



May 20, 2009

The Honorable Max Baucus
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Charles Grassley
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Grassley:

Trust for America's Health, a nonprofit, nonpartisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority, would like to thank you for the opportunity to submit comments on the Senate Finance Committee's policy options paper entitled: *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans*.

We applaud the inclusion of prevention and wellness options, such as the creation of a personalized prevention plan for Medicare beneficiaries; the removal or limit on cost-sharing for certain preventive services in Medicare and Medicaid; enhanced access to preventive services for eligible adults enrolled in Medicaid; the consideration of Right Choices grants and prevention and wellness innovation grants; and the inclusion of employer wellness tax credits. If enacted, we believe that these provisions would go a long way toward helping to identify and address chronic disease risk factors. However, we urge the Committee to invest not only in clinical prevention but also in community-based prevention initiatives. These initiatives create healthy environments and give consumers the tools and support necessary to live healthy lifestyles and avoid developing chronic disease risk factors.

We also commend your inclusion of proposals to expand access to affordable quality coverage for all Americans through the development of a public insurance option and a Health Insurance Exchange; the provision of tax credits for low income taxpayers who purchase health insurance through the exchange; tax credits for small businesses purchasing employer provided health insurance; and revised eligibility standards for Medicaid.

As you move toward marking up a comprehensive health reform package, we urge you to consider incorporating the following healthy living and disease prevention components:

- **Create a Public Health and Wellness Trust Fund (Trust Fund) to assure adequate funding for community prevention activities that occur outside the clinical setting. This will provide added value beyond the clinical preventive benefits contained in the options paper.** High rates of chronic disease are one of the biggest drivers of health care costs. The country will continue to struggle to contain health care costs until we do

a better job of keeping people healthier and preventing disease. A small, strategic investment in effective disease prevention programs in communities can help significantly reduce trips to the doctor's office, rates of disease, and health care costs. A study by Trust for America's Health, entitled *Prevention for a Healthier America*, found that investing \$10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use, could save the country more than \$16 billion annually within five years. Out of the \$16 billion in savings, Medicare could save more than \$5 billion, Medicaid could save more than \$1.9 billion, and private payers could save more than \$9 billion. To realize these benefits and prioritize our investment in public health, we recommend the creation of a Trust Fund that could be funded through a mandatory appropriation or set-aside of a portion of new revenues generated through the financing of health reform. Resources from the Trust Fund would be allocated to specific public health programs or activities as determined through the annual budget process. Funding would augment, not supplant, current annual baseline funding for Function 550 public health programs. The Trust Fund would support expansion of public health functions and services that surround, support, and strengthen the health care delivery system. It would finance:

- The core governmental public health functions of assessment, assurance, and policy development at the federal, state, and local levels.
 - Population-level non-clinical prevention and wellness programs, which can be delivered through governmental agencies and non-governmental agencies. Programs would be evidence-based community prevention programs that target priority health outcomes.
 - Clinical preventive services (such as screenings and immunizations) that are not covered by third party payers delivered in community settings or by health departments.
 - Workforce training and development, as well as public health research.
- **Establish an innovative demonstration program targeting the pre-Medicare population to help reduce chronic disease risk factors and promote better health before entry into Medicare.** Seven out of every ten deaths in the U.S. are attributable to chronic diseases, which account for 96 percent of Medicare spending and 83 percent of Medicaid spending.¹ Yet, the vast majority of cases of chronic disease could be better prevented or managed. The World Health Organization has estimated that if the major risk factors for chronic disease were eliminated, at least 80 percent of all heart disease, stroke, and type 2 diabetes would be prevented, and more than 40 percent of cancer cases would be prevented. To help control the growth of Medicare costs, we should explore approaches that promote the health of Americans before they enter Medicare. We urge you to develop a demonstration program that targets the pre-Medicare population (55-64 years old) by providing grants to be used to provide chronic disease screenings and community prevention programs promoting nutrition and physical activity. By targeting interventions to individuals before they enter Medicare, we can facilitate healthy lifestyles and work to reduce disease risk factors before the onset of a costly chronic disease.

- **Address the childhood obesity epidemic through health reform.**
 - **Develop a Medicaid demonstration that expands access to community prevention interventions that engage families and children.** Approximately 23 million children are obese or overweight. Obese children and teens are developing diseases that were formerly only seen in adults, such as type 2 diabetes. The national cost of childhood obesity is estimated to be approximately \$11 billion for children with private insurance and \$3 billion for those with Medicaid.ⁱⁱ To help mitigate this epidemic and prioritize the health of our children, we recommend that you develop a Medicaid demonstration that funds community-based prevention interventions that target improvements in eligible children’s nutrition and physical activity behaviors in schools and in communities to test initiatives for reducing the risk and incidence of childhood obesity. Given the fact that low-income children are at excess risk of obesityⁱⁱⁱ, targeting interventions through the Medicaid program, which serves the low-income population, would help ensure that children at high risk for obesity have access to interventions to reduce this risk.
 - **Provide additional clarity for providers as to what clinical obesity prevention benefits are covered in Medicaid and encourage states to include clinical prevention benefits for children who are obese or at-risk for obesity in their Children’s Health Insurance Program (CHIP) and Medicaid programs.** Within Medicaid, reimbursement codes are available to bill for all recommended childhood obesity prevention services. Yet, state Medicaid provider manuals tend not to include specific reference to coverage of obesity prevention and treatment services. As a result, some providers remain uncertain about which services they can provide and if they can be reimbursed.^{iv} To address these issues, we urge you to require the Centers for Medicare and Medicaid Services (CMS) to disseminate information about the importance of childhood obesity risk to state Medicaid and CHIP programs; require CMS to augment existing Medicaid pediatric obesity coverage guidelines, with special guidelines on using managed care, integrated service delivery and disease management techniques to develop obesity prevention programs for at-risk children;^v and require states to report to CMS on the number of CHIP & Medicaid enrollees that they: (1) screen for obesity and overweight, and (2) for those children identified to be at-risk, the number for whom the state provides follow-up counseling and services. CMS should also be required to report on an annual basis to Congress on the percentage of CHIP and Medicaid enrollees receiving these services.

Health reform affords a great opportunity to reorient our system to focus on prevention and wellness. We should ensure that all Americans have access to the programs, services and coverage they need to be healthy and that they live, work and go to school in communities that support healthy lifestyles.

We greatly appreciate the opportunity to comment and hope to work with you on this and other important prevention and wellness initiatives in the future.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeffrey Levi". The signature is fluid and cursive, with the first name "Jeffrey" being larger and more prominent than the last name "Levi".

Jeffrey Levi, PhD
Executive Director

ⁱ Partnership to Fight Chronic Disease. "2009 Almanac of Chronic Disease."

http://www.fightchronicdisease.org/pdfs/PFCDAmanac_Final2.pdf

ⁱⁱ Marder, William D. and Stella Chang. "Childhood Obesity: Costs, Treatment Patterns, Disparities in Care, and Prevalent Medical Conditions." Thomas Medstat Research Brief. 2006.

ⁱⁱⁱ Kumanyika, Shiriki and Sonya Grier. "Targeting Interventions for Ethnic Minority and Low-Income Populations." *The Future of Children*, Vol 16, No.1 (Spring 2006).

^{iv} "Analysis Shows Existing Medicaid Benefit Codes Cover Childhood Obesity-Related Health Care Treatment." July 2007. Robert Wood Johnson Foundation. <http://www.rwjf.org/reports/grr/053842.htm>

^v Rosenbaum, Sara; Wilensky, Sara; Cox, Marisa, and D. Brad Wright. *Reducing Obesity Risks During Childhood: the Role of Public and Private Health Insurance*. July, 2005.