Point32Health, parent company of
Harvard Pilgrim Health Care & Tufts Health Plan
ETHICS ADVISORY GROUP (EAG) Deliberation

Deliberation Report
'Food is Medicine' – Considerations for Payers
April 16, 2024

Purpose
To seek input from the multi-stakeholder Ethics Advisory Group (EAG) on health plan considerations of its roles related to the concept of 'Food is Medicine'.

Customers for the Ethics Advisory Group and Expert Guests
The Point32Health customer for the EAG deliberation was Tami Ireland, BA, MPH, Director of Health Engagement. Lauren Taylor, BA, MPH, MDiv, PhD, Assistant Professor, Department of Population Health, NYU Grossman School of Medicine, Kurt Hager, BS, MSc, PhD, Instructor, Department of Population and Quantitative Health Sciences, University of Massachusetts Chan Medical School, and David Waters, BA, MA, CEO, Community Servings offered expert remarks.

Background
Food, health, equity, and economics
Poor diet, exacerbated by food insecurity, is a leading cause of disease and death in the U.S., including from heart disease, stroke, type 2 diabetes, obesity, hypertension, and some cancers. Poor nutrition is estimated to account for 500,000 deaths every year.[1] Diet-related diseases and deaths affect all populations, and they are inequitably distributed, with higher rates among individuals with lower incomes, living in rural areas, or belonging to racial or ethnic minorities for whom access to affordable, nutritious food is limited.[2,3]

Poor nutrition is estimated to cost society $1.1 trillion each year in health care spending and lost productivity,[1] the same amount that the entire food sector contributes to the economy.[4] This means that "our national 'bill' for diet-related disease is equal to all the money we currently pay for the food itself."[2]

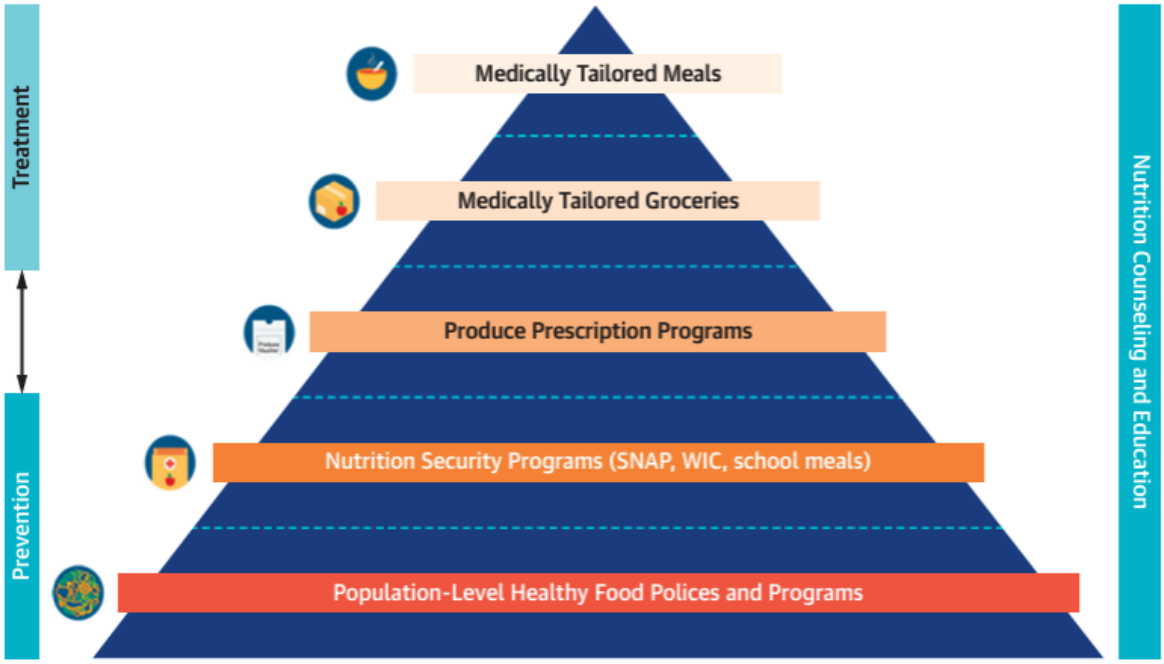
'Food is Medicine'[5,6,7]
'Food is Medicine' means different things to different people. Often, 'Food is medicine' (FiM) refers to "[t]he integration of specific food and nutrition interventions in, or in close collaboration with, the health care system."[8] Interventions are intended to prevent or treat food insecurity[9] and/or diet-related health conditions among high-risk individuals.

Figure 1 and Table 1 below describe FiM interventions along a spectrum from prevention to treatment of diet-related diseases. Underpinning food-based interventions are population-level food policies and programs. At the next level of the FiM pyramid, government nutrition security programs are aimed at tackling food insecurity and hunger. Next, three interventions with increasing intensity and costs follow: Offerings of vouchers for unprepared fruits and vegetables, known as produce prescriptions; the provision of healthy food boxes, known as medically tailored groceries for individuals with certain conditions; and the delivery of dietician-designed meals for individuals with certain conditions, known as

medically tailored meals (MTM).

The federal government and private sector actors actively support the FiM concept.[6] The 2022 White House Conference on Hunger, Nutrition, and Health announced the Biden administration's support for insurance coverage of FiM initiatives and generated $8.5 billion in commitments to help end hunger and reduce diet-related diseases and disparities by 2030.[5,10] Major organizations, including the American Heart Association, the Rockefeller Foundation, and Kroger have pledged $250 million to create a research initiative to make FiM "a regular and reimbursable component of Americans' health care" and "billions more are being invested in food-focused start-ups".[6] With public and private sector funding (including funding by Tufts Health Plan), Tufts University has recently launched the Food is Medicine Institute, bringing together experts from across disciplines and organizations to advance FiM research, training, patient care, community engagement and policy development. With funding from The Rockefeller Foundation, Kroger, Instacart, Kaiser Permanente and the Walmart Foundation, the American Heart Association has started the Health Care by Food™ initiative to build "the evidence needed to show clinical and cost effectiveness so patients with acute or chronic conditions or with risk factors for disease can access cost-effective food is medicine programs as a covered benefit through public and private health insurance."[11]

Figure 1. Food is Medicine Pyramid [4,7,12,13]



SNAP=Supplemental Nutrition Assistance Program; WIC=Special Supplemental Nutrition Program for Women, Infants, and Children

Table 1. Example interventions from the Food is Medicine Pyramid[4]

	Target population	Intervention	Examples of efficacy
Medically tailored meals	People with severe, complex chronic conditions that limit activities of daily living and cause high burdens of disability, illness, and health care utilization, such as poorly controlled diabetes, heart failure, cancer, kidney failure, and HIV.	Prepared, medically tailored meals delivered to individuals living with severe illness through a referral from a medical professional or health care plan. Meal plans are tailored to the medical needs of the recipient by a Registered Dietitian Nutritionist (RDN). Often provided as 10 (and up to 21) weekly meals, in combination with nutrition and culinary education.	Improved food security and disease management; lower hospital, emergency room, and nursing home admissions, and lower net health care costs.
Medically tailored groceries	People with one or more major diet-related health risks or conditions but who can still prepare and cook their own meals. Often, but not always, used for people on low-incomes and/or those with food insecurity.	Healthy food items that are pre-selected, often by an RDN or other qualified professional, and provided to eligible patients, in combination with nutrition and culinary education.	Improved food security and diet quality; inconsistent associations with health outcomes.
Produce prescriptions	People with at least one diet-sensitive health risk or chronic condition, such as diabetes, pre-diabetes, hypertension, obesity, or heart disease, as well as people with low incomes and/or who are food insecure.	Discounted or free produce such as fruits and vegetables (and sometimes also nuts, seeds, beans, whole grains, dairy, and eggs) are provided by electronic benefit cards or paper vouchers redeemable at grocery stores or farmers markets; picked up in the healthcare setting or by home delivery; in combination with nutrition and culinary education.	Improved food security and diet quality; lower hemoglobin A1c, blood pressure, and body mass index.
Government nutrition security programs	People from low-income or other marginalized households with food and/or nutrition insecurity. Children from households with lower incomes.	Community, public health, and healthcare system screening, connecting, and supporting enrollment of eligible individuals into government nutrition programs, like the U.S. Supplemental Nutrition Assistance Program (SNAP), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), school breakfast and lunch programs, and nutrition programs for older adults.	SNAP: reduced poverty and improved food security; inconsistent associations with health outcomes. WIC: improved maternal and child diet quality, birth outcomes, and child preventative care and cognitive outcomes. School meals: improved diet quality, food security, and academic performance (lunch); less consistent findings for school breakfast.
Population-level healthy food programs and policies	Children and adults within the general population at risk for poor metabolic health.	Programs and policies to address systems and environmental barriers to equitable healthy food in communities. Examples include consumer education strategies like food package and restaurant menu labels, including warning labels; nutrition standards for institutional procurement including charitable food; employer-based wellness programs with education and incentives for healthier eating; fiscal approaches or incentives to support the affordability of healthful foods; taxes or other disincentives for unhealthful foods or beverages; and regulatory approaches to food additives.	Increased community availability of healthier foods and beverages, healthier industry reformulations of packaged foods and restaurant items, reduced sales of unhealthy items, and improved nutritional habits of consumers.

Note: For MTMs, medically tailored groceries, and produce prescriptions, clinicians or other health system staff including RDNs, social workers, and community health workers screen and refer eligible patients to appropriate services as part of their treatment plan.

Impacts of 'Food is Medicine' interventions

Research on FiM interventions is rapidly growing.[7,8] A review of 49 studies documented that FiM interventions are associated with improvements in dietary intake, health status, disease-specific health outcomes and biomarkers, mental health, and decreased health care utilization and spending.[8] However, quality of the existing research varies widely. The most rigorous peer-reviewed research exists for MTM which have been shown to improve health outcomes for patients with HIV/AIDS, type 2 diabetes, heart failure, and chronic liver disease; and to reduce health care utilization and spending for people who are seriously ill.[8] A national population simulation study estimated that MTM provided to more than 6 million US adults on Medicare, Medicaid or privately insured, with at least 1 severe diet-sensitive condition (cardiovascular disease, diabetes, and cancer) and 1 limitation in activities of daily living, could potentially avert almost 1.6 million hospitalizations. The program was estimated to cost $24.8 billion and avert $38.7 billion in health care expenditures in one year, resulting in estimated net savings of almost $14 billion.[4,14]

Another simulation study estimated that, over an average of 25 years, implementing produce prescriptions for 6.5 million US adults with diabetes and food insecurity may prevent 292,000 cardiovascular disease events, generate 260,000 quality-adjusted life-years, cost $44.3 billion to

implement, and save $39.6 billion in health care costs and $4.8 billion in productivity costs. From a societal perspective over an average 25 years, the program was estimated to result in net savings of $0.05 billion.[4,15] However, a recent randomized clinical trial of an intensive FiM program (healthy groceries for 10 meals per week for an entire household, dietitian consultations, nurse evaluations, health coaching, and diabetes education, for about 1 year) for 465 adult patients with diabetes and food insecurity did not improve their glycemic control compared with usual care among adult participants.[16] Average annual cost per patient was $2000. A 6-month program in which patients with diabetes were given $60/month vouchers for produce did not improve glycemic control compared to a control group.[17]

Importantly, research has yet to document what conditions at which levels of acuity best respond to FiM interventions and what intensity of MTM – how many meals, for how long, for whom in a household – results in better health, at what cost, and how recipients of MTM may be able to transition to medically tailored groceries or produce prescriptions and maintain health outcomes.[7,8]

Concerns about 'Food is Medicine'

There are concerns about the FiM concept. In addition to calling for more sound research evidence, skeptics of the idea that FiM interventions will lead to long-term improvements in diet or health point out significant system barriers: a fragmented, uncoordinated, over-burdened health care system creates lack of access to needed care for disadvantaged individuals and challenges providers to prescribe and patients to receive and adhere to FiM interventions.[18,19] They highlight that "patient adherence to chronic disease medications is low even though the positive health effects from medications are relatively immediate. Eating healthy foods involves a far more complex sequence of behaviors, often resulting in a less direct and immediate effect on health outcomes."[18]

Further, critiques argue that attention and resources focused on FiM interventions risk "shifting public discourse away from commercial interests as major drivers of disease."[18] These commercial interests contribute to an unhealthy, inequitable, unaffordable, and unsustainable food system.[20,21,22] "It is no surprise that many large, influential food companies such as Amazon, Instacart, and Kroger have loudly touted their support for food is medicine by joining task forces, supporting pilot programs, and integrating programming into corporate social responsibility campaigns."[18] Critiques of the FiM concept recommend focusing on "changing food industry behavior to ensure that unhealthy foods are not ubiquitous and not as cheap and heavily marketed while ensuring that our existing nutrition assistance programs are accessible and health promoting."[18]

Point32Health efforts related to FiM

Advocacy

Point32Health advocates at the federal level for advancing nutrition policies and programs. With other supporters, it has proposed that the Center for Medicare & Medicaid Innovation (CMMI) launch a Nutritional Equity Pilot Model for Medicaid and Dual Eligible beneficiaries. The model proposes that health plans serve as partners with other stakeholders, using care navigation, technology, and resources (including SNAP and WIC dollars), to improve individuals' and households' access to healthy food options.

Philanthropy

Among other programs, the Point32Health Foundation funds equity-focused initiatives to increase access to affordable, nutritious food in Connecticut, Maine, Massachusetts, New Hampshire, and Rhode

Island.[23,24,25] In March 2024, Point32Health and Point32Health Foundation pledged more than $1.5 million in grants to community organizations addressing food insecurity.

Pilot studies
The organization conducts pilot programs to understand potential approaches for addressing social determinants-related health disparities.

Insurance coverage of food
There is excitement about FiM, "[b]ut food is medicine isn't fully integrated into the health care system, largely because most insurers are choosing not to pay for it, or are barred by law from paying for it."[5] Legally, options for covering FiM differ for public and commercial plans.

Medicare
There is debate about whether Medicare will cover food for sick seniors.[26] Under current law, traditional Medicare is barred from covering food. "These benefits are most common in so-called Medicare Advantage plans, which are offered to seniors by private insurers. But these services are still the exception. Just 14% offered a food and produce benefit for the chronically ill last year."[5] "Medicare Advantage plans are only able to offer food benefits and other "special supplemental benefits" to seniors with severe chronic conditions that put them at an outsized risk for death or hospitalization."[5]

Medicaid
Following the 2022 White House Conference, the Biden-Harris administration encouraged states to use Section 1115 waivers to cover FiM interventions through their Medicaid programs.[27] Massachusetts was among the first 5 states to do so.[6] Through MassHealth's Flexible Services Program, in partnership with community-based organizations, eligible members can receive access to different FiM interventions. Members must be enrolled in a MassHealth Accountable Care Organization, have at least one of a list of eligible health conditions (e.g., diabetes or high-risk pregnancy), and have a social risk factor (e.g., not having a home, having trouble getting enough food or the right kinds of foods) to access FiM benefits.[28]

Commercial insurers and self-insured employers
Point32Health food coverage considerations
Commercial payers are increasingly interested in FiM and some integrated delivery systems (Kaiser, Geisinger) are experimenting with FiM programs.[7] Currently, Point32Health does not provide insurance coverage of FiM interventions for its commercially insured members.

Ethical questions regarding health insurance coverage of food as medicine
Insurance coverage of food as medicine raises difficult ethical questions. Food security is a human right.[29] It is closely related to all human rights, including the rights to health, education, and housing. Traditionally, social factors such as food, education, and housing are outside the scope of health care. However, these factors – social determinants of health - determine a person's health and the needs for and costs of the health care they receive. And healthy food security is a pre-condition for health equity.

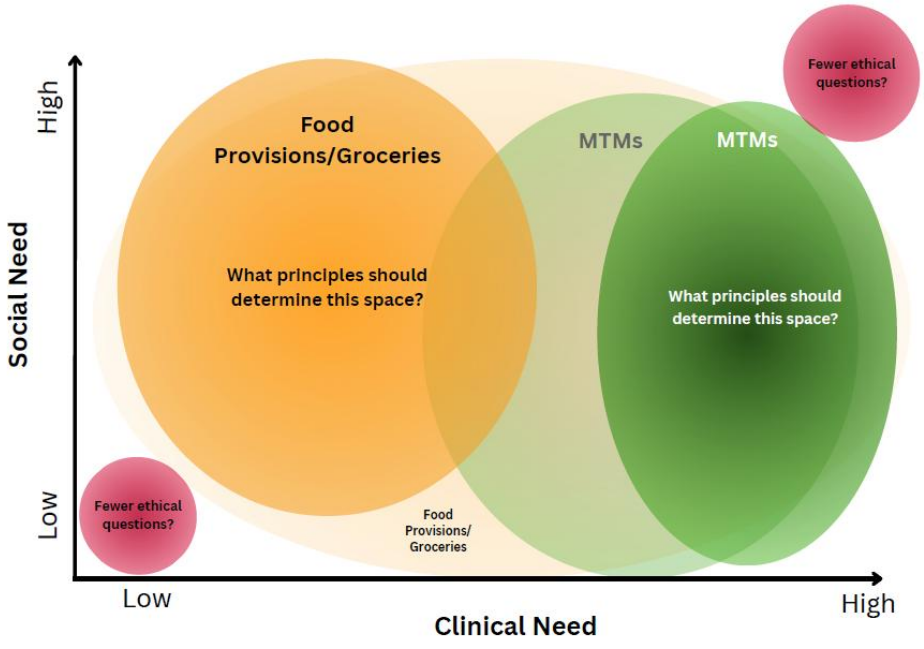
Federal and state governments are responsible for social services and public health. Compared to other high-income countries, the U.S. is an outlier in terms of high health care spending, mediocre health outcomes, and a reversed balance of spending on social services compared to spending on health care: For every $1 spent on health care, OECD countries spend about $1.70 on average on social services; the U.S. spends 56 cents.[30] Within the U.S., states with a higher ratio of social to health spending have

significantly better health outcomes for multiple chronic conditions including adult obesity, asthma, acute myocardial infarction, and diabetes,[31] suggesting a need for rebalancing the medical-to-social spending at federal and state levels.[30]

Proponents argue that "the FIM framework extends beyond the concept of food security as a social determinant of health by recognizing that poor nutrition is a foundational determinant of health, one that must be directly addressed by the healthcare system through evidence-based, integrated interventions like any other disease risk factor."[4] While social policies are needed to prevent food insecurity, the FiM concept gives clinicians tools to mitigate the harms that food insecurity causes.[9]

For payers, the interconnectedness of food and health, along social and clinical needs axes, highlighted in the FiM concept, raises the overarching question: *What are the boundaries of responsibility of a health insurer for the health of a human being?* Different stakeholders will legitimately hold different values and have different perspectives on this question. In Ethics Advisory Group (EAG) deliberations over the past 20 years, participants have considered aspects relevant to this discussion. The Appendix (page 11) provides a summary which the present EAG discussion can build on.

Figure 2. Situating ethical questions around insurance coverage of FiM interventions[a]



One way of thinking of principles to answer this question is by identifying types of members and types of FiM interventions for whom coverage questions would arise. Figure 2 illustrates the spaces in which members and interventions could be considered, along members' clinical and social needs. Arguably, there may be fewer ethical questions around MTM coverage for patients who are so severely ill that MTM are a precondition for effective health care (e.g., specific diet-sensitive severe illnesses such as end-stage renal disease) and whose social needs are such that they cannot cook appropriate meals for themselves, for economic or other reasons (upper right corner): For these patients, it could be argued that MTM should be covered as necessary to enable their traditional health care (such as dialysis) to be effective. Further, there would presumably be no ethical concerns about MTM not covered by health insurance for members without clinical and without social needs (bottom left corner). Arguably, ethical questions arise mainly in the middle, for members with

[a] Graphic by Alyssa Halbisen

FiM needs not at the extremes of the clinical and social continua.

A mission-driven community-based health insurer could define principles for decisions on coverage of FiM interventions for members who do not have both social and clinical needs by reference to its core obligations. Those obligations include *providing access to medically necessary care for individuals* and *maintaining affordability of health insurance for all*, with a focus on *equity*. That largely means, prioritized access and affordability for those who need care and affordable health insurance most. These obligations are not easily balanced. As for all interventions, a key criterion to decide on FiM intervention coverage is *documented evidence of benefit.* Benefits of FiM interventions may include more effective use of and fewer resources spent on traditional health care interventions, and better health outcomes. Other important criteria include the payer's *ability to ensure the quality*[b] of, *member adherence* to, and *member and clinician satisfaction* with covered FiM interventions. FiM interventions are more complex than traditional medical care interventions and require more and different organizational structures for implementing effective coverage, managing utilization, and monitoring outcomes. Effective and efficient administration of a complex FiM benefit requires building *trustworthy relationships* with partners outside of the traditional health care delivery system.

At the population level, a health insurer must balance its obligation to cover medically necessary services for individual members with its obligation to steward resources for all its members, with a priority focus on disadvantaged populations. Increasing spending on insurer-covered medical care interventions risks increasing commercial insurance premiums which, in turn, is associated with increasing rates of underinsurance and inequitable effects on wages.[33] On the other hand, FiM interventions may offer a different approach to the dilemma faced by insurers with respect to GLP-1 agonists. As discussed in the December 2023 EAG deliberation,[c] a large eligible population (about 93 million people in the U.S.) and high costs (about $12 000/per person/year) of these weight management drugs which must be taken for life make the drugs unaffordable. An alternative could be to use GLP-1 agonists for 12 to 18 months, with a planned cessation of GLP-1 agonists and continued FiM interventions for weight maintenance.[34]

At the level of society, some may ask whether health insurance coverage of FiM interventions risks misaligning incentives[35] to investigate and change the systemic causes of an unhealthy, unaffordable, inequitable industrial food system. What, if any, are the responsibilities of payers to try to mitigate these system-level commercial determinants of ill health?

Questions for the Point32Health Ethics Advisory Group Deliberation

On April 16, 2024, the EAG is asked to reflect on the following questions: Given the interconnectedness of food and health, social determinants of health and health care, highlighted in the FiM concept,

1. What are the boundaries of responsibility of a health insurer for the health of a human being?
2. What are principles for a health insurer considering its role(s) with respect to 'Food is Medicine'?

[b] The national Food is Medicine Coalition of community-based nonprofit food providers recently proposed stringent accreditation standards for providers of MTM.[32]

[c] EAG deliberation reports are available from anita_wagner@hms.harvard.edu.

Summary of the Point32Health Ethics Advisory Group Deliberation
Almost 70 individuals joined the meeting. At the outset, the Point32Health customer and invited experts highlighted the following points:

From a payer perspective:
- FiM interventions are not part of traditional health care.
- Point32Health leaders are assessing which FiM interventions should be considered as part of a (commercial) health plan and which interventions employer clients should consider including in their benefit plans. A focus among some employers is on employees for whom the workplace limits access to healthy food (e.g. shift workers).
    - Experts suggested that corporate programs for certain types of employees would be better considered workplace wellness programs rather than a FiM intervention.

From a FiM provider perspective:
- Putting FiM interventions into perspective, one should consider that "if we can prevent one hospitalization, we can save enough money to feed someone for 6 months."
- Community Servings currently serves annually more than 6000 patients with chronic conditions in Massachusetts and Rhode Island. Education and training are part of the FiM interventions.
- A medically tailored diet for a patient with multiple chronic illnesses is complex. MTM can meet the nutritional requirements of more than 15 diets with more than 100 specialized variations. These diets are intended to meet medical nutrition needs regardless of food insecurity.
- Among those in need of FiM interventions are patients with disabilities (e.g., neurodegenerative disorders, blindness).
- While at the top of the FiM intervention pyramid, MTM are expected to also have "downstream" effects.

From a FiM research perspective:
- Large scale randomized studies are beginning.
- Current evidence is strongest for MTM among patients with heart failure for whom MTM reduced hospitalizations and mortality.
- The modeling study[14] estimating $13 billion in saved health care expenditure per year assumed very sick populations receiving MTM nationwide in a highly controlled environment.
- FiM program design matters for FiM effectiveness: outcomes may differ when patients must pick up medically tailored groceries compare to when such groceries are home-delivered.
- Research is lacking on the effects of ending FiM interventions for individuals.

From an ethical perspective:
- The dilemma around a payer's decision to cover food as it covers medicines for individuals with chronic illnesses arise from the following considerations:
    - Healthy food is a human right and a pre-condition for health and effective health care.
    - Healthy food access is not traditionally a responsibility of a health insurer. It is a responsibility of governments.
    - Providing healthy food access challenges the traditional role of health insurance (as do life-time medications for chronic illnesses).
    - However, given urgent need, employer demand, and opportunities for a health plan to improve health through FiM interventions in a non-ideal environment (e.g., lack of sufficient

government investment in social determinants of health), is there a moral obligation on the part of health plans to provide FiM benefits?

The majority of EAG participants responding to poll questions agreed that the three FiM interventions (MTM, medically tailored groceries and produce prescriptions) should be considered in the same way as medicines for members with diet-sensitive conditions lacking capabilities to meet appropriate nutritional needs. Most endorsed MTM to be considered as medicines. More respondents were unsure about medically tailored groceries and produce prescriptions.

Table 2. EAG participants' responses to questions on FiM interventions

	Question #1. Do you think the health plan should consider *medically tailored meals* for members with diet-sensitive conditions and without (physical, mental, or economic) capabilities to access appropriate nutrition in the same way it considers medicines for such individuals? (n=41)	Question #2. Do you think the health plan should consider *medically tailored groceries* for members with diet-sensitive conditions and without (physical, mental, or economic) capabilities to access appropriate nutrition in the same way it considers medicines for such individuals? (n=38)	Question #3. Do you think the health plan should consider *produce prescriptions* for members with diet-sensitive conditions and without economic capabilities to access appropriate nutrition in the same way it considers medicines for such individuals? (n=40)
Yes, n (%)	30 (73)	23 (61)	23 (58)
Not sure, n (%)	4 (10)	9 (24)	13 (33)
No, n (%)	7 (17)	6 (16)	4 (10)

EAG participants provided the following additional considerations:

- FiM interventions should be patient centered. That is, given that diet is highly personal, MTM should be consistent with a patient's dietary preferences to avoid food waste, need to be easily accessible, and accompanied by individually tailored education and coaching.
- MTM should be of high quality, that is, locally sourced, made from scratch, and fresh (not highly processed). Of note, the national Food is Medicine Coalition of community-based nonprofit food providers recently proposed stringent accreditation standards for providers of MTM.[32]
- Local community-based organizations (CBO) play a key role in implementing FiM interventions. In addition to providing FiM interventions, they can build trustworthy relationships and connect people to other nutrition programs (e.g., SNAP, WIC) as "off ramps" from MTM and to other social supports. (See January 2022 EAG deliberation on "Justice, Equity, Diversity, Inclusion: Principles to Guide a Health Plan's Partnerships with Communities"[d] for EAG suggestions on health plan engagement with CBO.)
- FiM interventions are complex. Attention is required on several levels. Health plans could support *identification* (that is, identify members with illnesses that present complex nutritional needs and possibly limitations for accessing healthy meals), *coordination* of resources (that is, help eligible [likely not commercially-insured] members combine SNAP, WIC, and other government food benefits), and *navigation* (that is, help members access appropriate FiM interventions). These functions may benefit from use of medical informatics tools.

[d] Available from anita_wagner@hms.harvard.edu

- If FiM can reduce illness and save money, health plans may have a fiduciary responsibility to provide FiM benefits.
- As with every health insurance benefit, it will be necessary to consider for whom a FiM benefit would be provided. A concern was raised that providing a FiM benefit for a small group would require payment by the larger population through higher premiums.
- A suggestion was made for a health plan to negotiate with pharmaceutical companies to bundle provision of certain drugs with comprehensive nutritional interventions.
- There are lots of social investments (e.g., for housing security, financial security, safety, clean air) that would improve individual health more than direct healthcare (e.g., diagnostics, medicines, surgery). Should an analysis of FiM interventions for possible health plan coverage differ from considerations of other social investments in health?

In summary, most EAG participants endorsed FiM, especially MTM, as a "powerfully effective intervention with positive benefits and outcomes and very few to no adverse effects" and as a covered health plan benefit for members for whom increasingly available evidence suggests that FiM interventions are effective (and likely cost-effective). They suggested that effectively implementing a FiM benefit requires pre-emptive attention to numerous barriers (including meeting individual dietary preferences) and partnership with community-based organizations.

This report is respectfully submitted, with gratitude to Point32Health leaders, expert guests, and all who generously shared their perspectives, for making this important and timely Point32Health EAG conversation possible. Thanks also go to Alyssa Halbisen, Kelsey Berry, and Caitlyn Tabor for supporting this EAG deliberation.

Anita Wagner, PharmD, MPH, DrPH, Director, Ethics Program, Point32Health, Email: awagner@hms.harvard.edu

Appendix

Selected Related Prior Ethics Advisory Group (EAG) Deliberations

Numerous prior EAG deliberations have focused on related topics, including responsibilities of the health plan related to social determinants of health, equity, community partnerships, communication with stakeholders, and expanding benefits fairly.[c] Following are selected summary points from some of the relevant prior EAG deliberations.

2002, 'The Ethics of Benefit Design, with Reference to Physical Therapy: Trying to do the Right Thing in an Imperfect Health System (and World)': Regarding the complexity of providing and administering a benefit that is relevant to many members and is usually limited by number of covered sessions, the EAG recommended a framework of values that included *educative communication, consistent benefit administration, administrative simplicity, enlisting members and providers in co-management of the benefit, care navigation for transition to self-care, and benefit exceptions* when clinical need requires longer-term coverage. Exceptions should be guided by the mission of the health plan to "improve the health of the people we serve," explicit clinical criteria, and be consistent with prudent management of the plan's financial resources. When clinical criteria are clear enough, "exceptions" could be transformed into explicit policy, which enhances *predictability and understandability*.

2015, 'The Role of Health Plans in Addressing Health Disparities': The EAG strongly endorsed the health plan's efforts to promote health equity as consistent with society's moral obligation to reduce/eliminate health disparities. The EAG identified *five pathways for the health plan to promote health equity* and reduce disparities: (a) continue to improve data on health-relevant aspects of member demographics; (b) create synergies among health plan components to promote health equity; (c) develop partnerships with employers, community groups, and public agencies to combat disparities; (d) set strategic priorities and assess outcomes; and (f) monitor unintended consequences.

2017, 'A Framework of Values for Health Insurance and the Social Determinants of Health': The EAG suggested that health plans are in an excellent position for identifying high needs patients for whom social determinants are especially important, and that addressing social determinants effectively requires *partnerships with providers and community organizations*. In turn, *partnerships require trust* between health plans, members, providers, and community partners. Specific strategies for cultivating trust should be developed, and work with high needs patients around social determinants should be conducted in a climate of respect, care, and even "love." Because addressing social determinants would be a new activity for most health plans, it is *crucial to be clear about short- and long-term return on investment for any new undertaking*.

2018, 'Medicare and Social Determinants of Health': EAG participants stated that health plans have little experience addressing social determinants of health and recommended *pilot programs and carefully assessing results to gather evidence about what works*. For example, a health plan could specify a pool of funds for addressing social determinants to limit financial exposure and assuage the fear that increasing coverage related to social determinants would lead to out-of-control expenditures. Social determinant investments from insurance funds should be evaluated the way medical interventions are – via *evidence about effectiveness for improving member health*. When social determinants affect patients with complex health conditions, EAG participants predicted positive health and financial returns on health plan investment in social determinants of health. EAG participants also underscored that health plans should not be expected to repair the frayed U.S. social safety net.

2019, 'Compassion in Health Care – The Roles of a Health Plan': the EAG discussed *compassion as a key value* and the default frame for direct and indirect actions of a health plan. Compassionate responses to an individual's suffering must consider a health plan's responsibilities to *fairness, equity, and fiscal stewardship within the complex health system*.

2022, 'Justice, Equity, Diversity, Inclusion: Principles to Guide a Health Plan's Partnerships with Communities': EAG participants highlighted that it is important to match the unique competencies and assets of the health plan to what is needed, and to be clear about what a health plan cannot do. Health plans cannot remedy, at least not alone, the upstream causes and consequences of structural injustice: poverty, food and housing insecurity, psychological and environmental stresses, unjust education and carceral systems, and many more. Community-health plan partnerships will require trusting partners at a shared table.

2023, 'Affordability of New Therapies - Principles for Health Plan Communication': the EAG underscored a need for and responsibility of the health plan to *engage with all its stakeholders proactively and visibly about the trade-offs* that are required, locally and nationally, by increasing spending. Communication should include *a focus on equity* and will require a long-term strategy to be effective.

2023, '*Fertility Care – Considerations for Health Plans*': the EAG suggested that *coverage expansion* should be implemented prudently, in a step-change fashion, and following fair priority-setting processes. *Fair priority setting* requires deliberation by all 'fair-minded' stakeholders (including those affected by the decision), transparency of the decision and reasons behind it, and mechanisms through which stakeholders can appeal a decision and it can be revised.

References

1. The Nutrition Policy Initiative at Tufts University. Food is Medicine. Published online August 2023. https://tuftsfoodismedicine.org/wp-content/uploads/2023/09/Tufts-Food-is-Medicine-Institute_2023-FIM-Fact-Sheet.pdf

2. The Rockefeller Foundation. True Cost of Food. Published online July 2021. https://www.rockefellerfoundation.org/report/true-cost-of-food-measuring-what-matters-to-transform-the-u-s-food-system/

3. Statement by Dr. Rajiv J. Shah, President of The Rockefeller Foundation, and Nancy Brown, CEO of the American Heart Association, on New Food Is Medicine Research Initiative. The Rockefeller Foundation. Accessed February 23, 2024. https://www.rockefellerfoundation.org/news/statement-by-dr-rajiv-j-shah-president-of-the-rockefeller-foundation-and-nancy-brown-ceo-of-the-american-heart-association-on-new-food-is-medicine-research-initiative/

4. Sharib JR. True Cost of Food: Food is Medicine Case Study. Food is Medicine. Published September 26, 2023. Accessed February 26, 2024. https://tuftsfoodismedicine.org/true-cost-fim-case-study-report/

5. Florko N. Can food be medicine? Will insurers cover it? And other big questions about a new health movement. STAT. Published February 16, 2023. Accessed February 16, 2024. https://www.statnews.com/2023/02/16/food-is-medicine-will-insurers-cover-whats-next/

6. Bleich SN, Dupuis R, Seligman HK. Food Is Medicine Movement—Key Actions Inside and Outside the Government. *JAMA Health Forum*. 2023;4(8):e233149. doi:10.1001/jamahealthforum.2023.3149

7. Mozaffarian D, Aspry KE, Garfield K, et al. "Food Is Medicine" Strategies for Nutrition Security and Cardiometabolic Health Equity. *Journal of the American College of Cardiology*. 2024;83(8):843-864. doi:10.1016/j.jacc.2023.12.023

8. Downer S, Clippinger E, Kummer C. *Food Is Medicine Research Action Plan*.; 2022. Accessed February 26, 2024. https://www.aspeninstitute.org/wp-content/uploads/2022/01/Food-is-Medicine-Action-Plan-Final_012722.pdf

9. Berkowitz SA, Terranova J. Medically Tailored Meals to Address the Health Consequences of Food Insecurity. *N Engl J Med*. 2024;390(9):775-776. doi:10.1056/NEJMp2313222

10. Food is Medicine: A Project to Unify and Advance Collective Action | health.gov. Accessed March 5, 2024. https://health.gov/our-work/nutrition-physical-activity/food-medicine

11. American Heart Association. Health Care by Food - Accelerating the Integration of Food is Medicine in Health Care. Health Care by Food - Accelerating the Integration of Food is Medicine in Health Care. Accessed March 24, 2024. https://healthcarexfood.org/

12. Mozaffarian D, Blanck HM, Garfield KM, Wassung A, Petersen R. A Food is Medicine approach to achieve nutrition security and improve health. *Nat Med*. 2022;28(11):2238-2240. doi:10.1038/s41591-022-02027-3

13. Food is Medicine — Food is Medicine Massachusetts. Accessed February 26, 2024. https://foodismedicinema.org/food-is-medicine-interventions

14. Hager K, Cudhea FP, Wong JB, et al. Association of National Expansion of Insurance Coverage of Medically Tailored Meals With Estimated Hospitalizations and Health Care Expenditures in the US. *JAMA Network Open*. 2022;5(10):e2236898. doi:10.1001/jamanetworkopen.2022.36898

15. Wang L, Lauren BN, Hager K, et al. Health and Economic Impacts of Implementing Produce Prescription Programs for Diabetes in the United States: A Microsimulation Study. *J Am Heart Assoc*. 2023;12(15):e029215. doi:10.1161/JAHA.122.029215

16. Doyle J, Alsan M, Skelley N, Lu Y, Cawley J. Effect of an Intensive Food-as-Medicine Program on Health and Health Care Use: A Randomized Clinical Trial. *JAMA Intern Med*. 2024;184(2):154. doi:10.1001/jamainternmed.2023.6670

17. Hager K, Shi P, Li Z, et al. Evaluation of a Produce Prescription Program for Patients With Diabetes: A Longitudinal Analysis of Glycemic Control. *Diabetes Care*. 2023;46(6):1169-1176. doi:10.2337/dc22-1645

18. Moran AJ, Roberto CA. A "Food Is Medicine" Approach to Disease Prevention: Limitations and Alternatives. *JAMA*. 2023;330(23):2243. doi:10.1001/jama.2023.24472

19. Food is Medicine Approaches to Address Diet-Related Health Conditions - Bill of Health. Published February 28, 2024. Accessed March 8, 2024. https://blog.petrieflom.law.harvard.edu/2024/02/28/food-is-medicine-approaches-to-address-diet-related-health-conditions/

20. Freudenberg N, Nestle M. A Call for a National Agenda for a Healthy, Equitable, and Sustainable Food System. *Am J Public Health*. 2020;110(11):1671-1673. doi:10.2105/AJPH.2020.305926

21. Food Politics by Marion Nestle. Food Politics by Marion Nestle. Accessed November 22, 2023. https://www.foodpolitics.com/

22. An Annotated Bibliography on Structural Racism Present in the U.S. Food System, Tenth Edition. Center for Regional Food Systems. Accessed November 22, 2023. https://www.canr.msu.edu/resources/structural_racism_in_us_food_system

23. What we fund. Point32Health Foundation. Accessed March 4, 2024. https://www.point32healthfoundation.org/funding-grants/what-we-fund/

24. Point32Health Foundation awards $750K to food justice efforts in New England. Accessed October 17, 2023. https://pbn.com/point32health-foundation-awards-750k-to-food-justice-efforts-in-new-england/

25. Point32Health Foundation. Point32Health Foundation awards $700,000 to New England food banks. Point32Health Foundation. Published December 16, 2022. Accessed March 4, 2024. https://www.point32healthfoundation.org/point32health-foundation-awards-700000-to-new-england-food-banks/

26. Florko N. Why won't Medicare deliver food to sick seniors, if it could get them healthy? STAT. Published February 28, 2024. Accessed February 28, 2024. https://www.statnews.com/2024/02/28/medicare-food-as-medicine/

27. Khan A. Medicaid Is a New Tool to Expand Healthy Food Access. Center For Health Law and Policy Innovation. Published January 10, 2023. Accessed March 4, 2024. https://chlpi.org/news-and-events/news-and-commentary/health-law-and-policy/medicaid-is-a-new-tool-to-expand-healthy-food-access/

28. Commonwealth of Massachusetts Executive Office of Health and Human Services. Flexible services program directory. Published online March 13, 2024.

29. OHCHR and the right to food. OHCHR. Accessed March 20, 2024. https://www.ohchr.org/en/food

30. Re-balancing medical and social spending to promote health: Increasing state flexibility to improve health through housing | Brookings. Accessed February 26, 2024. https://www.brookings.edu/articles/re-balancing-medical-and-social-spending-to-promote-health-increasing-state-flexibility-to-improve-health-through-housing/

31. Variation In Health Outcomes: The Role Of Spending On Social Services, Public Health, And Health Care, 2000–09 | Health Affairs. Accessed March 22, 2024. https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0814

32. Florko N. The Food is Medicine movement originators are trying to standardize medically tailored meals. STAT. Published March 27, 2024. Accessed March 29, 2024. https://www.statnews.com/2024/03/27/food-is-medicine-medically-tailored-meals-standard/

33. Hager K, Emanuel E, Mozaffarian D. Employer-Sponsored Health Insurance Premium Cost Growth and Its Association With Earnings Inequality Among US Families. *JAMA Netw Open*. 2024;7(1):e2351644. doi:10.1001/jamanetworkopen.2023.51644

34. Mozaffarian D. GLP-1 Agonists for Obesity—A New Recipe for Success? *JAMA*. Published online February 29, 2024. doi:10.1001/jama.2024.2252

35. Writer APHS. Are new weight-loss drugs the answer to America's obesity problem? Harvard Gazette. Published July 10, 2023. Accessed July 11, 2023. https://news.harvard.edu/gazette/story/2023/07/are-new-weight-loss-drugs-the-answer-to-americas-obesity-problem/