

# Legislative Strategies to Reduce Obesity<sup>1</sup>

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## Introduction

In 1850, The Report of the Sanitary Commission of Massachusetts (the Shattuck Report<sup>5</sup>) found that the average life expectancy in the United States was between 25 and 35 years, and the major cause of mortality was infectious disease. This galvanized the first public health revolution in the United States. Over the next 100 years life expectancy more than doubled and infectious diseases were no longer the primary cause of mortality and morbidity in the U.S. The first public health revolution was based on the science of Snow and Jenner, and later Pasteur and Koch, and combined intensive environmental and sanitation regulation with personal health measures such as disease reporting and investigation, mandatory vaccinations, and personal restrictions. Law was an integral part of this public health revolution and the United States Supreme Court gave public health authorities almost unbridled powers over persons and property when it was necessary to protect the public's health.

Since the 1950s, chronic diseases have become the major threat to the health of the public in the U.S. Some of these diseases are the inevitable consequences of old age and the increased lifespan, but most can be greatly ameliorated or even prevented through environmental and lifestyle modifications. The second public health revolution will be the transformation of a health care and public policy system based on the treatment of the consequences of chronic diseases to one that is based on the primary and secondary

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<sup>5</sup> Massachusetts. Sanitary Commission., L. Shattuck, et al. (1850). Report of a general plan for the promotion of public and personal health. Boston., Dutton & Wentworth, state printers. Available at: <http://biotech.law.lsu.edu/cphl/history/books/sr/index.htm>

prevention of chronic diseases and their sequella. As with the first public health revolution, law will be a key tool in shifting behavior in ways that reduce the incidence and severity of chronic diseases. Law is already the primary tool for the control of smoking, the most important preventable cause of chronic disease. Law will be a major tool in the control of obesity, the second most important preventable cause of chronic illness, and in increasing levels of physical activity. Physical activity has a role in obesity prevention, and an independent role in the prevention of the complications of chronic diseases. Law is also key to reshaping the medical care system to provide better access to preventive care for chronic diseases such as diabetes and hypertension, which would reduce the severity and progression of these diseases.

### **How does the Second Revolution differ from the First?**

There are critical differences between the first and second public health revolutions. The control of communicable disease was based on simple, clearly understood strategies that were well accepted by most of the population. This acceptance was driven by a constant level of fear of communicable diseases. In 1910, Dr. Rosenau, Professor of Preventive Medicine and Hygiene at the Harvard School of Medicine and the author of the first textbook of preventive medicine, wrote:

"Fear is lessening, but we would not want it to disappear entirely, for while it is a miserable sensation, it has its uses in the same sense that pain may be a marked benefit to the animal economy, and in the same sense that fever is a conservative process. Reasonable fear saves many lives and prevents much sickness. It is one of the greatest forces for good in preventive medicine, as we shall presently see, and at times it is the most useful instrument in the hands of the sanitarian."<sup>6</sup>

The fear of communicable diseases was simple - if you or your family member caught the disease, you lived or died pretty quickly, and even if the process was long, as with tuberculosis, you were clearly sick. It was not a continuum - the risk was binary. Tobacco control has been difficult because the link between smoking and disease is not obvious, it requires statistical analysis to understand. Some smokers live long lives with little apparent ill effect. While the majority of smokers do suffer smoking related illness, it takes years, often decades to manifest. This is profoundly different from the quick and clear cause and effect that is easily observed with communicable diseases. The disconnect in time between the risky behavior and its consequences dramatically reduces the fear and the consequent support for swift and comprehensive public action. Banning smoking in the workplace and in public places was driven by the effect of secondary

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<sup>6</sup> M. J. Rosenau, The Uses Of Fear In Preventive Medicine, Boston Medical and Surgical Journal, Vol. 162, #10, 305 - 307, Mar. 10, 1910. Available at: [http://biotech.law.lsu.edu/cphl/history/articles/Rosenau\\_fear.htm](http://biotech.law.lsu.edu/cphl/history/articles/Rosenau_fear.htm)

smoke on non-smokers, and to a great extent their support was based as much on the short-term smell and irritation of the smoke as on an appreciation of any long term risk.

Obesity poses more difficult issues than tobacco. Using tobacco is a dangerous habit with benefits, so the control model is simple - stop using tobacco if possible, if not, use as little as possible. Everyone must eat, so the prohibition model does not work for food. While it is currently fashionable to focus on "bad" foods and fast food in particular, obesity is much more complex. Some people do eat too much fast food, but others get equally fat without eating fast food. Steaks and bacon were seen as classic bad food a few years ago, now many people see them as diet food on the Atkins diet. The best medical research shows that obesity is a life long problem that requires fundamental changes in behavior. It is tied up in both how much people eat and how much physical activity they get. It takes a long time and great effort to change behavior - even the best laws will take years to make a difference in the obesity level of the population. The changes also depend on the individual. Laws can produce an environment that makes it easier to eat less and get more physical activity, but they cannot mandate it. (K-12 schools can control the behavior of students in school, but if the students do not change their attitudes and behaviors, school-based laws will have little long term effect.)

Obesity is not uniformly distributed throughout the population. It is confounded by race, sex, class, and genetic co-factors. While the health effects of obesity take years to manifest, being fat is obvious and stigmatizes individuals in many situations. Unlike smoking, obesity cannot be hidden, and it takes months to years of hard work to make visible changes in one's appearance. Since overeating is influenced by a person's mental health, increasing the stigma associated with obesity may be counterproductive. To the extent that being fat is culturally accepted, attacks on obesity can be seen as attacks on the culture. As the medical evidence mounts that obesity is a disease with profound medical consequences, the courts are likely to revise their views of obesity as a disability under the Americans with Disabilities Act, further complicating laws that seek to punish or stigmatize fat people.

### **Unintended Consequences**

Obesity is suddenly a hot legislative topic and there is tremendous pressure to pass laws to "deal with" obesity. This is a natural part of the political process. Legislators respond to their constituents. Unless the constituents or a powerful citizen or industry lobby care about an issue, there is little time and few resources to address it. Once an issue becomes one of public concern, then laws are passed to deal with it. For a complex problem like obesity, which has no clear solutions, it is inevitable that many of the laws will not have the desired impact. Programs which might be effective in the long run will see their funding cut because they make little short-term difference, and other issues will capture the public imagination.

Obesity is an issue that deserves thoughtful legislation based on a long term plan, can be modified as more scientific information becomes available. While we might want this for all laws, it is especially important for obesity because the obesity epidemic is rooted in earlier laws. No legislature in the United States ever sat down to pass a law that would make people fat. Yet many of the factors that contribute to the obesity epidemic are the unintended consequences of legislation with laudable goals.

### **Farm Policy**

The most obvious cause of the obesity epidemic is the cost and availability of food. As late as the 1950s, the cost of food was such that it influenced portion size and eating habits. Historically, being fat, especially for men, was seen as being prosperous. U.S. agricultural policy was directed toward making food more available and cheaper. Food chemists sought ways to process food to make it less perishable. Substitutes such as high fructose corn sweetener were developed to replace more expensive cane and beet sugar. Industrial methods were applied to food production and processing, dramatically reducing the cost of food and increasing the variety of processed foods on grocery shelves. In constant dollars, food prices today for meat and processed foods are much lower than they were in 1950. Restaurants and fast food outlets began to compete over portion sizes, vying to offer the largest portions. More importantly, portion size increased at home, where most people still eat the majority of meals. Increased portion size, which is a consequence of cheaper and more available food, is probably the most important cultural change behind the obesity epidemic. Yet who would legislate for more expensive food or less available food?

### **Schools**

Schools are seen, probably correctly, as major contributors to childhood obesity. In the 1950s and 1960s, snacks were carefully monitored milk breaks, with acrimonious debates about whether chocolate milk would be allowed. School lunches were classic institutional food, prepared on the premises, and students were offered little choice. The meals were planned by dieticians to be well balanced and students were served fixed portions. Now schools have vending machines with snacks and soft drinks and serve unlimited amounts of fast food and candy in the cafeteria. At the same time that snacks and fast food invaded schools, organized physical activity or even recess time was reduced or eliminated for many students.

Schools are an easy legislative target, and one many states are addressing. These laws often ignore the underlying reasons that schools changed their policies on snacks, fast food, and physical activity. The most important reason is money. Public schools in all but the wealthiest communities are chronically under funded. Those in poor neighborhoods, where obesity is also most common, are usually the most poorly funded. Soft drink and fast food companies pay the schools for the right to sell their products in schools, and pay significant premiums for exclusive contracts. This is money that is not

allocated to specific budget categories, which makes it very valuable when dealing with unexpected budget problems.

Many of these schools are also operating with many more students than they were designed for, which means that they cannot prepare traditional meals without expensive kitchen renovations and expansions, and an increase in skilled staff to prepare the meals. Selling prepackaged or outside vendor provided food may be the only way they can provide lunches to the students they have to serve. Over crowding is also a factor in the reduction or elimination of organized physical education. Reducing staff saves money, and crowding increases the risk of violence if students are not in structured settings. Recess and physical education time was also cut by many schools to increase the time available for substantive education when financial constraints limited the length of school days.

Banning vending machines and fast food may make nutritional sense, but doing it without consideration for the reasons it was allowed into the schools can have unintended consequences. If the school does not have the facilities to serve the students a traditional lunch, it may allow them to leave campus for lunch. This will allow the student to get the prohibited food, and will increase truancy and other educational problems. Some legislation does not ban the vending machines but allows them to stay with "healthful" juice substituted for soft drinks. Unfortunately, most juice has as many calories as soft drinks and no more nutritional value. Water is a better choice, and providing adequate water fountains would probably be the best choice.

### **Drugs**

There are recognized problems with teenaged boys using steroids for body shaping, independent of their use for sports enhancement. There is also a significant methamphetamine problem in the United States. One possible unintended consequence of increased pressure on teens to lose or keep off weight may be increased use of weight loss drugs, both unregulated stimulants, prescription drugs (obtained legally and illegally), and illegal stimulants such as amphetamine.

### **Land Use**

Daily physical activity is an important part of a healthy life style. Irrespective of any effect on weight, physical activity has direct beneficial effects on the cardio-vascular system and other systems in the body. One of the most striking contrasts between the United States and Europe is the amount of walking people do as part of routine activities. European cities encourage walking and discourage driving automobiles, both directly through high taxes and indirectly through city designs that do not favor the automobile. In the United States, we have built a society of suburbs and single use neighborhoods that discourage walking because there is nothing close to the residential housing to walk to. With low density neighborhoods it is not economic to provide mass transportation. Since

there is no place to walk, there are no sidewalks, and the price of gasoline is kept low because people must drive everywhere they go.

The result of these changes in housing patterns and neighborhoods is that most individuals in the United States get little physical activity in their daily routine. While some compensate for this by taking time for exercise, most people do not have the time or inclination to do this regularly. In most places these changes were the result of land use planning and zoning decisions. The legislatures and city governments that made these decisions intended to reduce the cost of housing and to make it safer by separating residential housing from industrial and commercial uses. Once these housing patterns were established, they became self-perpetuating as each new neighborhood moved farther from the original city centers. While these edge cities have had an adverse effect on physical activity, they have resulted in a much higher rate of home ownership than in Europe. With so much of the population already in suburban neighborhoods, it will be difficult to change housing patterns. Changing existing zoning regulations to allow small businesses into neighborhoods to encourage walking will be resisted because of the fears of crime and the lowering of property values.

The fear of crime has had a major effect on housing patterns and physical activity. In many urban areas where the geography is conducive to walking, fear of crime keeps people inside. Even in suburban neighborhoods parents are frightened of allowing their children to play unattended and wander far from home as children did in prior generations. Physical activity is done through organized sports. This leaves many children out and does not build activity into the daily lives of the children who do participate. Reversing these patterns will be very difficult, and must start with restoring the public's confidence in safety of public spaces and neighborhoods.

### **Avoiding Unintended Consequences**

Unintended consequences come in two forms. The first is the direct, but unintended consequence of the law. An agriculture policy directed at lowering the cost of food indirectly increased the portion size as food became cheaper in constant dollars. The second is the displacement problem. New laws or responsibilities that are not fully funded and staffed force agencies to cut back in other areas. Schools have faced ever greater administrative burdens over the past decades. Most of these burdens are important social goods, such as the Rehabilitation Act and the Americans with Disabilities Act, but they did not come with additional funding and thus reduced the schools resources for the basic educational mission. Many schools saw their enrollment increase beyond their design capacity, their budgets cut in real terms, or both. These forced the schools to seek income where ever possible and to use outside vendors to support the lunch programs.

Avoiding the direct effects of the law starts with an overall plan for what the legislature wants to accomplish and realistic goals. Stopping the increase in the incidence of obesity in adults and children over ten years is realistic. Reducing the incidence of obesity in the

population over three years is not. Once there is a realistic goal, such as stopping the increase in the incidence of obesity, the first step is a surveillance system to find out real extent of the problem and to track changes over the next 10 years to see if the legislation is working. There should be a plan of interventions (eliminating vending machines in schools) and incentives (schools get state employees sent to the schools to collect the surveillance data so that it does not burden school staff). There should be community input into the plan and it must be based on sound scientific principles, not food fads. The legislature must resist attempts by interest groups to use the plan for their own political agendas, whether these are to keep vending machines in schools or to punish fast food outlets. The most important part of the plan is a guide to how it will be carried out over the next ten years, including funding and modifications in response to the data from the surveillance system and new findings in medical research.

The displacement problem is easier to identify but politically even more difficult to avoid. Few of the states that are passing laws to control soft drinks and fast food in schools are addressing the financial issues that drove schools to adopt these unsound nutritional policies. This assures that these laws will have unintended consequences because schools will have to cut other necessary activities to make up for the loss in revenue or staff time.

### **The Impact on Health Departments**

The biggest displacement threat is to health departments. There are few health departments at the state or local level that are adequately staffed or funded. Giving a new problem to a health department means diluting existing resources and weakening other public health activities. Almost all health departments are worse off post 9/11 because they have had to add new emergency preparedness and bioterrorism planning exercises and planning. The federal government provided some money for these efforts, but none of it could go to staffing, which is the most limited resource. Departments might have federal money for equipment, but every minute of staff time had to come from another public health activity.

Public health departments should deal only with problems they are uniquely able to handle. For example, they can enforce restaurant labeling requirements because that is a logical extension of existing food sanitation activities. They are also the best agency to collect and analyze epidemiologic data collected by others, such as schools. But for the most part, obesity does not fit the health department's regulatory and enforcement model. There are no clear cut interventions to fight obesity, there are no simple regulatory actions that will make a significant difference, and there is enormous evidence that significant long-term weight loss and maintenance requires ongoing involvement with each individual. In this sense, obesity is an individual health problem that is better dealt with through the medical care system, which deals with problems that require individual intervention and long-term care and monitoring. The medical care system has vastly greater resources, and it bears the brunt of the costs of obesity.

Most importantly, the economics of obesity make it a health care issue. Underlying all the rhetoric about the health effects of obesity is the bottom line issue: obesity costs the health care system a lot of money, and is going to cost it a lot more. Any savings from reducing obesity in the population are going to be savings in medical care dollars, not in public health dollars. It is difficult to create incentives in medical care to spend money now to save money in the future. It is impossible to create a long term system that will take savings from the medical care system and put them into the public health system to reduce the level of disease. This has failed in tobacco control in most states and is doomed to failure for obesity. The cost of managing obesity must be borne by the same system that will benefit from the long term savings if obesity is controlled.

## **Potential Areas for State Legislation**

### **Surveillance and Epidemiology**

The starting point for all public health is good data about the nature of the condition, its incidence, prevalence, and severity, and the factors which may correlate with its development. The collection and reporting of basic individual epidemiologic data has historically been done through the state police power. While the federal government might have the legal authority to require the reporting of communicable diseases that could affect interstate commerce and travel, it has chosen to work through the states. It often uses the spending power to encourage the states to pass laws to collect the data that it wants.

Most of the data that is available for obesity comes from behavioral science studies that depend on self-reported data. While this data is very useful, it would be valuable to have broader based data, especially on children. Data that is developed through a reporting system based on medical records, schools records, and other objective sources is an important complement to self-reported data. This is especially important for obesity, which is not a simple binary state but requires estimation along a continuum, and which carries a social stigma.

States have the legal power to collect epidemiologic data. While objections have been raised under the federal HIPAA privacy rules, these do not restrict the collection of public health data. Having the power and using it are very different. Public health reporting has fallen out of favor with the public over the past 30 years. Physicians and school officials resist reporting under claims about privacy concerns, but the more important problem is that reporting is an unpaid public duty that takes staff time and resources. Parents resist reporting because they want to protect the privacy of their children and because they do not want them stigmatized as obese. Without comprehensive reporting, however, it will be impossible to collect reliable data and to evaluate whether strategies to reduce obesity are working.

### **Personal Interventions**

Personal interventions are what the individual can do to prevent or mitigate the public health problem. Vaccinations for communicable diseases are classic personal interventions. Law has a role in encouraging individuals to take these actions. This might include laws that directly specify behavior, such as mandating vaccinations for school enrollment, preventing smoking in public places, and mandating testing and treatment for tuberculosis. Law can also encourage desired behavior by providing incentives. The tax code provides an incentive for home ownership by making mortgage interest deductible. Life insurance can include a discount for non-smokers, and health insurance can exclude preventive care from deductibles and co-pay requirements.

It is not anticipated that laws mandating specific behaviors will play a major role in controlling obesity or encouraging physical activity in adults. The law should have a greater role in childhood obesity. Morbid obesity in a child can be evidence of neglect. This should be reportable under the child abuse and neglect laws, which will allow child protective services to intervene to change the parents' behavior to protect the child.

Incentives are expected to play a large part in encouraging healthy eating and physical activity. There are many legislative proposals to use insurance surcharges, fitness bonuses on tax returns, and incentives to weight loss and disincentives to weight gain. It is important to differentiate between allowable incentives and incentives that are really disguised punishments. These can pose significant civil rights issues because of the linkage between obesity and race and ethnicity. Obesity incentives and regulations may also run afoul of the Americans with Disabilities Act and state antidiscrimination laws.

### **Building Regulation**

Both states and the federal government set building standards for public buildings. Multi-floor office buildings are a good opportunity for many people to be more active by using the stairs. Codes could require that the stairs be integrated into the design to encourage their use. Buildings might be laid out in ways that would encourage walking within and between buildings. Such changes pose a conflict with traditional fire codes and general building design that make it hard to use the stairs in most buildings. Post 9/11 security concerns are exacerbating the problem in many buildings by preventing persons from using the stairs to go between floors. These conflicts between security and health will be difficult to resolve and will require careful risk management analysis, a classic public health function.

### **Federal, State, and Private Nutrition Support Programs**

Many people in the United States, especially children, receive nutrition support. Research has shown that people who face food insecurity, who face going hungry when their money runs out before the end of the month, also have problems with obesity. Even

if they do not face food insecurity, it can be difficult to put together a nutritious diet from nutrition support programs.

The major federal programs are WIC and Food Stamps. In addition, the federal government helps support state programs. States cooperate with the federal government in implementing food programs and the states also have their own programs, such as meals on wheels. Churches and other private organizations provide community pantries and food boxes, and some, such as the Salvation Army, provide structured meal programs. There has been little attention paid to coordinating the programs to assure that individuals who depend on them can get a balanced and nutritious diet.

States and the federal government should coordinate the organization of governmental food assistance programs, which agencies control them, and the extent to which their regulations affect healthy diet choices. States should work with private nutrition support groups to assure that persons who depend on these programs get a proper diet.

### **Health Insurance Regulation**

The current health insurance system does not account for the costs savings and other benefits of prevention. Because of this, most health plans do not properly pay for or encourage preventive services. The trend to shift more of the cost to the insureds to encourage them to be better consumers will further undermine preventive care by encouraging people to only go to the doctor when they sick.

This is a particular problem for obesity because most physicians are not skilled in providing obesity preventive care and many do not appreciate its significance as a dangerous health condition. The problem is complicated by the spotty coverage of the health insurance system and by the problem that insurance mandates, as favored by many states, often provide little effective increase in care because they also increase the cost of insurance and thus decrease its availability. States are also constrained by federal law from regulating the most common types of insurance policies.

States bear a lot of the costs of obesity through the Medicaid program and through the loss of productive citizens from disability. States should consider developing categorical clinic programs for obesity, diabetes, and hypertension to assure that persons needing care get it without regard to their insurance status. If these are public health diseases, then, as with tuberculosis and syphilis, their treatment should not depend on whether the patient has money or insurance. Private health plans could be required to allow their insured to participate in these clinics, with the incentive they would provide cost effective and consistent care. The objective of these disease specific programs is to assure that patients with chronic diseases get consistent care irrespective of job or insurance status.

## **REPRESENTATIVE STATE LAWS, PROPOSED AND ENACTED TOPIC SUMMARY**

(This is not intended to be comprehensive. It is provided as a sampling of state legislative proposals.)

1. Vending Machine Regulation
2. Food and Drink Company Contracts
  - a. Soft Drink Regulation/Prohibition
3. Nutrition Education
4. School Nutrition Programs
  - a. Vegetarian Lunch Availability
  - b. Nutrition
  - c. Childhood Nutrition in Schools, Recess and Lunch Breaks
5. Obesity Prevention
6. Food Establishment Nutritional Education
7. Child and Prenatal Nutrition
8. Product Liability
  - a. Common Sense Acts
  - b. Frivolous Lawsuits
9. Physical Activity
  - a. Programs
10. Health Insurance/Benefits
  - a. Obesity Reduction Plan—Mandated Covered Health Benefit
  - b. Services Related to Morbid Obesity
  - c. Surgical Treatment for Morbid Obesity
11. Childhood Obesity Prevention Programs
  - a. State Advisory Council
12. Obesity Classified as a Disease
13. State Commissions on Preventing and Management of Obesity

**The following are examples of state legislative proposals targeted towards matters surrounding obesity and its prevention through appropriate nutrition.**

**ALASKA** <http://www.legis.state.ak.us/basis21.htm>

**(1) BILL ID: HB 80**

**TOPIC:** Prohibiting Sales of Certain Soft Drinks in Public Schools

**SUMMARY:** Between the hours of 8:00 a.m. and 5:00 p.m. during a day in session at a public school, carbonated soft drinks and soft drinks that contain 42 or more grams of sugar per 20-ounce serving may not be sold in a public school building or on public school property. This section does not apply to soft drinks that contain at least 50 percent fruit juice.

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**CALIFORNIA** <http://www.leginfo.ca.gov/bilinfo.html>

**(1) BILL ID: AB975**

**TOPIC:** Nutrition Education—Healthy Eating Habits

**SUMMARY:** Existing law requires the adopted courses of study for grades 7 to 12, inclusive, to include, among other courses, a course in physical education, with an emphasis given to physical activities that are conducive to the health and vigor of the body and mind. This bill would additionally require a course in physical education to include nutrition education, with an emphasis on the importance of establishing healthy eating habits at an early age. By requiring physical education courses to include this additional component, this bill would impose a state-mandated local program.

**(2) BILL ID: ACR16**

**TOPIC:** Nutrition—Vegetarian School Lunches.

**SUMMARY:** This measure would urge the State Departments of Education and Health Services to develop nutritionally sound school lunch menu plans that would provide daily optional plant-centered vegetarian school lunches and would state that nutrition educational materials and instruction should include information about multicultural eating patterns and vegetarian/vegan eating patterns.

**(3) BILL ID: SB65**

**TOPIC:** School district governing boards—Contracts.

**SUMMARY:** Existing law prohibits the governing board of a school district from entering into a contract that grants exclusive advertising rights, or grants the right to the

exclusive sale of carbonated beverages, throughout the district to a person, business, or corporation unless the governing board of the school district has adopted a policy after a public hearing to ensure that the district has internal controls in place regarding the expenditure of public funds. This bill would make those provisions applicable to any contract for the sale of carbonated beverages or nonnutritious beverages or nonnutritious food, as defined, within the school district. The bill would, in addition, prohibit a governing board from entering into or renewing that contract or authorizing a school within the district to enter into or renew that contract, unless the governing board provides to parents, guardians, pupils, and members of the public an opportunity to comment on the contract during a public hearing conducted at a regularly scheduled board meeting. The bill would require the board to clearly identify in the meeting agenda the contract to be discussed. The bill would, in addition, specify certain activities that would meet the public hearing requirements for beverage and food contracts. The bill would prohibit the contract from including a confidentiality clause, and would require the board to make the contract accessible to the public.

**(4) BILL ID: SB 74**

**TOPIC:** Vending Machines

**SUMMARY:** This bill would require each vendor that operates or maintains a vending machine on designated state property to satisfy the requirement that at least 50% of the food and beverages offered in the vending machine meets accepted nutritional guidelines, as defined.

**(5) BILL ID: SB677**

**TOPIC:** The California Childhood Obesity Prevention Act.

**SUMMARY:** Existing law prohibits the sale of certain beverages at elementary schools regardless of the time of day and restricts the sale of certain food items on those campuses during specified times. Existing law further prohibits the sale of carbonated beverages in middle schools from 1/2 hour before the start of the school day until after the end of the last lunch period. Existing law makes those provisions operative on January 1, 2004, if funding is appropriated for specified nutrition purposes on or before that date. This bill would instead make those restrictions on the sale of food items operative if funding is appropriated for those specified nutritional purposes regardless of the date on which the appropriation is made. The bill would prohibit the sale of certain beverages to pupils in elementary, middle, or junior high schools commencing July 1, 2004. The bill would, in addition, exempt the sale of certain beverages at specified school events from those prohibitions.

**(6) BILL ID: SB679**

**TOPIC:** Food Establishments—Nutritional Information.

**SUMMARY:** *The California Uniform Retail Food Facilities Law (CURFFL) provides for the regulation of health and sanitation standards for retail food facilities by the State Department of Health Services. Under existing law, local health agencies are primarily responsible for enforcing CURFFL. A violation of any of these provisions is punishable as a misdemeanor. This bill would require each food establishment, as defined, in this state that is part of a large chain, as defined, to either post complete nutritional information on all standard menu items on a wall in a public area, and in a conspicuous manner, or by providing it to customers with complete nutritional information, upon request, on all standard menu items sold at the food establishment, in which case the food establishment would be required to post a sign on the premises that nutritional information concerning food items is available upon request.*

**(7) BILL ID: SB875**

**TOPIC:** Child and Parental Nutrition.

**SUMMARY:** Existing law requires the State Department of Health Services to maintain a program of maternal and child health. Existing law requires the department to investigate and disseminate educational information relating to conditions affecting the health of the children of the state. This bill would require the department to develop or obtain a brochure to educate pregnant women and new parents about issues related to maintaining a healthy lifestyle and preventing chronic diseases in pregnant women, new mothers, and young children. The bill would require the department to include the brochure on the department's Web site. The bill would also require that the brochure be distributed by the department to each individual who contacts the BabyCal program and receives certain information and by a provider to each participant in the Access for Infants and Mothers (AIM) program, as prescribed. The bill would provide that it shall only be implemented if, and to the extent that, federal or private funds, or both, are available for that purpose. This bill would declare that it is to take effect immediately as an urgency statute.

**(8) BILL ID: AB1909**

**TOPIC:** Product liability.

**SUMMARY:** Under existing law, everyone is generally responsible, not only for the result of his or her willful acts, but also for an injury occasioned to another by his or her want of ordinary care or skill in the management of his or her property or person, except so far as the latter has, willfully or by want of ordinary care, brought the injury upon himself or herself. Among other things, existing law sets forth certain exemptions with

regard to product liability, as specified. This bill would provide that no manufacturer, distributor, or seller of food or nonalcoholic beverages intended for human consumption shall be subject to civil liability for personal injury or wrongful death based on an individual's consumption of that food or nonalcoholic beverages in cases where liability is premised upon the individual's weight gain, obesity, or a health condition related to weight gain or obesity and resulting from his or her long-term consumption, as defined, of food or nonalcoholic beverage that is in compliance with applicable statutory and regulatory requirements, with specified exceptions.

**(9) BILL ID: SB1171**

**TOPIC:** Food Establishments—Nutritional Information.

**SUMMARY:** This bill would require each food establishment, as defined, in the state that is part of a large chain, as defined, to include calorie information on menu boards and to include in printed menus the total number of calories, grams of saturated plus transfat, and milligrams of sodium per serving. The bill would provide that a food establishment would be in violation of the act and guilty of an infraction only if it knowingly or negligently fails to comply with these requirements.

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**CONNECTICUT**      <http://www.cga.state.ct.us/default.asp>

**(1) BILL ID: HB1150**

**TOPIC:** Childhood Nutrition in Schools, Recess and Lunch Breaks; Physical Activity

**SUMMARY:** Each local and regional board of education shall ensure that (1) each child, in the schools under its jurisdiction, is provided with an opportunity for a lunch break that is a minimum of twenty minutes every full school day, and (2) each child in grades kindergarten to five, inclusive, in the schools under its jurisdiction, has the opportunity for physical activity for a minimum of twenty minutes every full school day or a minimum of one hundred minutes every full school week, except that the planning and placement team may develop a different schedule for a child requiring special education and related services in accordance with chapter 164 of the general statutes and the Individual With Disabilities Education Act, 20 USC 1400 et seq. , as amended from time to time. On and after September 1, 2004, each local and regional board of education shall require the schools under its jurisdiction to make available for purchase dairy products, including low-fat dairy products, water, one-hundred per cent natural fruit juices and fresh or dried fruit at all times when food or drink is available for purchase in school buildings.

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**HAWAII** <http://www.capitol.hawaii.gov/site1/docs/docs.asp?press1=docs>

**(1) BILL ID: HB1799**

**TOPIC:** Vending Machine--Nutrition

**SUMMARY:** One way of addressing the problem of poor dietary habits in school-aged children is to more strictly regulate the kind of food items sold in vending machines located in public schools. Currently, the nutritional standards maintained by the department of education for the school lunch program do not apply to food items sold in public school vending machines. This Act will ensure that all food and drink items sold in public school vending machines are nutritionally acceptable to promote a healthier diet and lifestyle for public school children.

**(2) BILL ID: HB1891 / SB2147**

**TOPIC:** Childhood Obesity Prevention Description--Nutrition

**SUMMARY:** Establishes nutrition standards for food and beverages sold to students in public and private elementary, middle, and intermediate schools; establishes school nutrition advisory council

**(3) BILL ID: HB2105**

**TOPIC:** Obesity Reduction Program; Children/Adolescents; Mandated Covered Health Benefit Description

**SUMMARY:** Requires insurers, hospital and medical services plans, and health maintenance organizations to provide children and adolescent obesity reduction programs to their policyholders, members, and enrollees.

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**IDAHO** <http://www3.state.id.us/oasis/minidata.html>

**(1) BILL ID: HO708**

**TOPIC:** HEALTH INSURANCE

**SUMMARY:** Amends existing law relating to health insurance to require coverage for expenses for services related to morbid obesity.

**(2) BILL ID: HO590**

**TOPIC:** Idaho Commonsense Consumption Act—Prevention of Frivolous Lawsuits

**SUMMARY:** Except as provided in section 39-8703, Idaho Code, a manufacturer, packer, distributor, carrier, holder, seller, marketer or advertiser of a food, as defined in section 39-8704, Idaho Code, or an association of one (1) or more of such entities, shall not be subject to civil liability arising under any Idaho law for any claim, as defined in section 39-8704, Idaho Code, arising out of weight gain, obesity, a health condition associated with weight gain or obesity, or any other generally known condition allegedly caused by or allegedly likely to result from long-term consumption of food.

**EXEMPTION:** Notwithstanding section 39-8702, Idaho Code, civil liability shall not be precluded where the claim of weight gain, obesity, a health condition associated with weight gain or obesity, or any other generally known condition allegedly caused by or allegedly likely to result from long-term consumption of food is based on: (1) A material violation of an adulteration or misbranding provision set forth by statute, rule or regulation in Idaho or the United States provided the claimed injury was proximately caused by such violation; or (2) Any other material violation of federal or state law applicable to manufacturing, marketing, distribution, advertising, labeling or the sale of food, provided such violation is knowing and willful, as defined in section 39-8704, Idaho Code, and provided further that the claimed injury was proximately caused by such violation.

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**ILLINOIS**      <http://www.legis.state.il.us/legislation/default.asp>

**(1) BILL ID: HB3981**

**TOPIC:** Illinois Commonsense Consumption Act.—Lawsuits

**SUMMARY:** Provides that no person shall bring a qualified civil action in State court against any manufacturer, seller, or trade association of a qualified product. Defines "qualified civil action" to include a civil action brought by any person against a manufacturer or seller of a qualified product, or a trade association, for damages or injunctive relief based on a claim of injury resulting from a person's weight gain, obesity, or any health condition that is related to weight gain or obesity. Makes exceptions to the limited liability.

**(2) BILL ID: SB2742**

**TOPIC:** Childhood Obesity Prevention Program

**SUMMARY:** Department of Public Health shall establish a childhood obesity prevention program designed to prevent and reduce the incidence and prevalence of

obesity in children and adolescents, especially among populations with high rates of obesity and obesity-related health complications. Requires the Department to periodically collect and analyze information from certain sources in order to (i) determine the prevalence of childhood obesity in the State and (ii) evaluate the effectiveness of the program. Provides that the Director of Public Health may directly administer the program and authorizes the Department, subject to appropriation, to make grants for community-based projects targeted at populations at high risk for childhood obesity.

**(3) BILL ID: SB2748**

**TOPIC:** Health Insurance/Benefits--Surgery

**SUMMARY:** Provides that health benefits provided to employees under those Acts must include coverage for surgical treatment for morbid obesity.

**(4) BILL ID: SB2749**

**TOPIC:** Obesity Classified as a Disease

**SUMMARY:** Requires the Department of Public Health to classify obesity as a disease.

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**INDIANA**      <http://www.in.gov/apps/lisa/session/billwatch/billinfo>

**(1) BILL ID: HB1014**

**TOPIC:** Department of Education—Preventing Childhood Obesity

**SUMMARY:** Requires the department of education to develop: (1) recommendations for school corporation nutritional policies and curricula; and (2) model policies for the measurement of student body mass indexes. Prohibits vending machines at elementary schools from being accessible to students. Requires that healthy foods and beverages account for 50% of the food and beverage sales in middle and high schools. Requires school corporations to adopt nutritional integrity policies. Requires 30 minutes of daily physical activity for elementary school students in public schools. Allows a school to continue a vending machine contract in existence before April 1, 2004.

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**LOUISIANA**      <http://www.legis.state.la.us/>

**(1) BILL ID: SB409**

**TOPIC:** Insurance Policies

**SUMMARY:** Mandates offering of optional insurance coverage for treatment of morbid obesity.

**(2) BILL ID: SB413**

**TOPIC:** School Nutrition—Vending Machines

**SUMMARY:** Requires schools boards to establish nutritional policy for vending machines and to limit the hours of operation.

**(3) BILL ID: SB534**

**TOPIC:** Students—Establishing Physical Fitness

**SUMMARY:** Provides for establishment and implementation of a pilot program in no more than 8 schools establishing a baseline assessment of the physical fitness of students.

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**MARYLAND**    <http://mlis.state.md.us/#bill>

**(4) BILL ID: HB309**

**TOPIC:** State Advisory Council on Obesity in Youth

**SUMMARY:** Established to provide advice and recommendations to the General Assembly on public awareness of obesity in youth and its prevention; specifying the membership, chairman, staff, and purpose of the Advisory Council; requiring the Advisory Council to issue reports to the Governor and the General Assembly by June 1, 2006, and by June 1, 2008; requiring the Advisory Council to conduct a specified study and to report to specified committees of the General Assembly by January 1, 2005; etc.

**(5) BILL ID: HB340**

**TOPIC:** *Counseling for Obesity*

**SUMMARY:** *Adding services related to the prevention and treatment of and counseling for obesity in specified children to the minimum package of child wellness services required in specified plans and policies; and providing for the application of the Act.*

**(6) BILL ID: HB346**

**TOPIC:** *School Nutrition Program*

**SUMMARY:** *Prohibits specified beverages and specified foods from being served in public schools between the hours of 12:01 a.m. and the end of the last lunch period; authorizing local school systems to implement more stringent measures to improve nutrition in the public schools; etc.*

**(7) BILL ID: 1410**

**TOPIC:** *Task Force to Study Utilization Review of the Surgical Treatment of Morbid Obesity*

**SUMMARY:** *Clarifying the circumstances under which insurers, nonprofit health service plans, health maintenance organizations, and managed care organizations must provide coverage for the surgical treatment of morbid obesity.*

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MISSOURI <http://www.house.state.mo.us/jointsearch/Default.aspx>

**(1) BILL ID: SB796**

**TOPIC:** State Board of Education—Health Program

**SUMMARY:** This act directs the State Board of Education to establish a coordinated health program board. The Coordinated Health Program Board shall make available to each school district in the state a coordinated health program designed to prevent obesity, cardiovascular disease, and type II diabetes in elementary and secondary students. The programs must provide for the coordination of health education, physical education and physical activity, nutrition services, and parental involvement.

**(2) BILL ID: SB902**

**TOPIC:** Missouri Commission on Prevention and Management of Obesity

**SUMMARY:** This act establishes the Missouri Commission on Prevention and Management of Obesity within the Department of Health and Senior Services. The Commission will exist until August 28, 2006 and will have the following duties:

- (1) Collecting and analyzing data regarding obesity in Missouri;
  - (2) Listing programs and services currently available to overweight adults and children;
  - (3) Listing the funds available for maintaining these programs and services;
  - (4) Examining the economic impact of the failure to treat obesity;
  - (5) Identifying cultural, environmental, and socioeconomic barriers related to obesity;
  - (6) Providing specific recommendations to increase obesity prevention and management in Missouri.
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**NEW MEXICO**     <http://legis.state.nm.us/newsite/BillFinder.asp#bnumber>

**BILL ID: HB563**

**TOPIC:** Vending Machines—Excise Tax on Low-Nutrition Foods

**SUMMARY:** Imposing an excise tax on low-nutrition foods sold by vending machines on school district property; providing for distribution of school vending machine excise tax revenues to support physical education and nutrition programs in the public schools

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**RHODE ISLAND**     <http://www.rilin.state.ri.us/BillText/BillText04/BillText04.html>

**(1) BILL ID: H7301**

**TOPIC:** Rhode Island Healthy Weight Pilot Program Established

**SUMMARY:** The state shall establish pilot programs in communities of the several cities and towns to encourage and promote healthy weight and weight management in children. These programs shall incorporate a combination of exercise and nutrition plans that may include, but shall not be limited to, physical exercise, including walking and jogging, as well as information on healthy food choices.

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**TENNESSEE**

<http://www.legislature.state.tn.us/bills/currentga/billLookup.asp>

**(1) BILL ID: SB2073 / HB2246**

**TOPIC:** Health Insurance

**SUMMARY:** This bill would require health insurance agreements to offer coverage for bariatric surgery to treat clinically severe obesity, effective January 1, 2005. The covered procedures would include any gastrointestinal surgeries identified by the National Institutes of Health (NIH) as effective for treating clinically severe obesity. This bill would require health insurance providers to use the same reimbursement formula for bariatric surgery that they use for other procedures. Also, health insurance providers would be required to follow NIH guidelines when developing standards and barriers to access for bariatric surgery. Providers would be authorized to require documentation that the insured was unable to overcome clinically severe obesity via a physician assisted weight loss program whether or not the insurance provider covers physician assisted weight loss programs. This bill would not apply to the following types of health insurance policies: government health plans such as Medicare or TennCare, short term travel, accident-only, limited or specific disease, or short term nonrenewables of up to six months.

**(2) BILL ID: HB2783 / SB2743****TOPIC:** Schools—Nutrition

**SUMMARY:** This bill would restrict the types of food sold to students in public schools with kindergarten through eighth grade students from before school hours until at least 30 minutes after school to the following: grain products, fruits and 100 percent fruit juices, water, milk and dairy products, soy-based products, vegetables and vegetable juices, electrolyte-replacement beverages, and nut products. This bill's food-type restrictions during school hours and 30 minutes thereafter would apply to vending machines and student sales. This bill would not prohibit school cafeterias from selling food items that are part of a meal component as defined by the U.S. department of agriculture. This bill would prohibit non-compliant food vendors from selling non-compliant foods and require them to reimburse the school nutrition plan for any penalties assessed against the program due to a violation.

**(3) BILL ID: HB3041 / \*SB2379****TOPIC:** Lawsuits

**SUMMARY:** This bill would prohibit a party from bringing a civil lawsuit for damages against a manufacturer, packer, distributor, seller or advertiser of food claiming weight gain or obesity caused by long-term consumption of the food unless: (1) The alleged weight gain is a direct result of violation of state or federal regulations on food content and labeling; or (2) The weight gain is a direct result of intentional violation of state or federal law on manufacturing, marketing, distribution, advertising, labeling or selling the food. Lawsuits brought under exception (1) must state the law or regulations being violated, the facts supporting the allegations and how the violations directly caused the obesity. If the lawsuit is based on exception (2) above, additional facts to show an intent to deceive or injure the consumers would be required.

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**WASHINGTON**     <http://www.leg.wa.gov/wsladm/billinfo1/bills.cfm>

**(1) BILL ID: HB260****TOPIC:** Schools—Nutrition

**SUMMARY:** Requiring development of a model policy for nutrition and physical activity for schools.