Notes from the Field

Eight Lessons Learned

from Collaborating with Insurers, Employers, and Healthcare Provider Associations to Prevent Obesity

KEYBRIDGE Public Policy Economics

ALLIANCE FOR A HEALTHIER GENERATION

The Alliance for a Healthier Generation, a national nonprofit organization working to empower kids to develop lifelong, healthy habits, is the founding organization leading the coordination of the Healthier Generation Benefit. The development of this article was informed by lessons learned through nearly a decade of implementing the Benefit with input from participating insurance companies and employer groups. Healthier Generation is also a founding organization guiding the development of the My Healthy Weight Initiative.

Keybridge is an economic and public policy consulting firm based in Washington DC and has served as the evaluator for the Healthier Generation Benefit since 2015. Keybridge conducted the signatory interviews, prospective return on investment analysis, background research and literature review, and program evaluation activities which contributed to this article.

I. INTRODUCTION

Childhood obesity threatens to reduce the quality of life for generations of Americans. When left unaddressed, the lifetime costs of obesity contribute billions to U.S. healthcare expenditures. Meaningful reductions in childhood obesity rates will be possible when children and their families have the tools to proactively manage their weight and cultivate healthy habits. In 2010, the U.S. Preventive Services Task Force (USPSTF) recommended that all children aged six and older receive screening and comprehensive interventions for obesity to support healthy weight. Many insurance plans at that time only provided weight management counseling to children with a documented weight-related comorbidity, such as type 2 diabetes or high cholesterol. In effect, many children did not have access to the tools to effectively manage weight concerns.

In response, the Alliance for a Healthier Generation ("Healthier Generation") coordinated a cross-sector collaboration involving insurers, large employers, and healthcare provider associations to implement an insurance reimbursement intervention. This collaboration, called the Healthier Generation Benefit ("HG Benefit"), set out to expand access via insurance coverage to pediatric weight management and nutrition counseling. The HG Benefit consists of voluntary commitments from 19 major insurers and self-insured employers ("signatories") to provide access to at least eight annual weight management consultations — four with a primary care provider and four with a registered dietitian — to children ages 3-18 with a body mass index (BMI) over the 85th percentile. Approximately 2.9 million children are currently covered by one of the insurance plans included in this initiative.

To support implementation, Healthier Generation partnered with the American Academy of Pediatrics (AAP) and the Academy of Nutrition and Dietetics (the Academy). These professional associations draw on their expertise in working with and learning from primary care providers, dietitians, and nutritionists. Through the HG Benefit, they support signatories across a wide range of issues, from billing and claims to provider networks and member outreach.

Evaluation is another critical mechanism that supports implementation of the HG Benefit. From the beginning, Healthier Generation has initiated and participated in a robust evaluation process. Assessment tools, including surveys, in-depth interviews, claims data analysis, logic modeling analysis, and an economic analysis, have helped to identify and prioritize HG Benefit improvements and offer lessons that can be applied to the HG Benefit and other insurance-based prevention efforts.

Through the approach of bringing multiple and diverse stakeholders to the table and facilitating close cooperation among them, Healthier Generation has developed a unique perspective on cross-sector collaboration within the healthcare system. This perspective is summarized in the form of key insights, which are grouped into three categories: (1) systemic factors in the insurance market that may influence the HG Benefit; (2) insurance benefit design features that may affect utilization; and (3) implementation insights related to the HG Benefit. These insights are supported by observations drawn from economic theory and peer-reviewed evidence. Additionally, many sections include a call-out box to showcase notable strategies and initiatives related to the key insights. Finally, the article closes with a set of conclusions to summarize the insights discussed.

II. SYSTEMIC FACTORS

2.1 | Collective Action Lowers the Cost of Prevention

INSIGHT: Several economic considerations influence the extent to which payers (i.e., a health insurer or self-insured employer) will invest in obesity prevention. First, preventive health efforts are characterized by up-front costs and delayed benefits. The HG Benefit, for example, requires an investment in weight management counseling today, while the majority of the benefits of preventing or treating pediatric obesity emerge years later. Second, most people have health insurance from different payers over time. If the majority of benefits from an investment in obesity prevention occur in the future, there is a good chance that these benefits will go to other payers, due to member turnover. Investing in obesity prevention with other payers, however, increases the chance of capturing the future payoff of lower health expenditures. Therefore, collective action around obesity prevention improves the economic case for such investments.

Supporting Observations

Payback Period: Investments in prevention must be assessed over the long term to capture the full economic benefits. In childhood, the medical costs attributable to obesity are relatively low. Children who are overweight, however, are at greater risk of developing obesity in adulthood. Over a lifetime, the costs of weight-related chronic diseases among adults with obesity are significant. Finkelstein et al. (2009) estimate that per capita medical spending is $1,429 higher per year for adults with obesity compared to those with a healthy weight. Therefore, comparing costs and benefits of an obesity prevention initiative in a typical business time horizon (i.e., 5 to 7 years) will capture most of the treatment costs but only a fraction of the medical cost savings that accumulate in adulthood. The 2015 evaluation effort for the HG Benefit set out to calculate the break-even point—that is, where costs equal benefits – under different scenarios. A prospective return on investment (ROI) analysis illustrated that an investment in the HG Benefit can be recovered in fewer years as more payers offer it.

Member Turnover: For payers, an evaluation of the costs and benefits of obesity prevention must incorporate member turnover rates. This factor is especially important when only a few payers in a market cover obesity prevention and treatment services. The benefits of an investment in obesity prevention emerge years later in the form of savings in healthcare spending. As such, some payers that did not make the original investment may still enjoy the benefits of lower healthcare spending (i.e., an illustration of free riding). This outcome reduces the incentive to offer preventive services. When many insurers reimburse for the same or similar obesity prevention services, future health costs can be lowered for all, and payers will be well-positioned to recover their investments in prevention.

2.2 | Aligning Health & Economic Incentives

INSIGHT: Payment systems can influence treatment decisions. While preventive care can achieve better health outcomes at a relatively low cost, some payment systems undervalue this care. In the United States, fee-for-service is the prevailing reimbursement model. In this system, the price for a given service depends more on the cost of providing the service than the expected clinical value to the patient. For care like weight management counseling, where the insurer is only covering the cost of a provider's time, payers tend to reimburse at lower rates than for services which require specialized staff, equipment, or complex procedures. Within a value-based system, providers are reimbursed based on the value of care to the patient. Therefore, efforts to prevent illness and coordinate treatment of chronic conditions are encouraged and financially rewarded.

Featured Efforts

The Launch of The My Healthy Weight Initiative: Expanding on the early momentum of the HG Benefit, the Bipartisan Policy Center (BPC), The American College of Sports Medicine (ACSM), and Healthier Generation launched the Obesity Prevention and Treatment Payer Task Force in 2016 with support from the Robert Wood Johnson Foundation. Comprised of participants including state Medicaid directors and representatives from large self-insured employers and private insurers, this task force resulted in the creation of the My Healthy Weight* initiative, a collective of private and public health care payers and employers offering obesity prevention and treatment for individuals for all ages. Launched in November 2017, this initiative will provide millions of individuals nationally with consistent coverage to support healthy weight change.

Long Term Signatory Engagement: An initiative like the HG Benefit is not a quick fix. It requires a sustained institutional commitment. To encourage this, Healthier Generation prioritizes signatory engagement by creating a peer-to-peer community for signatories to spread best practices and celebrate successes. Quarterly calls with signatories and partners, customized quarterly check-ins, and venues for signatories to share their perspectives help to sustain motivation and encourage signatories in their efforts to implement their respective child-wellness commitments. One compelling example of this engagement: In 2015, Healthier Generation extended an invitation to signatories to participate in a meeting on prevention at the White House with First Lady Michelle Obama's *Let's Move!* Campaign and the White House Task Force on Childhood Obesity.

* For more information on the My Healthy Weight Initiative visit: https://www.healthiergeneration.org/take_action/businesses/healthcare/my_healthy_weight/.

Supporting Observations

Fee-for-Service Incentives: In a fee-for-service model, reimbursement is based on specific activities, represented by unique billing codes. While payers and providers are both working toward the goal of the best healthcare at the lowest cost, the system is set up to accomplish this goal through a push-and-pull negotiation between the two entities. While payers seek to control costs, providers are incentivized to provide as much care as possible while maximizing reimbursement. By paying for volume rather than value, this reimbursement model under-rewards efforts to prevent illness and coordinate care.

Value Based Payment Model: In a value-based reimbursement system, providers are paid for keeping people healthy and improving patients' health in the most cost-effective way. One well-documented illustration of a value-based innovation is the Hospital Readmission Reduction Program, which financially rewards hospitals when patients do not return for the same problem after they have been discharged. Preliminary results are promising, with national Medicare readmission rates beginning to fall.

2.3 | Navigating Reimbursement

INSIGHT: The complexity of the U.S. fee-for-service billing and reimbursement system may create a barrier to entry for providers to deliver new preventive services. Efforts to implement the HG Benefit have revealed that there is no one-size-fits-all approach for navigating reimbursement. To receive payment for a weight management session, for example, each payer requires a unique combination of diagnosis codes, procedure codes, and modifiers. Providers must then correctly record diagnoses and care received, and office staff must submit the bill according to insurer specifications. This complexity means that providers may have to investment significant time in learning how to receive reimbursement for new types of services. As a result, to minimize the risk of unreimbursed care, some providers may choose not to actively promote newly covered services.

Supporting Observations

Billing for Weight Management: Coding and billing is a costly, uncertain endeavor for most providers. Complicated billing procedures often result in high administrative costs to determine which services are covered by insurance. As a reference point, two leading surveys of physician practices found that clinics use 12 to 14 percent of revenues to cover the costs of billing and reimbursement. Services like weight management counseling can prove especially difficult to bill for given the different requirements across insurers and the many ways to code for obesity-related services. Of the 1,622 respondents to the AAP's 65th Periodic Survey of Fellows, many providers (62 percent) reported that they were unfamiliar with billing codes for managing and treating obesity. Furthermore, in-depth interviews with HG Benefit signatories suggest that this issue may be tied to variation across insurers in reimbursement requirements. While insurers are usually transparent about the diagnosis and procedure codes associated with obesity treatments, these requirements vary across insurers. For providers who bill to multiple insurers, keeping track of these insurer-specific requirements is burdensome, and mistakes can be costly.

Variability of Reimbursement: Providers face some uncertainty regarding the amount they will be reimbursed. There is evidence showing that reimbursement for routine office visits can be more than double for physicians at the high end of the payment distribution compared to the low end. One study, for example, documented a fifteen-fold difference between the 10th and 90th percentile of reimbursement for treating a selection of common chronic conditions. For vaccines, a highly standardized product, researchers found that reimbursement could range anywhere from $8 to $80 for the same immunization. This variability in reimbursement increases the challenge of implementing a new insurance benefit if providers are unsure of the value proposition.

III. DESIGN

3.1 | Targeted vs. Universal Benefits

INSIGHT: New insurance benefits available to a payer's entire book of business are typically easier to promote than benefits that are available to select members. For payers, identifying eligible members for targeted communications can be resource intensive. For providers, it can be difficult to offer or recommend treatments and services that are covered for only a few patients. In the context of the HG Benefit, some signatories signed on to offer coverage on a limited basis, agreeing to pilot test the initiative before expanding it to other members. While the reasons for targeting the HG Benefit to select members are justifiable, doing so likely hindered communication efforts to inform eligible families of their access to this benefit.

Supporting Observations

Provider Awareness of Targeted Benefits: Providers are less likely to offer or recommend a service if insurance coverage for the care is not common. One explanation for this – referred to as the norms hypothesis—is that providers are unlikely to find out what is covered under each patient's insurance and adjust their recommendations accordingly. Instead, they will make recommendations based on what is covered for their average patient. Therefore, if a majority of patients do not have insurance coverage for weight management counseling, this hypothesis suggests that a provider is more likely not to offer weight management counseling at all. Further evidence suggests that nearly one in three providers may not be offering medically useful services to their patients based on perceived insurance coverage restrictions. These challenges may depress utilization if providers are not encouraging patients to use weight management counseling sessions.

3.2 | Making a Service Easy to Use

INSIGHT: Insurance access may not translate into utilization if the steps required to use an insurance benefit are overly burdensome. Situational factors that influence behavior, referred to as channel factors, can either facilitate certain behaviors or contribute to inaction. Thinking through and streamlining the administrative and logistical steps required to use a particular insurance benefit, like weight management counseling, can strongly influence uptake.

Supporting Observations

Negative Channel Factors: Every additional step required to use a program or benefit will diminish utilization. For example, requiring patients to complete an application and seek approval from the insurer prior to receiving the care will discourage use. These "hassle costs" are not just annoyances, but can actively prevent use of services. Removing these barriers to action, such as through auto-enrollment or enrollment assistance in the case of health insurance, has been shown to increase participation.

Positive Channel Factors: Any action taken to make a program easier to use will likely have a positive impact on utilization. A well-known study by Leventhal et al. (1965) demonstrated the power of channel factors in increasing tetanus vaccination rates among college students. Giving students a campus map with the health center circled and asking about their plans to get to the clinic resulted in a nine-fold increase in vaccination rates, as compared to the group that received a communication about tetanus risks and where to get vaccinated. In this example, encouraging students to take the first step – i.e., articulating a time and route to get to the clinic—was effective in influencing behavior.

IV. IMPLEMENTATION

4.1 | Awareness of Health Plan Benefits

INSIGHT: Communication barriers between insurers and members may constrain awareness of insurance plan benefits. While insurance companies provide comprehensive plan details to members each year, it is not always clear how benefits change from one year to the next. One lesson from implementing the HG Benefit is that insurers are limited in their capacity to contact members directly about benefits linked to a specific health condition such as obesity. Given these barriers, families are often responsible for educating themselves about their covered benefits and figuring out how to use them.

Supporting Observations

Health Insurance Literacy: Awareness of insurance benefits varies across members due, in part, to different levels of health insurance literacy – that is, the degree to which consumers are able to find and evaluate information about health plans and then optimally use the plan once enrolled. A 2014 Kaiser Family Foundation survey assessing health insurance knowledge found that 28 percent of consumers answered, at most, four out of ten questions correctly. Similarly, a 2016 study found that only 47 percent of those surveyed knew that a basic set of preventive services were covered by their insurance plan with no cost sharing, despite significant efforts to promote these benefits.

Transparency: The clarity and consistency in health plan communications also affect awareness of benefits. As part of the Affordable Care Act, insurers are now required to communicate certain information about many of their plans. This rule mandated that all consumers purchasing insurance on the health exchange or through Medicaid must receive two disclosure documents (i.e., Summary of Benefits and Coverage and a Uniform Glossary of Key Terms). These documents represent a step toward increasing the ability of consumers to find and compare health plan information. These documents, however, only explain a small fraction of the insurance benefits available in any given plan. To increase transparency, HG Benefit signatories agreed, as part of their commitment, to send end out targeted communications to members, informing them of access to weight management and nutrition counseling.

4.2 | Building Demand

INSIGHT: Increasing utilization of newly covered health services requires a careful consideration of the factors driving demand. Two fundamental components of the demand for a medical service are awareness of health conditions and the interventions available to treat it. Despite being relatively straightforward for physicians to diagnose, families often do not recognize pediatric overweight and obesity as health concerns. Furthermore, it is not commonly understood that weight management counseling is available, in part due to the wide range of care under the umbrella of “weight management”. Additionally, weak ties between physicians and dietitians diminish the likelihood that physicians will refer patients for nutrition counseling with a dietitian.

Supporting Observations

Family Recognition of Obesity in Children: Recognition of pediatric obesity among families is a critical step to building demand for weight management. A meta-analysis of studies examining parental recognition of childhood weight problems found that over half of parents of overweight or obese children underestimated their child’s weight. Building demand for weight management counseling must not only focus on access to treatment, but also raise awareness among families about obesity risks and the need for early action.

Obesity Stigma: The stigma associated with obesity, which is often rooted in misperceptions about the causes of weight gain, may discourage families from acknowledging excess weight. Furthermore, if providers sense discomfort among families around discussing weight, they may avoid the conversation and forgo treatment. Survey data illustrate the effect of obesity stigma on the provision of care. The AAP's 65th Periodic Survey of Fellows found that while most providers (89 percent) felt prepared to talk with children and parents about weight, only 59 percent felt that families wanted them to raise weight concerns.

Impact of Provider Referrals on Demand: Primary care physicians are a main point of contact in the healthcare system for many patients. Physicians are therefore well-positioned to inform and encourage patients to use certain healthcare services, such as counseling by a dietitian or nutritionist. A 2008 survey of pediatricians and family practice physicians in the American Medical Association found that only 18 percent of primary care providers reported "always" or "often" referring children with an increased BMI for additional evaluation or management related to their weight. Likewise, many providers (53 percent) indicated in the AAP's 65th Periodic Survey of Fellows that there was a lack of adequate services and resources for weight management to which they could refer patients. These factors partially explain why a review of medical records in a primary care center found that only 22 percent of children diagnosed with obesity were referred to a dietitian.

4.3 | Building Supply

INSIGHT: For patients to be able to use weight management services, there must be local providers who are able and willing to provide the care they need. Though it is a key step in ensuring access, the expansion of insurance coverage may not empower patients to get care if there are not enough providers to meet the uptick in demand. For the HG Benefit, full utilization is constrained in some places by limited dietitian networks. Additionally, primary care physicians must be aware of and trained in strategies to address obesity. Physicians' willingness to recommend follow-up weight management counseling will be influenced by how certain they are about the effectiveness of available treatments. Limited training in pediatric obesity management, for example, may reduce physicians' confidence in recommending that patients seek additional weight management counseling.

Supporting Observations

RD Credentialing: To participate in an insurer's network, dietitians must be credentialed to verify their professional qualifications. One way to boost the supply of in-network dietitians is to streamline and expedite the credentialing process. This process can be administratively cumbersome. For some dietitians, the time and effort required can dissuade them from applying for credentialing, thereby depressing the supply of in-network nutrition professionals. A reduction in the supply of credentialed dietitians constrains patients' access to nutrition counseling. The Academy of Nutrition and Dietetics, partnering with the Commission on Dietetic Registration, conducted an analysis of the dietetics workforce showing that by 2020, only 75 percent of the demand for dietetic services will be met by the supply of credentialed practitioners.

Obesity Management Training: Medical schools in the United States provide limited training in weight management and nutrition counseling. Less than 30 percent of schools meet the minimum recommended hours of education in nutrition and exercise science. Furthermore, only one in four providers feel they received adequate training in these areas. Low physician confidence in their ability to assist patients with managing weight may, in part, be due to a lack of training and resources available to treat obesity.

Featured Efforts

Expanding RD Networks: Recognizing a dietitian shortage, one insurer signatory initiated a comprehensive effort to recruit and credential dietitians. This insurer identified that the credentialing process was a key barrier to creating a network of nutrition experts and set out to streamline the process, working across multiple departments. Specifically, the credentialing department assisted with trainings on the licensing process; the management department addressed questions from dietitians; and the marketing department provided members and physicians with lists of credentialed dietitians. This insurer also collaborated with the state dietetic association to communicate with dietitians, and worked with the state licensing board to recruit dietitians. Through these steps, this insurer succeeded in expanding its network of dietitians, which contributed to an increase in utilization of dietetic services.

Quality Improvement Pilot Project: The AAP Institute for Healthy Childhood Weight sponsored a pilot project called the Childhood Obesity Performance Improvement in partnership with Healthier Generation to improve the quality of primary care for children with weight concerns. The goals of this practice-level collaborative were three-fold: (1) to align practice systems with the evidence base; (2) to improve collaboration and care coordination between pediatric practices and dietitians; and (3) to facilitate use of the HG Benefit. The pilot organized participating professionals into teams including a lead pediatrician, an office staff member, clinical support staff, and a dietitian. Focused on effective professional relationships, BMI assessment and documentation, and use of the HG Benefit, the pilot generated insights on coordinating weight management care across providers.

Obesity Competency Education: Recognizing the need for multidisciplinary provider confidence and competence in supporting weight management, Healthier Generation, BPC, ACSM and the Provider Training and Education (PTE) Workgroup* seek to advance reform in America's health professional training systems. Stemming from a grant provided by the Robert Wood Johnson Foundation, one initiative being led by PTE includes the development of core competencies in obesity prevention and treatment. These competencies serve as a set of guidelines that can be integrated into health professional training of all types, from early professional degrees to continuing education. Once implemented, they will help to ensure that all professionals engaged in the prevention and management of obesity have a common set of skills and knowledge to effectively treat and collaborate on obesity prevention and management.

* The PTE Workgroup of the Integrated Clinical and Social Systems for the Prevention and Management of Obesity Innovation Collaborative is an ad hoc activity associated with the Roundtable on Obesity Solutions at the National Academies of Sciences, Engineering, and Medicine.

EIGHT THINGS TO KNOW ABOUT IMPLEMENTING A PREVENTIVE INSURANCE BENEFIT

1. **Investing collectively in obesity prevention with your competitors** can increase the chance of capturing the future payoff of lower health expenditures.

2. **Healthcare payment models**—which determine how and for what providers are paid—establish incentives that can influence care. Fee-for-service models often undervalue preventive care.

3. **Primary care physicians play an important role in referring patients for follow-up weight management and nutrition counseling.** Clearly communicating the exact reimbursement process to physicians can minimize the financial risk they face in offering this care.

4. **Insurance benefits that are available to all members** can be easier to market and implement than benefits available only to select members.

5. **To increase utilization of a new insurance benefit,** minimize the steps required to use it, and create a clear roadmap for members on how to use the care.

6. **Communication gaps and low health insurance literacy depress awareness of insurance benefits.**

7. **Increasing family recognition of childhood obesity risks,** minimizing obesity stigma, and expanding physician confidence in managing obesity can help to build demand for pediatric weight management and nutrition counseling.

8. **Robust provider and referral networks** can help to ensure that an insurance benefit actually expands access to a healthcare service.

END NOTES

[1] Finkelstein, E.A., Trogdon, J.G., Cohen, J.W., & Dietz, W. (2009). Annual Medical Spending Attributable to Obesity: Payer-And Service-Specific Estimates. Health Affairs, 28(5), w822-w831.

[2] Simpson, L.A., & Cooper, J. (2009). Paying for Obesity: A Changing Landscape. Pediatrics, 123(5), S301-S307.

[3] Freedman, D.S., Khan, L.K., Serdula M.K., Dietz, W.H., Srinivasan, S.R., & Berenson, G.S. (2005). The relation of childhood BMI to adult adiposity: the Bogalusa Heart Study. Pediatrics, 115(1), 22-27.

[4] Finkelstein, E.A., Trogdon, J.G., Cohen, J.W., & Dietz, W. (2009). Annual Medical Spending Attributable to Obesity: Payer-And Service-Specific Estimates. Health Affairs, 28(5), w822-w831.

[5] Finkelstein, E.A., & Trogdon, J.G. (2008). Public Health Interventions for Addressing Childhood Overweight: Analysis of the Business Case. Health Policy and Ethics, 98(3), 411-415.

[6] Finkelstein, E.A., & Brown, D.S. (2006). Why Does the Private Sector Underinvest in Obesity Prevention and Treatment? North Carolina Medical Journal, 67(4), 310-312.

[7] Robinson, J.C. (2001). Theory and Practice in the Design of Physician Payment Incentives. The Milbank Quarterly, 79(2), 149-177.

[8] Porter, M.E., Pabo, E.A., & Lee, T.H. (2013). Redesigning Primary Care: A Strategic Vision to Improve Value By Organizing Around Patients' Needs. Health Affairs, 32(3), 516-525.

[9] Berenson, R.A. & Rich, E.C. (2010). Journal of General Internal Medicine, 25(6), 613-618.

[10] Porter, M.E. (2010). What is Value in Health Care? New England Journal of Medicine, 363(26), 2477-2481.

[11] Boccuti, C. & Casillas, G. (2017, May 10). Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program. Retreived from http://www.kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/

[12] Blanchfield, B.B., Heffernan, J.L., Osgood, B., Sheehan, R.R., & Meyer, G.S. (2020). Saving Billions of Dollars—And Physicians'Time—By Streamlining Billing Practices. Health Affairs, 29(6), 1248-1254.

[13] Sakowski, J.A., Kahn, J.G., Kronick, R.G., Newman, J.M. & Luft, H.S. (2009). Peering Into the Black Box: Billing and Insurance Activities In A Medical Group. Health Affairs, 28(4), w544-554.

[14] American Academy of Pediatrics (2006). Periodic Survey of Fellows #65 Counseling on and Management of Childhood Obesity/Overweight [Abstract]. Retrieved from https://www.aap.org/en-us/professional-resources/Research/Pages/PS65_Executive_Summary_CounselingonandManagementofChildhoodObesityOverweight.aspx

[15] Rask, K.J., Gazmararian, J.A., Kohler, S.S., Hawley, J.N., Bogard, J., Brown, V.A. (2013). Designing Insurance to Promote Use of Childhood Obesity Prevention Services. Journal of Obesity, 2013, 1-7.

[16] Baker, L., Bundorf, M.K., & Royalty, A. (2013). Private Insurers' Payments For Routine Physician Office Visits Vary Substantially Across the United States. Health Affairs, 32(9), 1583-1590.

[17] Ellis, P., Sandy, L.G., Larson, A.J., & Stevens, S.L. (2012). Wide Variation in Episode Costs Within A Commercially Insured Population Highlights Potential To Improve The Efficiency Of Care. Health Affairs, 31(9), 2084-2093.

[18] Freed, G.L., Cowan, A.E., Gregory, S., & Clark, S.J. (2008). Variation in Provider Vaccine Purchase Prices and Payer Reimbursement. Pediatrics, 122(6), 1325-1331.

[19] Landon, B.E. (2017). Tipping the Scale – The Norms Hypothesis and Primary Care Physician Behavior. The New England Journal of Medicine, 376(9), 810-811.

[20] Wynia, M.K., VanGeest, J.B., Cummins, D.S., & Wilson, I.B. (2003). Do Physicians Not Offer Useful Services Because of Coverage Restrictions? Health Affairs, 22(4), 190-197.

[21] Lewin, K. (1951). Field Theory in Social Science: Selected Theoretical Papers. Oxford, England: Harper.

[22] Baicker, K., Congdon, W.J., & Mullainathan, S. (2012). Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics. The Milbank Quarterly, 90(1), 107-134.

[23] Leventhal, H., Singer, R., & Jones, S. (1965). Effects of fear and specificity of recommendation upon attitudes and behavior. Journal of Personality and Social Psychology, 2(1), 20-29.

[23] Consumers Union, University of Maryland College Park, & American Institutes for Research. (2012). Measuring Health Insurance Literacy: A Call to Action. A Report from the Health Insurance Literacy Expert Roundtable. Washington, DC: Quincy, L.

[24] Norton, M., Hamel, L., & Brodie, M. (2013, November 11). Assessing Americans' Familiarity With Health Insurance Terms and Concepts. Retrieved from http://kff.org/healthreform/pollfinding/assessingamericans-familiaritywithhealthinsurancetermsandconcepts/

[25] Hamel, L., Firth, J., Levitt, L., Claxton, G., & Brodie, M. (2016, May 20). Survey of Non-Group Health Insurance Enrollees, Wave 3. Retrieved from http://www.kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/

[26] Koh, H.K., Berwick, D.M., Clancy, C.M., Caur, C., Crach, C., Harris, L.M., & Zerhusen, E.G. (2012). New Federal Policy Initiatives To Boost Health Literacy Can Help The Nation Move Beyond The Cycle of Costly 'Crisis Care'. Health Affairs, 31(2), 1-10.

[27] Lundahl, A., Kidwell, K.M., & Nelson, T.D. (2014). Parental Underestimates of Child Weight: A Meta-analysis. Pediatrics, 133(3), e689-e703.

[28] Puhl, R., & Brownell, K.D. (2001). Bias, Discrimination, and Obesity. Obesity Research, 9(12), 788-805.

[29] American Academy of Pediatrics (2006). Periodic Survey #65 Counseling on and Management of Childhood Obesity/Overweight [Abstract]. Retrieved from https://www.aap.org/en-us/professional-resources/Research/Pages/PS65_Executive_Summary_CounselingonandManagementofChildhoodObesityOverweight.aspx

[30] Huang, T.T.K., Borowski, L.A., Liu, B., Galuksa, D.A., Ballard-Barbash, R., Yanovski, S.Z., ... Smith, A.W. (2011). Pediatricians' and Family Physicians' Weight-Related Care of Children in the U.S. American Journal of Preventive Medicine, 41(1), 24-32.

[31] American Academy of Pediatrics (2006). Periodic Survey of Fellows #65 Counseling on and Management of Childhood Obesity/Overweight [Abstract]. Retrieved from https://www.aap.org/en-us/professional-resources/Research/Pages/PS65_Executive_Summary_CounselingonandManagementofChildhoodObesityOverweight.aspx

[32] O'Brien, S.H., Holubkov, R., & Reis, E.C. (2004). Identification, Evaluation, and Management of Obesity in an Academic Primary Care Center. Pediatrics, 114(2), e154-e1569.

[33] Rask, K.J., Gazmararian, J.A., Kohler, S.S., Hawley, J.N., Bogard, J., Brown, V.A. (2013). Designing Insurance to Promote Use of Childhood Obesity Prevention Services. Journal of Obesity, 2013, 1-7.

[34] Hooker, R.S., Williams, J.H., Papneja, J., Sen, N., & Hogan, P. (2012). Dietetics Supply and Demand: 2010-2020. Journal of the Academy of Nutrition and Dietetics, 112(3), S75-S91.

[35] Bipartisan Policy Center, American College of Sports Medicine, & Alliance for a Healthier Generation. (2014, June). Teaching Nutrition and Physical Activity in Medical School: Training Doctors for Prevention-Oriented Care. Washington, DC: Bipartisan Policy Center.

ABOUT THE AUTHORS

Jenny Bogard, M.P.H, is the Director of Healthcare Strategies at the Alliance for a Healthier Generation. Jenny oversees the healthcare initiative, which includes the implementation and day-to-day leadership of the Healthier Generation Benefit, and the My Healthy Weight Initiative. Before joining the Alliance, Jenny served in various leadership positions related to public health, product innovation and global operations. As a public policy consultant for Humana Inc., Jenny developed relationships with leading NGOs and federal agencies to advance Humana's public health efforts for beneficiaries and employees. She previously served as a consultant on staff with the Centers for Disease Control and Prevention in their Office of Strategy and Innovation developing wellness programs for CDC employees and worked on internal agency projects to spotlight and foster innovation. Jenny earned her B.H.S. in Heath Administration from Florida Atlantic University and a M.P.H from the University of Miami

Joshua Moore, J.D., is a Manager of Business Sector Strategies at the Alliance for a Healthier Generation. In his role, Joshua contributes to the strategic expansion of the Alliance's public-private partnership work in the education, healthcare, food and beverage, and technology industries. He serves as the program manager for the Healthier Generation Benefit. Prior to joining Healthier Generation, Joshua had extensive experience working with youth in juvenile centers, family courts, and after-school programs in several metropolitan cities. Joshua obtained a B.A. in Philosophy from Morehouse College and a J.D. from the University of Southern California.

Anne Valik, M.P.H., is a Manager of Business Sector Strategies at the Alliance for a Healthier Generation. In her role, Anne contributes to the strategic expansion of the Alliance's public-private partnership work, and directly leads collaborative project implementation with organizations from a variety of sectors including food and beverage, healthcare and technology. Prior to joining the Alliance, Anne served as a Food Policy Graduate Fellow for New York City Council Member Ben Kallos, and spent eight-years at Credit Suisse Securities where she managed institutional client relationships as a Vice President in Fixed Income Sales. Anne earned her B.S. in both Finance and International Business from Georgetown University's McDonough School of Business. She is also a Certified Integrative Nutrition Health Coach, and received an MPH in Health Policy and Management from Columbia University's Mailman School of Public Health.

Brendan Fitzpatrick, M.P.A. is a Senior Director at Keybridge, where he specializes in corporate social responsibility ("CSR"), impact evaluation, economic modeling, and environmental policy. For more than a decade, he has served as an evaluator and advisor to nonprofit organizations, industry associations, and private companies on their CSR commitments. Prior to joining Keybridge, Brendan served in the Office of the Chief Economist of the World Bank. He holds Bachelor's degrees in Bioengineering & Economics from the University of Illinois at Urbana-Champaign and a Master's degree in Public Administration in International Development from Harvard's Kennedy School of Government.

Leah Foecke is an Analyst at Keybridge, where she focuses on program and impact evaluation, public health and nutrition, and corporate social responsibility. She holds Bachelor's degrees in Economics & Biology from the University of Wisconsin at Madison.

KEYBRIDGE
Public Policy Economics

ALLIANCE FOR A
HEALTHIER
GENERATION