and encourages the state to partner with local recreation and park providers to create a healthier state.

STATUS: 08/16/06—Adopted.

CA SB 1556

Requires the Delta Protection Commission to establish a continuous recreation corridor, including bicycle and hiking trails, around the Sacramento-San Joaquin Delta, as defined. The bill also requires the plan to link the San Francisco Bay Trail system to planned Sacramento River trails in Yolo and Sacramento Counties.

STATUS: 09/30/06—Signed by Governor.

Hawaii

HI HB 2075

Notes the importance and benefits of bicycling and earmarks 2 percent of federally allocated moneys from the state highway fund for the establishment of bikeways.

STATUS: 06/02/06—Signed by Governor.

HI HR 93-06

Requests the state Department of Transportation to create a comprehensive statewide pedestrian safety action plan.

04/07/06—Adopted.

HI HR 182-06

Encourages the state Department of Transportation to apply for federal funding to establish "safe routes to school" program and to hire a full-time program coordinator.

STATUS: 04/07/06—Adopted.

HI SR 47-06

Urges local, state and federal governments to play an active role in creating healthy communities.

STATUS: 04/05/06—Adopted.

HI SR 66-06

Identical to H.R. 93-06.

STATUS: 04/04/06—Adopted.

Source: Health Policy Tracking Service, a Thomson West Business, Nov. 2006

Kentucky

KY SCR 98

Directs the Legislative Research Commission (LRC) to study the economic and public health impacts of the state's bicycling and pedestrian transportation activities. The commission also will examine options for addressing the state's obesity crisis. The commission report must include an analysis of public and private programs that improve physical exercise opportunities through biking and walking. The report also must contain an analysis of bicycle safety and options to improve safety. The report was to be submitted to the LRC by Oct. 1, 2006.

STATUS: 03/15/06—Signed by Governor.

Massachusetts

MA HB 1283

Provides that funds from the Environmental Trust Fund be used for land acquisition and construction of walking paths and bikeways around harbors and bays.

STATUS: 06/07/06—Signed by Governor.

New York

NY SB 6455

Appropriates state funds for projects to improve or develop trails, parks, parklands and recreation areas.

STATUS: 04/11/06—Signed by Governor.

Tennessee

TN HR 298

Celebrates International Walk to School Day and commends the participants' dedication to health, safety, physical activity and the environment.

STATUS: 05/10/06—Adopted.

Washington

WA SB 6241

Makes several transportation-related appropriations and provisions including $40,000 specifically for a school bicycle and pedestrian safety account and $5 million in state funds and $2 million in federal funds for pedestrian and bicycle safety projects and safe routes to schools projects. Requires the state Department of Transportation to issue a call for pedestrian safety projects and to submit a list of cost-effective initiatives to the legislature each year; the recommendations made to the legislature must allocate 60 percent of available funds to bicycle and pedestrian path projects and 40 percent to safe routes to schools projects.

STATUS: 03/31/06—Signed by Governor.

Source: Health Policy Tracking Service, a Thomson West Business, Nov. 2006

West Virginia

WV SR 5

Promotes the West Virginia on the Move program, the state branch of *America on the Move*, an initiative to help individuals and communities make positive dietary and physical activity changes to lead healthier lives.

STATUS: 01/20/06—Adopted.

Source: Health Policy Tracking Service, a Thomson West Business, Nov. 2006

Conclusion

Health and community advocates are working to create communities that support and encourage active lifestyles through a number of non-legislative campaigns aimed at promoting physical fitness and encouraging alternative transportation. Lawmakers are also taking action to prevent and reduce obesity by introducing legislation to create or improve access to and safety of parks, walking and biking paths, recreational areas and routes to schools. In 2006 eight states adopted laws or resolutions supporting the following: appropriating state funds to improve or develop trails, parklands and recreation areas; creating comprehensive statewide pedestrian safety action plans; and providing funds for land acquisition and construction of walking paths and bikeways.

Grocery Stores and Supermarkets

Overview

During the past 15 years at least 40 studies, articles or research papers have documented the problem of access to supermarkets and nutritious foods in urban and rural areas. However, very few legislative measures have been introduced that would create incentives for locating grocery stores or supermarkets in neighborhoods that need them the most.

In 2004 Health Policy Tracking Service (HPTS) identified just one state-initiated effort. However, **Pennsylvania's** approach to increase access to supermarkets in low-income urban and rural areas has the potential to become a model for the nation. Senate Bill 1026, a broad authorization of $3 billion for economic development in the state, contains a section that sets aside $100 million for the establishment of new supermarkets in Philadelphia. It has led to the creation of the Pennsylvania Fresh Food Financing Initiative (FFFI).

FFFI is an innovative program that works to increase the number of supermarkets and grocery stores in underserved communities across the state. Financing is available for supermarkets that plan to operate in communities where infrastructure costs and credit needs cannot be filled solely by conventional banks. FFFI is supported by a partnership of The Reinvestment Fund (TRF), The Food Trust and the Greater Philadelphia Urban Affairs Coalition.

Under the leadership of State Rep. Dwight Evans, who was instrumental in getting Pennsylvania to prioritize supermarket development in underserved areas, the state appropriated $20 million for FFFI. TRF has committed $60 million through its New Markets Tax Credits allocation as well as through private sources. Together the contributions total $80 million for financing fresh food retailers in underserved areas. As of September 2006 the FFFI has committed $21.9 million in grants and loans to 22 stores across the state. These stores will create and retain approximately 2,552 jobs and more than 1,133,595 square feet of retail space. Thus far, funds have been allocated to 14 of the projects.

Other efforts to bring grocery stores or supermarkets to low-income communities have been identified in only a few states.

In 2005 HPTS identified one bill–in **Nevada**–that provides a temporary tax incentive for locating or expanding grocery stores in southern parts of the state. Senate Bill 229 allows developers to submit an application for a partial abatement of one or more of the taxes imposed under state law.

In 2006 **California** lawmakers enacted S.B. 2384, establishing the Health Food Purchase Pilot Program. The overall goal of this program is to test strategies aimed at increasing the sale of fresh fruits and vegetables in low-income communities. Participants in the program will focus on developing the best approach for neighborhood grocery stores to provide fresh produce and increase consumption of fresh fruits and vegetables among food stamp recipients. Seven pilot programs will be established in counties that represent a geographic and demographic mix with regard to food stamp participation, income levels, rural/urban demography and rates of obesity.

The Food Trust, based in Philadelphia, is a recognized leader and innovator in the campaign to improve food access by bringing supermarkets to low-income and disadvantaged areas. This past September state legislators from **Louisiana, Michigan** and **New Mexico** visited The Food Trust, seeking advice on how to introduce similar legislation and financing initiatives in their states.

The Food Trust works on initiatives to improve food access, education and marketing campaigns to help consumers improve their health, and public policies to advance these initiatives.

Additionally, cities across the country are working to bring grocery stores to their low-income, urban communities. In February 2006 the Chicago Department of Planning and Development convened a grocery store expo to attract grocery chains to the city's urban neighborhoods.

Relevant Research

HPTS identified key studies that address the need for locating businesses to sell an abundant supply of fresh produce in low-income areas. One study conducted in 1995 by Ronald Cotterill, director of the Food Policy Center at the University of Connecticut, appears to be the seminal study on this issue, even though it was conducted more than 10 years ago.[1] Another prominent study conducted in 2003 by Dr. Kameshwari Pothukuchi at Wayne State University, involved surveying urban planners in 32 metropolitan areas (shown in the table below) to determine how to attract supermarket development in low-income communities.[2] Nineteen of the selected communities included *empowerment zones*, defined by the U.S. Department of Housing and Urban Development as, "distressed urban and rural communities where qualifying businesses are eligible for billions of dollars in tax incentives," or *enterprise communities*, which are areas that did not meet empowerment zone population and geographic size requirements, but qualify for similar incentives.[3]

As part of the study, researchers requested information about local initiatives that encourage grocery retail investment, reasons for the existence or absence of initiatives and specific factors that contributed to successful developments. Key findings from Dr. Pothukuchi's research include:

Grocery Development In and Near Underserved Neighborhoods

Atlanta, GA	Hartford, CT	*Pittsburgh, PA*
Austin, TX	Houston, TX	***Portland, OR***
Boston, MA	Knoxville, TN	**Rochester, NY**
Bridgeport, CT	**Los Angeles, CA**	**San Antonio, TX**
Buffalo, NY	**Memphis, TN**	***Seattle, WA***
Chicago, IL	***Milwaukee, WI***	***St. Louis, MO***
Cincinnati, OH	**Minneapolis, MN**	*Syracuse, NY*
Cleveland, OH	***New Haven, CT***	Toledo, OH
Dallas, TX	New Orleans, LA	**Washington, DC**
Dayton, OH	***New York, NY***	Wichita, KS
Detroit, MI	***Philadelphia, PA***	

Bold type: Cities with empowerment zones or enterprise communities.

Italic type: Cities with development facilitated by public subsidy.

Bold and italic type: Cities with empowerment zones or enterprise communities and development facilitated by public subsidy.

1 Cotterill RW and Franklin AW. Food Marketing Policy Center, University of Connecticut. *The Urban Grocery Store Gap* (1995).

2 Potchuchuki M. Wayne State University. *Attracting Grocery Store Retail Investment to Inner-City Neighborhoods: Planning Outside the Box* (2003).

3 U.S. Department of Housing and Urban Development. Community Renewal Initiative (Dec. 29, 2006) available at *http://www.hud.gov/offices/cpd/economicdevelopment/programs/rc/index.cfm.*

- The saturation of supermarkets within the suburbs is leading chains to consider new urban markets, since other growth opportunities, like mergers and acquisitions, have been exhausted.
- Chains that are third, fourth or lower in market penetration in a metropolitan area are often more interested in establishing a store in a low-income urban area to increase market share.
- The lack of information about urban opportunities and the tendency to apply the standard suburban model to urban areas may hinder supermarket development in such areas.
- Urban locations do present problems to development. For example, sites to accommodate the current standard big-box stores are scarce or need significant public intervention, which most cities seem reluctant or unable to offer.
- Often public agencies do not believe it is within their mission to advocate for supermarkets, although they tend to advocate for housing or other retail entities. If public agencies do get involved, their assistance focuses on needs assessment, reviewing rezoning applications or identifying sites.
- Costs associated with inner-city store operation, such as rent, labor and insurance, are higher than in suburban locations. In addition, the cost of catering to the tastes and cultures of smaller, minority populations can raise the marginal cost for leading supermarket chains, in comparison to suburban locations.

Based on these key findings, Dr. Pothukuchi concluded the following:

- Community-wide initiatives to attract supermarkets were rare in the cities surveyed.
- Successful initiatives were characterized by activities to assess market demand, to identify multiple sites, to assemble incentives and other development assistance, and to recruit multiple corporate supermarket chains.
- Successful initiatives involved political leadership, at the highest level, in collaboration with effective community-based, non-profit organizations.
- Despite the acknowledged absence of supermarkets, planning and development agencies were not proactive–they waited for proposals from developers. The passive behavior of planning and development agencies may be attributed to their assumption that developers would come forth with proposals only if market conditions are suitable.

Other prominent studies that explore the problem of access to supermarkets and fresh produce in low-income areas include:

- California Food Advocates. *Neighborhood Groceries: New Access to Health Food in Low-Income Communities* (Jan. 2003).
- Prevention Institute for the Center for Health Improvement. *Supermarket Access in Low-income Communities* (2003).
- Morris PM. Public Voice for Food and Health Policy. *Higher Prices, Fewer Choices: Shopping for Food in Rural America* (1990).
- Dalton E, Ehrlich S, Flores S, et al. Heinz School Review. *Food Availability in Allegheny County, Pennsylvania* (2003).
- Schaffer A. *The Persistence of LA's Grocery Store Gap: The Need for New Food Policy Approach to Market Development* (2002).
- Weinberg Z. *Race, Poverty and the Environment, No Place to Shop: Food Access Lacking in the Inner City* (Winter 2000).
- "Rural Poor's Access to Supermarkets and Large Grocery Stores." *Family Economics and Nutrition Review*, 12(3,4), 1999.

Conclusion

Research indicates that there is little access to supermarkets, grocery stores and nutritious foods in many urban and rural areas, especially in low-income communities. Over the past three years, only a few states have introduced legislation to address the problem. Innovative programs in Pennsylvania, such as The Food Trust and the Fresh Food Financing Initiative, are attracting interest from other states and may serve as a national model for increasing access to fresh food retailers in underserved areas.

Farmers' Market Access and Development

Overview

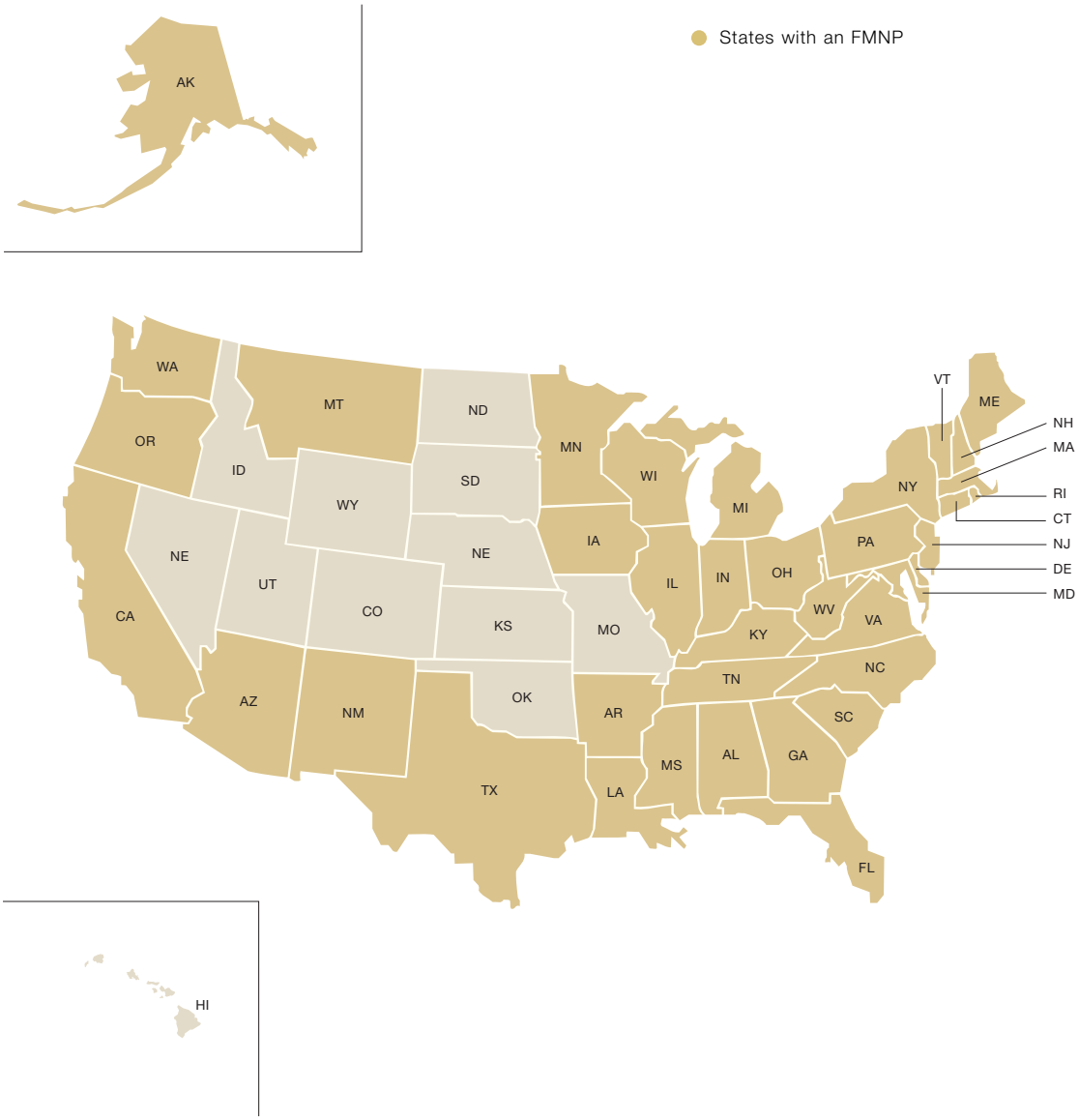
Farmers' market legislation considered by states commonly distributes general fund dollars in support of the federal Women, Infant and Children (WIC) Farmers' Market Nutrition Program (FMNP) and the Senior FMNP. The WIC FMNP distributes coupons to WIC recipients that can be used to purchase fresh vegetables, fruits and herbs directly from state-approved farmers' markets. The latest statistics from the U.S. Department of Agriculture (USDA) indicate that more than 2.5 million WIC recipients received FMNP benefits and that 14,050 farmers and 2,548 farmers' markets accepted coupons in 2004, which resulted in more than $26.9 million in revenue for farmers. Congress appropriated $19.8 million for the program in FY 2006, the same amount provided in FY 2005.[1]

The WIC program is funded primarily through federal dollars, with approximately 30 percent of the total cost of the program supported through state matching funds. Federal guidelines set the benefit level for FMNP recipients at no less than $10 and no more than $30 per year per recipient; states can supplement the benefit level with their matching funds. Authorized farmers or farmers' markets submit the WIC coupons to the designated state agency for reimbursement. Additionally, states may provide nutrition education to FMNP recipients.

According to the USDA, 37 states operate an FMNP as highlighted in the following map.

[1] United States Department of Agriculture, Food and Nutrition Service. *WIC Farmers' Market Nutrition Program*, available at *http://www.fns.usda.gov/wic/FMNP/FMNPfaqs.htm.*

States Operating a Farmers' Market Nutrition Program (FMNP)



Source: USDA Web site, July 2006

To assist seniors in purchasing fresh produce, Congress authorized $15 million for the Senior FMNP through FY 2007. The Senior FMNP provides funding to 38 states to provide low-income seniors (who are at least 60 years of age with household incomes at or below 185 percent of the federal poverty level guidelines) with access to fresh fruits and vegetables. In February the USDA announced the grant awards for FY 2006. The award list is available on the USDA Web site.[2]

2006 State Legislative Activity

Similar to last year's measures, most of the farmers' market legislation in 2006 provided general fund dollars to support the state/federal programs. Of particular interest are measures in **Connecticut, Illinois, Iowa, Mississippi, Vermont** and **Washington** that sought to provide additional funding to support their respective senior programs. In **Connecticut** the USDA awarded the state $84,000 to support its program, and sponsors of S.B. 171 requested that the state provide an additional $350,000. In Vermont, H.B. 685 sought to provide $50,000 for the state's Senior FMNP and the federal government agreed to provide $80,000 to the program. However, neither measure was enacted.

Measures were adopted in the other four states. **Illinois** lawmakers appropriated $1.5 million in state general funds to support the federal program with the enactment of S.B. 1520. In **Iowa** lawmakers appropriated an additional $77,000 on top of the $511,000 awarded to the state by the federal government. In **Mississippi** the federal government awarded the state $64,000 in support of the Senior FMNP and state lawmakers approved an additional $30,000 in state funds for FY 2007. In **Washington** $377,000 in state general funds was appropriated for FY 2007.

[2] United States Department of Agriculture, Food and Nutrition Service. *WIC Farmers' Market Nutrition Program*, (Aug. 30, 2006), available at *http://www.fns.usda.gov/wic/FMNP/FMNPgrantlevels.htm.*

Lawmakers in **Connecticut, New Mexico, New York** and **Pennsylvania** considered measures to promote the development of farmers' markets.

In **Connecticut**, S.B. 294 was adopted in May. The measure authorizes an expansion allowing the sale of honey, maple syrup, flowers, meat, milk and cheese–along with fresh produce–at farmers' markets that participate in the federal WIC program. To operate as a state-certified farmers' market, as required by WIC, two vendors must offer fresh produce. The approved budget bill, H.B. 5846, authorizes the Commissioner of Agriculture to develop a multiyear, statewide promotional campaign to promote Connecticut's fresh grown produce. The commissioner is charged with developing a Web site that will include a list of all the state's farmers' markets.

In **New Mexico** the enacted budget measure, S.B. 415, appropriated $75,000 to promote and develop the state's farmers' markets, and another $75,000 was specifically appropriated to the Santa Fe farmers' market.

Pennsylvania lawmakers enacted The Farmers' Market Development Act, H.B. 2472, to establish a farmers' market grant program to support the development or expansion of markets throughout the state. In addition, the approved state budget, H.B. 2499, appropriated $3 million in general funds to support the WIC and Senior FMNP programs.

Conclusion

The Women, Infant and Children Farmers' Market Nutrition Program and the Senior FMNP are federal programs that provide for the purchase of fresh vegetables, fruits and herbs directly from state-approved farmers' markets. Currently 37 states operate an FMNP and some states are seeking additional funding to support senior programs and develop farmers' markets across the state.

Biotechnology: Labeling of Genetically-Modified Products

Overview

Agriculture biotechnology, most commonly in the form of genetic modification, has sparked debate in the United States and across the globe, but more so in Europe than anywhere else. Genetic modification technologies allow scientists to alter the genetic makeup of plants and animals in an effort to make crops and farm animals disease-resistant, to increase crop yields and to increase muscle mass in animals. However, critics argue that not enough is known about this science and fear that these modifications may be harmful to humans.

U.S. farmers are the largest producers of genetically-modified (GM) crops. Product labeling of GM produce or meat is not federally mandated, but states are slowly taking up the issue to require the labeling of such products. **Vermont** became the first state in the nation to require the labeling of GM seeds in 2003. In 2005 **Alaska** Gov. Frank Murkowski (R) signed S.B. 25, requiring GM fish and fish products to be labeled as such.

According to research completed by the Pew Initiative on Food and Biotechnology, a new trend emerged in 2005 regarding biotechnology activity. Nine states introduced legislation that would preempt local and county regulations of GM products.[1]

[1] Pew Initiative on Food and Biotechnology. *State Legislative Activity Related to Agricultural Biotechnology in 2005*, June 2006.

2006 State Legislative Activity

In 2006 legislators in three states deliberated legislation calling for the labeling of GM products. **Hawaii** lawmakers introduced H.B. 2827, a measure similar to Alaska's, which would require the labeling of GM fish and fish products. In addition, three measures–H.B. 1781, S.B. 647 and S.B. 1764–were carried over from last year. All these measures died with the adjournment of the legislature. **New York** H.B. 115 and H.B. 8344 would require the labeling of GM seeds and H.B. 3165 and S.B. 1637 would require labeling of GM products, in addition to **Massachusetts'** H.B. 2667. None of these measures passed the chamber of origin.

Conclusion

While the federal government does not mandate the labeling of genetically-modified produce or meat, states are beginning to consider the issue; Vermont and Alaska are the first to require such labeling.

Innovative State-Level Initiatives on Nutrition and Physical Activity

Innovative Legislation

In the past several years, state legislators have introduced hundreds of bills aimed at addressing obesity by promoting nutrition, physical activity and wellness. While most of the bills are similar in nature, a few measures stand out from the rest as creative, innovative or stringent in their provisions. Some of the more innovative measures introduced in the 2006 session include the following:

Connecticut S.B. 373, An Act Concerning Healthy Food and Beverages in Schools, continues to allow for local control over food in schools, but provides a unique financial incentive for schools to offer healthy foods. The state Department of Education must publish nutrition standards for food items by August 1, 2006. School districts participating in the National School Lunch Program must decide and report to the Department each year on whether they will offer only food items that meet the new standards. Districts that do so will receive an additional 10 cents per lunch from the state–a substantial increase from the current rate of 5 cents per lunch. The law went into effect July 1, 2006.

Iowa lawmakers enacted a bill to establish a nutrition and physical activity community obesity prevention grant program. Senate Bill 2124 strives to increase fruit and vegetable consumption and raise physical activity to up to 60 minutes per day among elementary schoolchildren. What differentiates this bill from other bills that establish nutrition and physical activity pilot programs is that it focuses on communities rather than schools. The Department of Public Health will award grants to six communities in six regions.

Delaware H.B. 372, enacted in July, requires that each school district assess the physical fitness level of each student at least once at elementary school, middle school and high school levels, with all results reported to parents and guardians. The intent is to provide baseline and follow-up fitness results to students and their parents in an effort to raise awareness of obesity and related chronic illnesses.

Last year **California** implemented a pilot program to increase access to fresh fruits and vegetables in schools. This year lawmakers in California introduced two innovative bills to increase access to fresh produce in low-income communities. Senate Bill 1329, the *Healthy Food Retailing Initiative*, would provide grants or loans to businesses interested in opening grocery stores in these communities. This measure passed the Senate, but died on adjournment. House Bill 2384 establishes the *Health Food Purchase Pilot Program* to test strategies aimed at increasing the sale of fresh fruits and vegetables in low-income communities. Participants in the program will focus on developing the best approach for neighborhood grocery stores to provide fresh produce and increasing the consumption of fresh fruits and vegetables among food stamp recipients. This measure was enacted in September. Another California measure, H.B. 569, would have required nutritional content information to be provided in schools; however, that provision was later removed.

Oklahoma S.B. 1461 would have called on the state Board of Education to develop a fitness assessment software program to measure and track components of fitness, including body mass index (BMI), endurance, strength and flexibility. The bill passed the Senate but died in the House on adjournment.

A unique bill in **Tennessee** S.B. 3143 would have required local education agencies to review and report on the long-term health effects of structured and intramural sports on children. The bill also would have encouraged local education agencies that have implemented or expanded physical activity programs to report to the Department of Education on the actions taken and the effectiveness of the programs. However, the bill died on adjournment. This bill was unique in that it encouraged reporting on the long-term effectiveness of physical education programs. Most bills only focus on the program and not on the study of its long-term effects.

Several bills in recent years have called for child nutrition programs and school food service personnel to receive education on nutrition and meal planning. Two identical and innovative bills in **Virginia**, H.B. 1593 and S.B. 206, took this concept one step further and would require all superintendents to receive instruction on the causes, consequences, prevention and reduction of childhood obesity. The bills were carried over to the 2007 legislative session.

While the use of trans fat in foods has been criticized by health advocates for several years, proposed trans fat bans took center stage as a heated nutrition policy debate in the latter half of 2006. Taking unprecedented state legislative action, lawmakers in **New Jersey** introduced a bill, S.B. 2265, banning the use of artificial trans fats in all restaurants. **Chicago** and **New York City** proposed similar local bans. None have been enacted.

Although **Nevada** was out of session and did not consider legislation this year, the Nevada Association for Health, Physical Education, Recreation and Dance continued its push for a state constitutional amendment requiring public schools to provide daily physical education on the 2006 ballot. This was a unique, unprecedented effort to enhance physical activity in schools. The association needed to collect 83,184 signatures to be eligible for the November 2006 ballot; however, they fell short of the necessary signatures.

Non-Legislative State Initiatives

In addition to legislative actions, many state agencies and organizations have launched statewide programs to promote healthier lifestyles and reduce obesity among state residents. The following initiatives are representative of the non-legislative initiatives of 2006.

Illinois

Gov. Rod Blagojevich (D) established a Governor's Council on Health and Physical Fitness, as part of an effort to promote healthier lifestyles. Made up of health and fitness advocates, the council will work to address obesity and encourage state residents to incorporate physical fitness and healthier lifestyles into their daily routine. Otis Wilson, a former Chicago Bear and Super Bowl champion, will serve as chairman of the council. Blagojevich said in a press release, "My goal is to help families understand the importance of building the foundation of living healthy and active lifestyles at an early age. I'm committed to working with families across the state to help motivate and encourage them to participate in activities and services that will be offered through the council and the *Fit 4 Life* program." The governor and the departments of human services and public health launched the Fit 4 Life program in 2005 to promote physical fitness through various activities, including a *State Agency Walking Challenge* and a *Hula Hoop Challenge* for youth.[1, 2]

Iowa

The Iowa Sports Foundation, Iowa Department of Public Health, Iowa Games and Iowa State University partnered to create the state wellness program *Lighten up Iowa (LUI): Changing the Shape of Our State*. LUI was a five-month, team-based program designed to encourage Iowans to take steps toward a healthier lifestyle that ran from January to May. Teams were made up of two to 10 members and had the option of competing in one or both of two divisions: weight loss and minutes of activity. The weight loss division monitored progress by percentage of weight lost for each team while the minutes of activity division tracked activity minutes for each team. The program also gave participants nutrition and physical activity tracking logs, tips on physical activity and proper nutrition, free entry into the Iowa Games fitness walk and monthly incentives and prizes. More than 31,000 Iowans registered for the program in 2006. The four entities will sponsor the program again in 2007.

1 Office of the Governor. "Gov. Blagojevich Convenes Council and Makes Health and Fitness Priorities for the State" (Press Release, Aug. 18, 2006), *available at http://www.illinois.gov/ PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=5196.*

2 Illinois State Board of Education. "State Agencies Join Gov. Blagojevich Initiative to Get Fit" (Press Release, July 13, 2005), available at *http://www.isbe.net/news/2005/july13_05.htm.*

Kansas

In August the Department of Health and Environment partnered with a private software company to make the computer program *CheckUp: The Complete Personal Health Manager* available for state residents to download free of charge. The software provides tools to help individuals organize and monitor a variety of medical, nutritional and physical fitness information. "CheckUp reflects the wave of the future for personal health care management," Governor Kathleen Sebelius (D) noted in a press release.[3] The software offering is the latest addition to the governor's *HealthyKansas* initiative, a strategy launched in 2004 that includes measures to prevent obesity in children and adults.

Massachusetts

Last year state leaders kicked off a statewide public health awareness campaign to promote the benefits of exercise. *Every Body Move!* is designed to get residents of the state to be more physically active. The campaign was developed by the Massachusetts Governor's Committee on Physical Fitness and Sports (MGCPF). In January MGCPF and the Department of Education announced the creation of the *Every Body Move!* grant program to award 25 schools up to $7,500 each during the 2006–2007 academic year to develop or sustain physical activity programs before, during or after school for children between the ages of 8 and 14.

Minnesota

Governor Tim Pawlenty (R), in conjunction with the state Department of Health, set up the *Governor's Fit School* initiative in January to recognize schools that promote fitness, nutrition and healthy lifestyles for their students. Schools may apply online for the designation; if they meet several criteria, including the development of wellness plans, providing comprehensive nutrition education and physical fitness programs and meeting USDA standards for school meals, they will receive a certificate of recognition from the governor and their school's information will be posted on the Department of Health's Web site. Close to 100 elementary, middle and high schools have received the designation in the program's first year.

[3] Office of the Governor. "CheckUp Software Partnership Announced" (Press Release, Aug. 22, 2006), *available at http://www.governor.ks.gov/news/NewsRelease/2006/nr-06-0822b.htm.*

Ohio

The *Best Buckeye Healthy Schools* program, a five-year-old initiative, recognizes schools that have achieved a gold, silver or bronze standard in improving the overall health of children. The program is designed to track the progress of schools' efforts to achieve the highest standard in the area of tobacco, nutrition and physical activity education. Schools that achieve a gold standard are given a flag to fly outside their building. In February Gov. Robert Taft, Jr. (R) announced that the program will offer a one-time $450 award to schools that achieve the gold standard. This is a meaningful incentive to schools, where funds may be limited for physical activity programs and /or generated through sale of junk food and soft drinks.

Tennessee

Gov. Phil Bredesen (D) launched *GetFitTN*, a public awareness campaign focused on the prevention of type 2 diabetes. Former professional football player Eddie George was recruited as spokesman for the program, and he and a number of health professionals will tour the state for nine months promoting fitness and nutrition. The initiative targets all at-risk populations, but a particular emphasis is being afforded to children. The campaign is funded under the governor's Project Diabetes and Coordinated School Health plans, a two-pronged diabetes prevention strategy introduced in September. According to a press release from the governor's office, this broader strategy is designed to counteract "a 'perfect storm'–the ever-increasing prevalence of fast food combined with TV and video games and diminishing attention to physical activity." [4]

Texas

At the start of the 2006–2007 school year, the Texas Department of Agriculture launched the *Texas Think Bright!* campaign to promote good nutrition in elementary schoolchildren. The campaign provides tri-colored wristbands to every elementary school student in the state to remind them to select colorful, nutritious fruits and vegetables. Agriculture Commissioner Susan Combs said, "If we can get these children and their families to do their shopping around thinking bright, then they've got a better future." [5, 6]

[4] Governor's Communication Office. "Bredesen Outlines Diabetes-Prevention Strategy" (Press Release, Sept. 18, 2006), available at *http://www.tennesseeanytime.org/governor/AdminCMSServlet?action=viewFile&id=867.*

[5] Lane J. "Agriculture Official Urges Healthy Eating, Activity." *The Beaumont Enterprise*, Sept. 1, 2006.

[6] Texas Department of Agriculture. Think Bright Wristband Distribution (2006), available at *http://www.squaremeals.org/fn/render/parent/channel/0,1253,2348_2498_0_0,00.html.*

Earlier in 2006, in an effort to encourage all Texans to be more physically active, Gov. Rick Perry (R) launched the third annual *Texas Round-Up* challenge. The two-part program began with a six-week activity training program that led up to a variety of fitness events held on April 29. Texans of all ages had the opportunity to sign up for the online training program that included fitness schedules and an activity log. Adults were asked to complete 30 minutes of activity five days a week for six weeks, while children were encouraged to complete 60 minutes of activity five days a week for six weeks. Incentives were awarded to individual participants as well as to the family, employer and community with the highest level of participation. The events on April 29 included a 10-kilometer run/walk, 5-kilometer run/walk, family mile, health and fitness festival, health expo and post-race celebration concert.

Virginia

The Department of Health moved forward in its development of a statewide plan to prevent and control obesity, the *Commonwealth's Healthy Approach and Mobilization Plan for Inactivity, Obesity and Nutrition* (CHAMPION). Seeking input from a broad range of stakeholders, the agency held six regional forums to elicit comments and suggestions from community members. Three additional meetings were conducted with health care and social service professionals and minority representatives. Information from these sessions was then evaluated by a seven-member panel of policy experts and compiled into a 349-page report.[7] The data contained in the report will serve as a starting point for further research. A final state plan to address the obesity problem is set to be released next summer.

[7] Virginia Department of Health. *CHAMPION: Leading Virginia to the Finishline* (2006), available at *http://www.vahealth.org/wic/ChampionReport.pdf.*

West Virginia

The West Virginia Healthy Act of 2005 called for sweeping changes and actions throughout the state to promote healthy lifestyles and reduce obesity. The bill created the Office of Healthy Lifestyles within the Department of Health and Human Services, established school nutrition and physical education guidelines and called for the development of a statewide voluntary private sector partnership program to work with businesses that encourage and promote healthy lifestyles among their employees and communities. As a result, the *Partnership for a Healthy West Virginia* was created. The group's Web site, sponsored by the West Virginia Medical Foundation and the Healthy Lifestyle Coalition, serves as a portal for health programs throughout the state and focuses on four target populations–healthy kids and schools, healthy employees, healthy communities and healthy supports. It features a calendar of health promotion events throughout the state and showcases examples of successful programs addressing target populations. The Web site also hosts the *West Virginia on the Move* site, the state branch of *America on the Move*.[8]

In addition, the West Virginia Cycling Foundation hosted its second annual *Cheat Mountain Challenge* to promote health and physical fitness for all state residents through cycling. The event, held September 24 at Snowshoe Mountain, features a 65-mile metric century ride or a 100-mile century ride. The Foundation, founded in 2005, focuses on promoting safe, enjoyable cycling and cycling routes throughout the state, and focuses its programs on supporting fitness events and road and trail access, and on educating the public about the benefits of cycling, use of equipment, safety, training and cycling skills.

[8] Nett V. "Cycling Group Promotes Activity as Fun and Healthy." *Charles Gazette*, Aug. 12, 2006.

Non-profit Initiatives

In 2006 several national and state non-profit organizations also launched programs that encourage healthy eating and physical activity. Many programs, like the following examples, are local in scope and provide resources such as funding, educational materials and policy suggestions to schools, school districts and communities.

Action for Healthy Kids (AFHK)

AFHK's *Campaign for School Wellness* program provides resources to schools and school districts to help them comply with the provision under the federal Child Nutrition and WIC Reauthorization Act of 2004 that requires nearly all school districts in the country to adopt a local wellness policy by July 2006. The campaign is a supplement to the AFHK State Teams established in 2002 in every state, the District of Columbia and New York City. The teams are made up of school administrators, educators and health professionals to design and help implement strategies that improve school nutrition and physical activity. As part of the campaign, AFHK also launched *Game On! The Ultimate Wellness Challenge*, a series of back-to-school events for fifth to eighth grade students, parents, teachers and administrators that integrate nutrition, physical activity and learning through various activity stations. The program culminated with a national event in Washington, D.C., where six schools were awarded school wellness grants ranging from $1,000 to $3,000. AFHK also developed *ReCharge! Energizing After-School* with the National Football League, an activity kit that encourages healthy snacks, team-based physical activities and goal setting.[9,10,11,12]

Association for Supervision and Curriculum Development (ASCD)

The ASCD launched *Healthy School Communities* to shift public discourse about education from a strict academic focus to a "whole child" approach. In the first two years of the multi-year program, the ASCD plans to identify school communities that already integrate health and learning in the United States and Canada and sponsor the development of new ones; launch an advocacy and awareness campaign aimed to influence national, state, provincial and local education policy; and establish a system of collecting data to measure the effects of healthy school communities on students.[13]

9 Action for Healthy Kids. *Campaign for School Wellness* (2006), available at *http://www.actionforhealthykids.org/special_CswGameon.php.*

10 Action for Healthy Kids. *What's Happening in My State?* (2006), available at *http://www.actionforhealthykids.org/state.php.*

11 Action for Healthy Kids. *Game On! The Ultimate Wellness Challenge* (2006), available at *http://www.actionforhealthykids.org/special_GameOn.php.*

12 Action for Healthy Kids. *ReCharge!* (2006), available at *http://www.actionforhealthykids.org/special_after.php.*

13 Association for Supervision and Curriculum Development. *Healthy School Communities* (2006), available at *http://www.ascd.org/portal/site/ascd/menuitem.187f5eeabf5d4a29a62c2d69e3108a0c/.*

National Alliance for Nutrition and Activity

The alliance designed model nutrition and physical activity policies that school districts can choose to use to meet the Child Nutrition and WIC Reauthorization Act of 2004, which requires all school districts with a federally-funded school meals program to develop and implement nutrition and physical activity wellness policies by the start of the 2006–2007 school year.[14]

Northwest Health Foundation

The Northwest Health Foundation's Alliance for the Promotion of Physical Activity and Nutrition provides grants to community coalitions such as neighborhood associations, schools worksites and health systems in Oregon and southwest Washington that promote physical activity and healthy eating at the local level. Seven community coalitions received funding in the first round of grants.[15]

Conclusion

In the past year states have introduced numerous legislative measures aimed at preventing obesity and promoting nutrition, physical activity and wellness. A number of innovative proposals were set forth, including Connecticut's proposal to provide a unique financial incentive for schools to offer healthy foods, and Oklahoma's proposal to develop a fitness assessment software program to measure and track components of physical fitness. In addition to legislation, many state agencies and organizations launched statewide programs to promote healthier lifestyles and reduce obesity among state residents. One such effort was the Association for Supervision and Curriculum Development's Healthy School Communities initiative aimed at shifting public discourse about education from a strict academic focus to a whole child approach.

[14] National Alliance for Nutrition and Activity. *Model School Wellness Policies*, available at *http://www.schoolwellnesspolicies.org/index.html.*

[15] Northwest Health Foundation. *Alliance for the Promotion of Physical Activity and Nutrition*, available at *http://www.nwhf.org/opportunities/APPAN.php.*

Conclusion

Are We Making Progress?

Since 2003 various stakeholders have introduced a number of wide-ranging legislative and non-legislative actions designed to address the obesity epidemic in America.

But are these policies and programs having a positive impact? Are they making a difference? And what does the future have in store?

In 2004 the Institute of Medicine (IOM) released *Preventing Childhood Obesity: Health in the Balance*, a report with recommendations and an action plan to reduce the prevalence of overweight children and adolescents. In September 2006 the IOM released a subsequent report, *Progress in Preventing Childhood Obesity: How Do We Measure Up?* The IOM reported that recognition of childhood obesity as a public health epidemic with substantial economic consequences has increased, yet the public and private sectors are not doing enough to address the problem, particularly compared to their investments in other areas of public health, such as bioterrorism. The IOM's key recommendations for all stakeholders include:

- increased leadership and commitment to reducing childhood obesity;
- broader evaluation of policies and programs;
- improved monitoring of progress; and
- wider dissemination of promising practices.

The report also provided Next Steps for Confronting the Childhood Obesity Epidemic, and listed specific recommendations for the government, industry, media, communities, schools and households.

In August 2006 Trust for America's Health (TFAH) released its third annual *F as in Fat* report. The report, *F as in Fat: How Obesity Policies are Failing in America, 2006*, examined state obesity rates and government policies. It also provided a 20-step action plan for reducing the health and economic burdens associated with obesity.

TFAH reported that adult obesity rates rose in 31 states during the past year despite increased government intervention. Mississippi had the highest rate of adult obesity (29.5 percent), while Colorado had the lowest rate (16.9 percent). Like the IOM's recommendations, TFAH suggested a comprehensive approach involving all stakeholders–families, communities, schools, employers, the food and beverage industry, health professionals and state and federal governments. Some of the key recommendations included the following:[1,2]

- Fully funded, long-term solutions.
- Fast-track research to identify effective evidence-based interventions and best practices.
- Better indicators to measure success and progress (i.e., measures of physical fitness and nutrition, rather than weight and BMI).
- Community-based efforts to increase access to healthy foods and opportunities for physical activity.
- School-based efforts to enhance physical education and the nutritional content of foods and beverages offered.
- Employer-based programs to offer employees wellness programs, benefits and opportunities to be physically active.
- Food, beverage and marketing industry initiatives to encourage healthier options and better inform consumers.
- Federal government revisions to the USDA school meal program standards.

[1] Trust for America's Health. *F as in Fat: How Obesity Policies are Failing in America, 2006* (Aug. 2006), available at *http://healthyamericans.org/reports/obesity2006/Obesity2006Report.pdf.*

[2] Trust for America's Health. "America's Obesity Epidemic Getting Worse: New Report Finds Adult Obesity Rates up in 31 States; The South is the 'Biggest Belt'" (Press Release, Aug. 29, 2006), available at *http://healthyamericans.org/newsroom/releases/release082906.pdf.*

While the recent findings of the Centers for Disease Control and Prevention (CDC), IOM and TFAH demonstrate little to no improvement, some states have begun to see positive results. For example, three years after the passage of Arkansas Act 1220 of 2003, state data analyzed by the Arkansas Center for Health Improvement (ACHI) indicates that Arkansas has halted the obesity epidemic among its public schoolchildren.[3] This is especially noteworthy, as the nationwide rate of childhood obesity continued to increase during the same period. In the future Health Policy Tracking Service expects that more evaluations on the impact of such local and state policies and programs will be released.

Moving Forward

Before 2006 even came to a close, actions for 2007 and 2008 were in the works. Upcoming events include:

- The IOM is expected to release a report in March 2007 with a review of and recommendations for nutrition standards for foods in schools.[4]
- The Department of Health and Human Services will develop *Physical Activity Guidelines for Americans*, which will complement *Dietary Guidelines for Americans 2005*; the updated version is scheduled to be issued in late 2008. The new guidelines will be routinely evaluated and updated, and will be based on the latest scientific knowledge regarding activity and health, particularly for at-risk populations such as seniors and children. The report will be part of President Bush's *HealthierUS Initiative*, which encourages a culture of wellness with an emphasis on physical fitness, nutrition, healthy choices and preventive screening.[5, 6]

[3] Data available at *http://www.achi.net/current_initiatives/obesity.asp.*

[4] Institute of Medicine of the National Academies. *Nutrition Standards for Foods in Schools* (Feb. 5, 2007), available at *http://www.iom.edu/CMS/3788/30181.aspx.*

[5] Department of Health and Human Services. "HHS Secretary Announces Development of Physical Activity Guidelines at National Prevention Summit" (News Release, Oct. 26, 2006), available at *http://www.hhs.gov/news/press/2006pres/20061026.html.*

[6] Leavitt M. *National Prevention Summit, Remarks as Prepared at Prevention Summit* (Oct. 26, 2006), available at *http://www.hhs.gov/news/speech/2006/102606a.html.*

Memorandum of Understanding agreements are in place, and the current debates–over issues such as nutritional content information, the use of trans fats and the advertising of junk food to children–will continue to put pressure on the food and beverage and advertising industries to change their practices through 2007. Changes at the local level will also continue as schools implement wellness policies, consider MOU agreements and forge relationships with community-based organizations aimed at improving children's health. With New York City, Chicago and New Jersey paving the way, more states and localities may propose bans on the use of trans fats in restaurants and foods.

Initial legislation designed to prevent and reduce obesity tested the waters in 2003 and 2004, while 2005 was characterized by sweeping state laws aimed at addressing childhood obesity in schools. As demonstrated in this report, 2006 was a sentinel year for industry and local actions. It remains to be seen what course of action policy-makers will take in 2007, but it is clear that lawmakers at all levels–along with food, beverage and advertising industry leaders, education officials, health advocates and other stakeholders–will continue to address the problem.