

**INVESTING IN A HEALTHIER
AMERICA: CHRONIC DISEASE PREVENTION
AND TREATMENT**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

SEPTEMBER 18, 2024

Serial No. 118–HL06

Printed for the use of the Committee on Ways and Means



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United States House Committee on
Ways & Means
CHAIRMAN JASON SMITH

FOR IMMEDIATE RELEASE
September 11, 2024
No. HL-06

CONTACT: 202-225-3625

**Chairman Smith and Health Subcommittee Chairman Buchanan
Announce Subcommittee Hearing on Investing in a Healthier America:
Chronic Disease Prevention and Treatment**

House Committee on Ways and Means Chairman Jason Smith (MO-08) and Health Subcommittee Chairman Vern Buchanan (FL-16) announced today that the Subcommittee on Health will hold a hearing to examine the prevalence of chronic disease in America and the value of investing in prevention and innovative treatment options. The hearing will take place on **Wednesday, September 18, 2024, at 2:00 PM in 1100 Longworth House Office Building.**

Members of the public may view the hearing via live webcast available at <https://waysandmeans.house.gov>. The webcast will not be available until the hearing starts.

In view of the limited time available to hear the witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record can do so here: WMSubmission@mail.house.gov.

Please ATTACH your submission as a Microsoft Word document in compliance with the formatting requirements listed below, **by the close of business on Wednesday, October 2, 2024**. For questions, or if you encounter technical problems, please call (202) 225-3625.

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All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Please indicate the title of the hearing as the subject line in your submission. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

ACCOMMODATIONS:

The Committee seeks to make its facilities accessible to persons with disabilities. If you require accommodations, please call 202-225-3625 or request via email to WMSubmission@mail.house.gov in advance of the event (four business days' notice is requested). Questions regarding accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the Committee website at <http://www.waysandmeans.house.gov/>.

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**INVESTING IN A HEALTHIER
AMERICA: CHRONIC DISEASE PREVENTION
AND TREATMENT**

WEDNESDAY, SEPTEMBER 18, 2024

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The subcommittee met, pursuant to call, at 2:30 p.m., in Room 1100, Longworth House Office Building, Hon. Vern Buchanan [chairman of the subcommittee] presiding.

Mr. BUCHANAN. Subcommittee will come to order. Good afternoon. Thank you for the witnesses being here today to discuss the crucial issue before us, investing in a healthier America: chronic disease prevention and treatment. Chronic diseases such as cancer, heart disease, and Alzheimer's cases are skyrocketing.

According to the American Cancer Society, in the coming year we are expected to hit a bleak milestone, the first time new cases of cancer in the U.S. are expected to be across the 2 million mark. This daunting number tells me that we need to invest in technologies that will be able to catch these chronic diseases early and often.

We have another growing challenge. Over 45 percent of the nation's adults are obese. It is hard to imagine that number, but that is what the numbers said. And the sadder part of that, over 20 percent of the nation's children are obese. 20 percent of the nation's children. For the sake of ourself, our children, and our communities, we must do better. In fact, we are about to eclipse 19 percent of the GDP going towards healthcare expenditures while Medicare just surpassed first time \$1 trillion in history.

In Israel, for example, they live five years longer than the average American and spent less than eight percent of their GDP on healthcare. We need to learn from our neighbors and our friends about how to do a better job of it. Not that we don't do a lot of good things in terms of the health care space, but there is a lot more that can be done. Many families don't have the time or the resources to analyze and read the food labeling to understand what they are really putting in their bodies.

That is why it is critical that our nation's medical providers have the tools necessary to educate their parents on the importance of nutrition for them, and most importantly, for their children.

To bring awareness to this issue, Congresswoman Gwen Moore and I recently launched a Congressional prevention health and

wellness caucus. Our bipartisan group focuses on prevention, food is medicine, exercise, and doing what we can to get our military more ready. Effectively, the readiness for the military. I would like to thank Congresswoman Moore for joining me in that critical initiative and I urge my fellow members to take a look at the subcommittee as well.

The obesity epidemic has also, as we talked about, from a national security standpoint, according to the American Security Projects, obesity rates among active duty service members, I went in when I was 18, so I have got some sense of it, but the active duty service member rate has doubled in the past decade in terms of obesity.

This growing threat from our adversaries, across the globe, we cannot afford to have an unfit and unhealthy military to address major international dangers. Those that have tried to get in the military between 17 and 24, $\frac{1}{3}$ of the adults are overweight and unable to serve in terms of the military.

We are about to hear from a great group of folks and I followed these—especially the senator for the last 30, 40 years. It is hard to believe. I am very excited about a great group of folks that we have got today that are on the front line of these chronic conditions and ensuring prevention is the main priority in the medical field. As Senator Frist said in a recent article in Forbes, we all need to prioritize and going back to the very basics, and the food we put in our body is the key. I am pleased to recognize the gentleman from Texas, Mr. Doggett, for his opening statement.

Mr. DOGGETT. Well, thank you, Mr. Chairman. I know how passionate you are about healthy lifestyles and chronic disease prevention and I appreciate the panel that you pulled together for us today.

An estimated 2 million Americans die each year from chronic conditions, and there are so many steps that we can take as individuals. I am sure we will be hearing more about that today to be responsible for our own healthy choices, but I also think we need to explore the multitude of obstacles that are placed in the way of many Americans in making those choices.

My daughter, Dr. Lisa Doggett, is a family physician certified in lifestyle medicine. She recently came over with her lifestyle questionnaire with me and my wife Libby. I told her she was cutting out everything that was fun, but the reality is that many of the foods we are consuming aren't really food. They are engineered products designed to trigger addictive habits. And as a result of her visit, I started make some changes beginning with my breakfast cereal.

After successfully manufacturing a smoking crisis and getting millions of Americans addicted to nicotine, big tobacco is one of those obstacles. Replicating its playbook in the food industry with tobacco companies purchasing large food brands and beginning to re-engineer and alter and process their products until they bear little resemblance to natural foods. They load foods with additives to make them taste better. They are high in salt, sugar, and fat content.

In one egregious example, they took the same flavor of addictive additives in cigarettes and added them to sugary beverages mar-

keted to children. While companies across the food industry were shifting to alter processed goods, big tobacco-owned brands produced these hyper-palatable foods at a higher rate manufacturing another addiction crisis.

These companies also applied some of the same marketing tactics from the tobacco playbook, shifting the focus groups to include children rather than parents and repackaging products with colorful characters, catch phrases, and free toys, candy shaped like diamond rings, cookies in the shape of cartoon characters, and other tactics to appeal to kids. Adults were sold on the convenience of ready-to-eat meals and long-lasting, shelf-ready snacks.

Today we are paying the price, as the chairman indicated, in obesity rates and chronic disease rates that are skyrocketing, and particularly among young children. Mental health has declined as consumers cycle through shame and their diets contain insufficient nutrients. Many are feeling trapped from the addictions and the addictive nature of these products.

While each of us must take personal responsibility for our own health, these obstacles impair the choice. So many factors intrude. Economic insecurity makes it difficult to afford natural foods. The natural struggles can mean a deficit in time as workers juggle long hours and caregiving duties. Natural foods often require preparation while ultraprocessed foods come in ready-to-eat forms for fast on-the-go Americans.

Many Americans are also living in food deserts. I have some right on the edge of my district with few healthy food options at local stores, or perhaps in food swamps where the only options are ultraprocessed foods.

I appreciate some of the Medicare advantage plans that are making access to nutritious meals, but I remain concerned that too many plans severely restrict supplemental benefits to certain consumers in geographic areas. Meanwhile ads mislead consumers into thinking they will receive free meal delivery, gym, and more. For those who are eligible, fine print caveats limit the value, and the promoted—the promised benefits are often just nominal discounts.

Emanating plans, I believe, are being dramatically overpaid, costing taxpayers billions more each year than traditional Medicare. Rather than overpaying for private insurance plans, we can cut taxpayer waste and use the funds to improve traditional Medicare by covering nutritious meals and other benefits like dental, vision, and hearing.

These are important steps to treat the crisis that we are in, but we should not just be in the sick care business. We must also address root causes, including the proliferation of these cheap ultraprocessed food products.

I look forward to hearing from our witnesses about the challenges to maintaining a healthy lifestyle and the solutions that we can encourage to improve the health of all Americans.

Thank you, Mr. Chairman.

Mr. BUCHANAN. Thank you. I will now introduce our witnesses. Senator Bill Frist is a former United States Senate Majority Leader and a doctor from Tennessee.

Dr. Mark Hyman is the founder of the Institute for Functional Health.

Dr. Ann Peters is a senior scholar with the University of Southern California.

Dr. Rinaldo is the chief clinical innovation officer at SCAN Health Plan.

Dr. Ashley Gearhardt is the professor of psychology for food and addiction science and treatment at the University of Michigan.

Again, thank all of you for joining us today. Your written statements will be made part of the written record, and each of you will have five minutes to deliver your remarks. I might be a little more generous with that today, but try to keep it somewhat in the ballpark.

Senator Frist, if you are ready, you can begin.

STATEMENT OF SENATOR BILL FRIST, FORMER UNITED STATES SENATE MAJORITY LEADER, CHAIRMAN OF THE EXECUTIVES COUNCIL, CRESSEY & COMPANY

Dr. FRIST. Thank you, Chairman Buchanan, Ranking Member Doggett, and distinguished members of the committee. Having spent many more than a thousand hours on that side of the dais, I am truly grateful for the opportunity to be with you today to share my thoughts and my experiences as a physician, as a policymaker like each of you, and as a business person looking at innovative places to invest and approach this really challenging issue of food and nutrition.

I have personally written tens of thousands of prescriptions for treatment and for prevention of disease, literally with my hands, but I have never written a prescription for food. But that is really about to change. I know it is about to change. Here I am going to talk a little bit why. It is because nutritious foods are now recognized as being fundamental to prevention of disease, to the treatment of disease, to improving health, and to lowering cost.

As the chairman mentioned, in one of the articles I wrote, it is really because it is fundamental and we are going not to just treating the symptoms of a problem, of a challenge, the disease burden in this country, but to a fundamental root cause of disease.

I have got three points really to make. First the opportunity. Poor diets are the leading risk factor for death and disability in the United States causing more health harms than tobacco use, than alcohol, than opioids, than physical inactivity or air pollution. Americans of all income, races, and ethnicities and all political parties in every state in every city are affected. But in particular, those with lower incomes living in rural communities and from historically marginalized groups face the greatest burdens and they fall further and further behind due to these out-of-pocket expenses, to lost wages, to lost jobs, to depleted communities.

The nutrition problem really is not complicated. Americans eat first too much refined starch, sugar, and salt often as a part of the foods, as the ranking member just mentioned, processed far beyond their natural forms. And two, not enough fruits, vegetables, beans, nuts, corn, grain, seafood, and yogurt, which we know, scientifically know, promote health and protect against disease.

Poor nutrition was pointed out is crushing our economy. The numbers, the U.S. economy loses an estimated \$1.1 trillion each year in direct medical costs and productivity losses due to poor nutrition and has the impact of increasing the federal deficit and thus the federal debt.

As the chairman mentioned, poor nutrition is a national security issue. Nearly eight in ten young Americans do not qualify, eight in ten today, for military service. By far the number one disqualifier is overweight and obesity.

Second point, food is medicine. What is it? What is that power itself? Food is medicine refers to a set of food-based nutrient interventions, active interventions integrated into healthcare. That is where the failure lies. It is not integrated today into healthcare to treat and manage specific disease conditions, like diabetes and like high risk pregnancy and heart failure, my speciality, the heart, chronic kidney disease and cancer. We need to keep it clear it is not just about prevention. It is about medical therapy itself. I think you will hear more about that from the other witnesses.

The food is medicine programs include—what are they? They include treatment with medically tailored meals. Medically tailored meals. Those are meals that are specifically tailored for very specific conditions. More to come on that. It includes medically tailored groceries, produce prescriptions covered by health insurance, nutrition coaching and culinary education, medical nutrition education for doctors.

Again, this isn't a social program or another way of doing assistance. This is prevention and it is therapy. The demonstrated proven benefits include less food insecurity, more healthy food intake, better health including lower blood sugar levels, lower blood pressure and body weight. They make financial sense. Compared to other common medical interventions, these food is medicine programs are either a healthcare sort of best buy or they actually lower cost savings.

For example, research from Tufts University estimates that about 6 million Americans qualify for medically tailored meals, and providing this treatment to these patients will save nearly \$14 billion annually. Third, the policy implications, and I have outlined in my testimony, policy implications is that I hope that you will consider specific for this committee and also in that written statement what other committees might consider as well.

In closing, the food we eat really is directly as anything that I have seen in my 25 years of practicing healthcare and 12 years in policy directly and powerfully impact our health, directly and powerfully impact our economy. It hits at the root cause. They improve health, prevent disease, enhance well-being, save money for the individual, save money for the employer, save money for the community, and save money for the nation. Thank you, Mr. Chairman.

[The statement of Dr. Frist follows:]

Investing in a Healthier America: Chronic Disease Prevention and Treatment
Written Testimony Submitted to the U.S. House Committee on Ways and Means, Subcommittee on Health
 Wednesday, September 18, 2024
 1100 Longworth House Office Building, Washington, DC

Senator William H. Frist, MD
U.S. Senate Majority Leader, 2003-2007
Senior Fellow, Bipartisan Policy Center
Global Board Chair, The Nature Conservancy
Founding Partner, Frist Cressey Ventures

Dear Chairman Buchanan, Ranking Member Doggett, and distinguished members of the Committee:

I am grateful for the opportunity to testify and share what I have seen and learned about food and health as a heart and lung transplant surgeon, as the former Majority Leader of the U.S. Senate, and as a Senior Fellow at the Bipartisan Policy Center, including co-chairing the BPC's Food is Medicine Working Group.

I've personally performed many hundreds of heart surgeries, and written thousands of prescriptions, for patients to treat and prevent disease. But in all my years of practice, I never wrote a prescription for food. That is about to change. Why? Because nutritious food is finally being recognized as a fundamental component of health and health care.

WHERE WE ARE TODAY

- **Key point #1: Poor nutrition is the leading risk factor for death and disability in the United States,** causing more health harms than other major risk factors such as tobacco use, alcohol, opioids, physical inactivity, or air pollution (*Figure 1*).¹
 - Poor diets are estimated to kill 10,000 Americans each week, cause 1,500 new cases of cancer each week, and cause 16,000 new cases of diabetes each week.^{2,3,4}
 - Poor diets are a key contributor to 7 in 10 adults being overweight or having obesity,⁵ 1 in 2 having diabetes or prediabetes,⁶ and 14 in 15 (~93%) having suboptimal cardiometabolic health (less than suboptimal levels of body fat, blood pressure, blood cholesterol, or blood sugar).⁷
 - What these numbers tell us: more American adults are sick than healthy.
 - Children and teenagers aren't spared—among 2-5 year-olds, 1 in 8 has obesity. Among teens, 1 in 4 has obesity,⁸ and nearly 1 in 3 has prediabetes.⁹
- When I began my medical career, these national epidemics of obesity and type 2 diabetes did not exist. The proliferation of these diet-related chronic diseases has occurred in our adult lifetimes.

¹ U.S. Burden of Disease Collaborators, Mokdad AH, Ballestros K, et al. The State of US Health, 1990-2016: Burden of Diseases, Injuries, and Risk Factors Among US States. *JAMA*. 2018;319(14):1444-1472. <https://jamanetwork.com/journals/jama/fullarticle/2678018>

² Ibid.

³ Zhang FF, Cudhea F, Shan Z, et al. Preventable Cancer Burden Associated With Poor Diet in the United States. *JNCI Cancer Spectr*. 2019;3(2):pkz034. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6649723/>

⁴ O'Hearn M, Lara-Castor L, Cudhea F, et al. Incident type 2 diabetes attributable to suboptimal diet in 184 countries. *Nature medicine*. 2023;29(4):982-995. <https://www.nature.com/articles/s41591-023-02278-8>

⁵ <https://www.cdc.gov/nchs/fastats/obesity-overweight.htm> Accessed September 1, 2024.

⁶ CDC. National Diabetes Statistics Report 2024. <https://www.cdc.gov/diabetes/php/data-research/index.html>

⁷ O'Hearn et al. *JACC*. 2022 Jul, 80 (2) 138–151. <https://www.jacc.org/doi/10.1016/j.jacc.2022.04.046>

⁸ <https://www.cdc.gov/obesity/php/data-research/childhood-obesity-facts.html> Accessed September 1, 2024.

⁹ Liu et al., 2022. *JAMA Pediatrics*. <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2790364>

- Despite solid evidence that a nutritious diet is fundamental to living a healthy life, most Americans fall far short of following science-based dietary guidelines. The average score on the Healthy Eating Index (HEI) — a measure of how well one’s eating habits align with those recommended in the latest federal dietary guidance — is 58 out of 100.¹⁰ This is a failing score. Even if we separate the population by age groups, the highest score is still only 61 (that’s for individuals ages 60+).¹¹
 - The problem is two-fold. First, Americans eat too much refined starch, sugar, and salt, often as part of foods that have been processed far beyond their natural forms.
 - Second, most Americans eat too few fruits, vegetables, beans, nuts, whole grains, seafood, and yogurt (*Figure 2*). These minimally processed foods are rich in nutrients and other compounds that nourish our bodies and our gut bacteria.
 - We must deal with both problems. Yet, traditionally, we’ve spent much more time and focus on driving down excess intake of harmful components in the diet than we have on rewarding, incentivizing, and valuing health-promoting foods and their economic benefits. This is where Food is Medicine comes in.
- **Key Point #2: Poor nutrition is crushing our economy.** The U.S. economy loses an estimated \$1.1 trillion each year in direct medical costs and productivity losses due to poor nutrition.¹²
 - For just one condition, type 2 diabetes — a malady almost entirely preventable and treatable with good nutrition — the U.S. government spends nearly \$200 billion each year on direct medical costs alone.¹³ This is more than the entire budgets of many agencies.
 - The costs of diet-related diseases are a **major burden for families**. Over the last 30 years, the average family on employer-sponsored insurance has *lost \$125,000 in cumulative wages* due to rising healthcare premiums.¹⁴ Today, the leading cause of household bankruptcy is catastrophic medical expenses. And this economic pain is greatest for rural, low-income, Black, and Hispanic families.
 - The costs of diet-related diseases represent a massive burden for **U.S. businesses**. The average premium for employer-sponsored healthcare has risen 50% in just 10 years.¹⁵
 - The costs of diet-related diseases are also driving up the **federal budget and national debt**. In 1969, just 5% of the federal budget was spent on healthcare. Today, it’s nearly 30%.¹⁶ And over the next decade, healthcare spending is projected to account for more than a third of federal budget spending growth — more than any other budget expenditure — surpassing both Social Security and net interest on the debt.¹⁷
 - **If Congress wants to do the things that you believe are important for the American people, we will never have the funds you need until we reduce healthcare spending.**

¹⁰ Shams-White et al., 2023. [https://www.jandonline.org/article/S2212-2672\(23\)00246-0/fulltext](https://www.jandonline.org/article/S2212-2672(23)00246-0/fulltext)

¹¹ <https://fns-prod.azureedge.us/sites/default/files/media/file/AverageHealthyEatingIndex-2020ScoresfortheUSPopulation.pdf>

¹² The Rockefeller Foundation. True Cost of Food: Measuring What Matters to Transform the U.S. Food System. 2021.

<https://www.rockefellerfoundation.org/report/true-cost-of-food-measuring-what-matters-to-transform-the-u-s-food-system/>.

¹³ Parker ED, Lin J, Mahoney T, et al. Economic Costs of Diabetes in the U.S. in 2022. *Diabetes Care*.

2024;47(1):26-43. <https://pubmed.ncbi.nlm.nih.gov/37909353/>

¹⁴ 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

¹⁵ Center for American Progress. Federal Solutions To Address Rising Costs of Employer-Sponsored Insurance. 2024.

<https://www.americanprogress.org/article/federal-solutions-to-address-rising-costs-of-employer-sponsored-insurance/>. Accessed April 12, 2024.

¹⁶ [Cubanski J et al., FAQs on Health Spending, the Federal Budget, and Budget Enforcement Tools, Kaiser Family Foundation, March 20, 2023. https://www.kff.org/medicare/issue-brief/faqs-on-health-spending-the-federal-budget-and-budget-enforcement-tools/](https://www.kff.org/medicare/issue-brief/faqs-on-health-spending-the-federal-budget-and-budget-enforcement-tools/)

¹⁷ “84 Percent of Spending Growth Will Come from Health, Social Security, and Interest,” Committee for a Responsible Budget, Feb. 15, 2024, <https://www.crfb.org/blogs/84-percent-spending-growth-will-come-health-social-security-and-interest#:~:text=Spending%20on%20Social%20Security%20will,doubled%20between%202020%20and%202023.>

And healthcare spending will never be controlled until we fix food.

- **Key Point #3:** This is also an *urgent matter of national security*.⁸ Mission: Readiness, a group of more than 700 retired U.S. generals and admirals, have been making this case for more than a decade.
 - In 1941, President Franklin D. Roosevelt convened the National Nutrition Conference on Defense,¹⁸ to create urgent new policies to fix the food supply, when 1 in 3 young Americans did not qualify for the draft due to nutritional deficiencies.
 - Today, nearly *8 in 10* young Americans do not qualify for military service, and the top medical disqualifier is overweight and obesity.¹⁹
 - For our nation’s sake, our elected leaders today must have the same vision and urgency to fix our food system.
- **Key Point #4:** The burdens of our food are also *driving societal discord*. Americans of all incomes, races, and ethnicities —and all political parties, states, and cities — are experiencing high and rising levels of diet-related diseases and downstream family, community, and economic consequences. But those with lower incomes, living in rural communities and from historically marginalized racial and ethnic groups face the greatest burdens.²⁰ These challenges contribute to them falling behind economically, to lost wages, lost jobs, depleted communities.
 - 44 million Americans — about 1 in 8 households — experience food insecurity at some point during the year.²¹ Food insecurity is associated with worse nutrition, higher rates of diet-related diseases, and greater healthcare spending.
- **As we look to comprehensively expand treatment options for diet-related diseases, including obesity, and key in on prevention, we all need to prioritize going back to the very basics: the food we put in our bodies every day.** The lack of attention to our food explains so much about the problems we face today: hundreds of millions of sick Americans, hundreds of billions of dollars in preventable healthcare costs, exhausted federal and state budgets – and exhausted policy makers.

THE POWER OF “FOOD IS MEDICINE”

“Food is Medicine” (FIM) is a promising strategy to deal with our country’s nutrition crisis. This refers to a set of food-based nutrition programs and interventions, integrated into the health care system, to advance specific health needs and health equity in different populations. Recognizing the role that nutrition plays, FIM advocates for using nutritious foods to both prevent and treat illnesses. It includes improving access to nutritious foods and calls on healthcare providers—including doctors, nurses, pharmacists, and others—to recognize the role of nutrition in health and more deliberately collaborate with nutrition experts like registered dietitians to effectively engage with and educate patients on dietary needs. It empowers patients to take control of their own health.

¹⁸ National Nutrition Conference for Defense. National Nutrition Conference for Defense. *JAMA*. 1941;116(23):2598-2599.

¹⁹ Mission: Readiness. 2023. <https://www.strongnation.org/articles/2006-77-percent-of-american-youth-can-t-qualify-for-military-service>

²⁰ Benavidez et al. 2024. Preventing Chronic Disease. https://www.cdc.gov/pcd/issues/2024/23_0267.htm

²¹ <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/key-statistics-graphics/>

- This is not just about prevention, but about treating disease. Commonly targeted conditions include diabetes, pregnancy, heart failure, chronic kidney disease, and cancer.
- FIM is a medical therapy, not a social program. But it *also* helps address important social determinants of health like food insecurity and poverty.
 - This makes FIM a “double duty” intervention – an effective medical treatment that also addresses social determinants of health and advances health equity, giving all Americans a fair opportunity to achieve their top level of health.
- FIM programs¹² include several components:
 - Physician screening for appropriate medical conditions and, often, social needs like food or nutrition insecurity.
 - Treatment with specific food-based interventions like medically tailored meals, medically tailored groceries, or produce prescriptions, covered by health insurance. Coverage is critical given that access and affordability are leading barriers for many Americans to eat nutritious foods, particularly among low-income Americans who are at highest risk for diet-related chronic diseases.
 - Nutrition coaching and culinary education, often organized by Registered Dietitian Nutritionists (RDNs) via in person, telehealth, or digital interfaces.
- Other supportive aspects of FIM are important:
 - Links to electronic medical records and clinical care pathways, including reimbursement by federal and commercial payers.
 - Medical nutrition education for doctors.
 - Partnerships with community-based organizations for assessing eligibility and supporting enrollment in federal nutrition assistance programs like SNAP and WIC.
 - Rigorous research to understand what works, and for whom. Such research is critical to understand effects on food security, diet quality, physical health, mental health, and health care utilization. We must evaluate these outcomes to know which FIM interventions work best and how we might need to modify their implementation so they work better.

Whether using meals, groceries, or produce, FIM leverages healthcare to treat diet-sensitive conditions in a holistic, effective, and cost-effective fashion. These programs help cut through barriers such as cost, transportation, and inadequate knowledge around healthy food.

What evidence do we have to back it up?

Research conducted by experts around the country shows that FIM programs work to improve physical health by increasing intake of healthy foods, reducing food insecurity, and improving health outcomes.

- Observed benefits include lower hemoglobin A1c (a measure of average blood sugar levels over a 3-month period), body mass index, and blood pressure, as well as improved mental health and disease self-management.

When targeted to high-risk patients with complex medical conditions, FIM programs can also save money. Careful analyses indicate that FIM interventions will be either *highly cost-effective or even cost-saving* compared to many other common medical interventions.

- Considering that 1% of Americans produce 25% of healthcare costs; and 5% of Americans produce 50% of healthcare costs,²² such high-risk patients are among the best targets for FIM programs.

²² Kaiser Family Foundation. How do health expenditures vary across the population? 2024. <https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/> Accessed April 14, 2024.

- In one state-level analysis conducted by researchers at Tufts University, a medically tailored meals program resulted in net annual savings of \$9,000 for each patient treated – even after accounting for the costs of the program.
- Research estimates that about 6 million Americans qualify for medically tailored meals, and that providing this treatment to these patients will save nearly \$14 billion annually – even accounting for the costs of the program (*Figure 3*).²³
- Medical groceries and produce prescriptions are also highly cost-effective or even cost-saving.
 - North Carolina recently evaluated their Medicaid 1115 waiver experience, which included prominent FIM programming, delivered to 20,000 Medicaid beneficiaries across 33 mostly rural counties in the state. They found that, even accounting for the costs of the program, the intervention resulted in net cost savings for Medicaid.²⁴
 - Additional research from Tufts University estimates that if about \$45 per month of produce prescriptions were provided to Americans with diabetes and food insecurity, the program within 5 years would prevent 65,000 cardiovascular events and – due to healthcare cost savings – have no additional net cost. Over a lifetime, the program would prevent nearly 300,000 cardiovascular events and save more than \$3 billion.

FIM programs can also support local food systems, farmers, and rural communities.

- Several FIM programs, such as Recipe4Health in Alameda County, California, focus on procuring food from local small and mid-sized farmers. This serves as an economic engine for farmers, their families, and their communities.

THE MOMENTUM OF FOOD IS MEDICINE

Based on these health and cost benefits, FIM is accelerating across the nation. Action is occurring at federal and state levels, and across sectors including health systems, health care insurers, nonprofits, and more.

At the federal level, for example:

- The Department of Veterans Affairs and the Indian Health Service have launched produce prescription pilot programs.
- The Department of Health and Human Services held its first-ever FIM Summit in January 2024, drawing a packed house.
- CMS and CMMI are developing toolkits and definitions for FIM programs.
- The National Institutes of Health has an approved plan to launch FIM Networks or Centers of Excellence, similar to the NIH-funded Cancer Centers of Excellence that have been so critical to advance cancer research and treatment.²⁵
- Medicare Advantage programs across the country are implementing FIM based on Congress' 2018 expansion of Special Supplemental Benefits for the Chronically Ill (SSBCI). In 2020 when the program launched, 71 plans covered medically tailored meals, and 101 plans covered medical groceries and produce prescriptions. Today, 323 plans cover medically tailored meals, and 915 plans cover medical

²³ 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 Netw Open*. 2022;5(10):e2236898.

²⁴ Healthcare Innovation. North Carolina Plans to Expand Medicaid SDOH Pilot Statewide. 2024. <https://www.hcinnovalogroup.com/population-health-management/social-determinants-of-health/news/55002542/north-carolina-plans-to-expand-medicaid-sdoh-pilot-statewide>. Accessed April 12, 2024.

²⁵ "Concept Clearance - Food is Medicine Networks or Centers of Excellence," NIH Division of Program Coordination, Planning, and Strategic Initiatives, <https://dpcpsi.nih.gov/sites/default/files/Day-1-155PM-ONR-Concept-Food-is-Medicine-Lynch-background-508.pdf>. Accessed Sept. 13, 2024.

groceries and produce prescriptions.²⁶

At the state level, for example:

- At least ten states now have section 1115 waivers to implement FIM in Medicaid: California, Delaware, Illinois, Massachusetts, New Jersey, New Mexico, New York, Oregon, North Carolina, and Washington. Groups in other states are pushing for similar waivers, such as in Oklahoma, Florida, and others.

For-profit and non-profit organizations are investing in FIM, for example:

Healthcare-related companies and organizations:

- Large commercial payers are implementing FIM, including Elevance, Blue Cross Blue Shield, Geisinger Health, and Promedica.
- Kaiser Permanente, the largest nonprofit integrated health system in the nation, is coordinating its five years of growing FIM programs into the nation's first healthcare FIM Center of Excellence.
- EPIC and other large commercial EMRs are integrating food insecurity screening into their applications.
- Innovative FIM start-ups, such as Season Health, Territory Foods, NourishedRx, Good Measures, and more are emerging.

Non-profit and philanthropic organizations

- Nonprofits across the nation are implementing FIM, including within coalitions like the Food is Medicine Coalition and National Produce Prescription Collaborative.
- The Rockefeller Foundation and American Heart Association have committed \$250 million to FIM research.

Professional associations

- The American Academy of Pediatrics and American College of Lifestyle Medicine have committed to FIM-related training for all their members.
- The Accreditation Council for Graduate Medical Education (ACGME) has made statements about including nutrition competencies in its common program requirements for residency and fellowship programs.

Large, private sector companies are launching FIM programs, such as Instacart, Walmart, Kroger and more.

Other private sectors companies have a proven track record of providing *medically tailored*, home-delivered meals for decades. One example I've personally worked with is Mom's Meals. For 25 years, Mom's Meals has been delivering nutritious fully prepared meals to people aging in place, living with disabilities, discharging from the hospital, managing a chronic condition or experiencing a high-risk pregnancy while reaching every address in the US. And there is a strong evidence base that demonstrates the effectiveness of medically tailored meals as an intervention. Mom's Meals has been a part of five published studies quantifying impact on health status and high-cost utilization, in patients with nutrition-sensitive chronic conditions. Findings include:

- People with type 2 diabetes wearing a continuous glucose monitor (CGM) showed significant improvements in glucose control, with a 6.8% improvement in Time In Range (TIR).²⁷

²⁶ "Chartbook: 2024 Nonmedical Supplemental Benefits in Medicare Advantage," ATI Advisory, Oct. 30, 2023, <https://atiadvisory.com/resources/wp-content/uploads/2024/01/PY2024-Nonmedical-Supplemental-Benefits-Chartbook-ATI-Advisory.pdf>

²⁷ Callahan CN, Hart BB, McNeil CK, Duerr, JM, Weller GB. Improved Time in Range During 28 Days of Meal Delivery for People With Type 2 Diabetes. *Diabetes Spectrum*. 2022; 35(3).

- Dialysis patients lowered their intake of sodium by more than 1600 mg per day, had lower thirst scores, decreased volume overload, and directional lowering of blood pressure – 11% in systolic and 7% in diastolic blood pressure.²⁸
- Adults with chronic liver disease experienced a 30% reduced need for surgical punctures to remove fluid and a 25% improvement in quality of life.²⁹
- Medicare Advantage members with heart failure or other chronic conditions had 39-50% lower rates of 30-day rehospitalization and lower mortality.³⁰
- Veterans Administration patients age 65 or older hospitalized for heart failure had directionally reduced 30-day readmissions (11% versus 27%) and spent 69% fewer days re-hospitalized.³¹

Another example is a company I co-founded, Monogram Health. Monogram has made meaningful inroads in providing a new model of care to address chronic kidney disease (CKD) via Medicare Advantage capitated care. Research has highlighted that tailored diets can help prevent and treat CKD and its comorbid complications, slow CKD progression, and lower the risk of cardiovascular disease. Recognizing this, Monogram Health has fully integrated the food is medicine approach as a core component of its care model, putting nutrition on parity with medication management and high-value clinical interventions. By integrating dietary support – with diets tailored to each patient’s specific diagnosis, stage, and constellation of polychronic conditions and goals of care – and addressing food insecurity when necessary, Monogram Health has achieved measurable improved outcomes. Monogram’s data shows that patients who engage with their dietitian services experience a 7% reduction in Medical Loss Ratio (MLR) savings compared to those without dietitian visits due to lower ER utilization and readmissions. This model underscores the profound impact of combining clinical care with tailored nutritional interventions.

The evidence for the cost-effective approach of FIM continues to build. With support for FIM growing federally and at the state level, across sectors including health systems, healthcare insurers, nonprofits, and private sectors – we know that it can scale.

IMPLEMENTATION QUESTIONS AND CHALLENGES

When it comes to broader policy, FIM interventions face substantial obstacles of insurance coverage, payment, and coordination among health providers and organizations that provide nutrition-based services. Indeed, the vast majority of Americans cannot access FIM therapies.

- Most states have not applied for Medicaid 1115 waivers to implement FIM.
- Traditional Medicare Fee-For-Service, which covers nearly half of all Medicare enrollees, does not cover FIM.
- Many commercial plans are awaiting greater clarity in federal healthcare regulations around FIM.
- FIM vendors and suppliers are not available in most parts of the country.
- Most doctors remain poorly educated around nutrition and FIM.
- Most Americans are unaware of these FIM treatment options, and when told about FIM, most Americans would like to try it.

²⁸ Perez LM, Fang H-Y, Ashrafi S-A, et al. Pilot study to reduce interdialytic weight gain through low-sodium home-delivered meals in hemodialysis patients. *Hemodialysis International*. 2020.

²⁹ Tapper E, Baki J, Nikirk S, Hummel S, Asrani SK, Lok A. Medically tailored meals for the management of symptomatic ascites: the SALTFOOD pilot randomized clinical trial. *Gastroenterology Report*. 2020; 8(6):453-456.

³⁰ Nguyen HQ, Duan L, Lee JS, Winn TG, Arakelian A, et al. Association of a Medicare Advantage Posthospitalization Home Meal Delivery Benefit With Rehospitalization and Death. *JAMA Health Forum*. 2023;4(6):e231678.

³¹ Hummel S, Karmally W, Gillespie BW, Helmke S, Teruya S, et al. Home-Delivered Meals Post-discharge From Heart Failure Hospitalization. *Circulation: Heart Failure*. 2018; 11:1-10.

To scale access, we should look to expand reimbursement for medically tailored meals and groceries, and other proven interventions. And we should collect more comprehensive data on food is medicine interventions to further substantiate its effectiveness. This includes data that can help us answer key research questions that relate to:

- The most important eligible disease conditions and social needs criteria.
- The optimal dose (\$/month) and program duration for different patients.
- The best balance of meals vs. groceries vs. produce; and the ideal route of delivery such as clinic pick-up vs. supermarket shopping vs. online ordering and home delivery.
- The types, frequency, and delivery mode of nutrition coaching and culinary education.

POLICY IMPLICATIONS AND SOLUTIONS

Thanks to Congress, innovators in healthcare and industry, and philanthropic and academic organizations, FIM is shifting from theory to reality. But more needs to be done.

To manage diet-related diseases, we must directly address the American nutrition crisis. This can be greatly accelerated by the adoption of smart, comprehensive policies that address current hurdles such as provider education in nutrition and food affordability and accessibility. With the evidence and progress to date, the nation is at a tipping point to accelerate FIM.

The Ways and Means Committee is well-suited for making a difference in the lives of millions of Americans through sensible FIM policy. This includes:

- Authorizing pilot programs to treat qualified individuals with medically tailored meals (MTMs) and produce prescriptions through Medicare. At the end of June this committee advanced [H.R. 8816](#), the *American Medical Innovation and Investment Act*, which contains an updated version of H.R. 6780, the Medically Tailored Home-Delivered Meals Demonstration Pilot Act. This would pilot MTMs in 40 hospitals and be funded through the Medicare Trust Fund. *I urge the full House to pass H.R. 8816 during this Congress.*
- Encouraging CMMI to continue to build on FIM work by incorporating and testing FIM approaches in their existing and/or new demonstration pilots. Incorporating report language to encourage CMS to build on existing efforts that have accelerated food and nutrition security screening and clinical care and referral pathways in the EMR.
- Incorporating report language to make it clear that Health Savings Accounts can be used for accepted, structured, evidence-based FIM therapies, with clear language on what qualifies.
- Expanding nutrition counseling in healthcare. This should include passing [H.R. 6407](#), the Medical Nutrition Therapy Act of 2023. This bill would expand Medicare Part B coverage of medical nutrition therapy (MNT) services for a variety of chronic conditions. Medical nutrition therapy includes nutritional diagnostic, therapy, and counseling services furnished by a registered dietitian for the purpose of disease prevention, management, or treatment. Currently, MNT is covered for only diabetes and kidney disease, but a much longer list of conditions (such as prediabetes, obesity, cancer, and high blood pressure) would benefit from MNT, which is evidence-based and cost-effective.

Beyond the jurisdiction of this Committee, Congress should:

- Continue to grow pilots and plan to scale FIM at the Department of Veterans Affairs and Indian Health Service.
- Authorize pilot programs in the Department of Defense to provide eligible active-duty personnel and

- their families with FIM therapies.
- Include support for FIM programs at Community Health Centers that serve the most vulnerable Americans and are most likely to benefit from collaborations and support in this space.
 - Encourage CMS to require all Medicaid Home and Community-Based Services (HCBS) waivers to include Food is Medicine programs with nutritious medically tailored home-delivered meal benefits to: (1) help older and disabled individuals remain in the community for longer periods of time, and (2) reduce burden on the strained HCBS workforce.
 - Enact the nutrition-related provisions in the “Bipartisan Primary Care and Health Workforce Act” (S. 2840) to expand access to healthy food to low-income and uninsured patients with chronic disease.
 - Encourage CMS to continue to release guidance and toolkits to make it easier for states to apply for Medicaid 1115 waivers that include FIM and implement FIM through CHIP Health Service Initiatives.³²
 - Appropriate meaningful funding for the NIH Office of the Director for the specific purpose of launching the FIM Networks or Centers of Excellence, a concept which has already received clearance at NIH. This initiative will combine cutting-edge research with patient care, advancing FIM just as the NIH Cancer Centers of Excellence have advanced cancer treatment and control.
 - Provide a meaningful increase in support for the NIH Office of Nutrition Research, which is today woefully underfunded compared to other NIH Office of the Director offices (see Table 1 on following pages) despite the pressing importance of its research mission for the American people.
 - Incorporate report language to encourage NIH to implement FIM research across its institutes and centers, coordinated by the Office of Nutrition Research.
 - Expand support for produce prescriptions within the USDA Gus Schumacher Nutrition Incentive Program (GusNIP).
 - Make diet quality a core SNAP objective, eliminate or create disincentives for the purchase of sugar-sweetened beverages with SNAP benefits, and support healthy purchases by continuing and strengthening incentives for purchasing fruits and vegetables in SNAP.³³ Policymakers could also consider modeling SNAP on WIC’s approach, limiting purchases to nutritionally sound food. In 2024, USDA finalized changes to the WIC food packages, aligning them with current nutrition science.
 - Increase the sustainable supply of nutrient-rich foods as part of efforts to shift our nation’s reliance on ultra-processed foods which have been linked to numerous chronic conditions. Vegetable nutrients in the US, for example, have declined between 5 and 40% since the mid-1950s, largely due to changes in varieties that favor yield over quality.³⁴ Looking forward, expected changes in atmospheric CO₂ are anticipated to reduce protein, iron and zinc concentrations in food crops by 3-17%, which could cause up to 175 million people to become nutrient deficient.³⁵ Land-based solutions – such as regenerative agriculture and agroforestry – can be critical to addressing nutrient density and produce quality. Nature-friendly farming systems can also lower the risk of food contamination. Many of the practices promoted through Farm Bill funding (like no till, and cover crops) have the potential to build soil organic matter. This could lead to beneficial impacts on crop nutrient density, though this has not been widely studied in the US (and should be further studied).

³² Daniel Tsai, “Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children’s Health Insurance Program,” CMCS Informational Bulletin, Nov. 16, 2023, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib11162023.pdf>

³³ “Leading with Nutrition: Leveraging Federal Programs for Better Health,” Report, Bipartisan Policy Center, March 2018. <https://bipartisanpolicy.org/report/leading-with-nutrition-leveraging-federal-programs-for-better-health/>

³⁴ Davis D, Epp M, Riordan H, “Changes in USDA food composition data for 43 garden crops, 1950 to 1999,” Journal of the American College of Nutrition, 2004 Dec;23(6):669-82. <https://pubmed.ncbi.nlm.nih.gov/15637215/>

³⁵ Smith R., Myers S., “Impact of anthropogenic CO₂ emissions on global human nutrition,” Nature Climate Change, 834–839 (2018). <https://www.nature.com/articles/s41558-018-0253-3>

Recommendations specific to medical provider education:

Part of effectively ensuring nutrition is more effectively integrated into preventive healthcare, is educating our healthcare workforce on its benefits and appropriate application. In my years of medical education, I received little to no nutrition education, despite the clear link between a healthy diet and improved health outcomes. As a co-chair of the Bipartisan Policy Center's Food is Medicine Work Group, we crafted a series of recommendations that we released last November³⁶ to address this issue.

These recommendations focused on (1) training health care professionals and educating patients and the public about nutrition; and (2) engaging healthcare professionals in the delivery of interventions to spur the consumption of healthy food. Some of the specific recommendations include:

- A) Direct the Health Resources & Services Administration (HRSA) to review its workforce programs to incorporate nutrition education as a grantee requirement;
- B) Issue an executive order directing relevant federal agencies to educate their healthcare provider workforce on nutrition science, assess diet quality, and refer patients to nutrition services and FIM interventions;
- C) Undergraduate and graduate medical accreditation bodies should establish nutrition-specific competencies and report compliance, while Congress should encourage these efforts by letting accreditation and licensing bodies³⁷ know that it's time to act (I commend Chairman Buchanan, Rep. McGovern, and other Members for writing to the ACGME in support of increasing nutrition education in all phases of medical education³⁸);
- D) Convene stakeholders via an independent organization to set baseline nutrition education standards for various healthcare providers; and
- E) Fund efforts by the HHS and USDA to better disseminate the Dietary Guidelines for Americans through partnerships with healthcare professionals and other stakeholders.

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Today, less than 3% of U.S. health spend goes to public health, less than 5% to clinical preventive services, and less than 6-7% to primary care, and these three categories are not mutually exclusive. How we spend our resources defines our priorities, and our priorities define our values – the question for all of us is how healthy of a nation do we want to be?

The food we eat directly and powerfully impacts our health and wellness. By addressing nutritional needs for patients with specific diet-sensitive conditions within the context of healthcare, Food is Medicine interventions like medically tailored meals, medically tailored groceries, and produce prescriptions play an important role in preventing and/or managing many of the chronic conditions that drive health outcomes and drive health care costs in the United States, including obesity, diabetes, cardiovascular disease, and several cancers. Implemented at scale, these interventions can provide a powerful tool to tackle our leading health challenges and the unprecedented healthcare spending they command. **It's time for Congressional action to bring FIM to the American people.** Thank you for the opportunity to testify today.

³⁶ Healthy Eating Rx: Improving Nutrition Through Health Care, Report, Bipartisan Policy Center, November 2023,

https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2023/11/BPC_Food-is-Medicine_R06.pdf

³⁷ Licensing and accrediting bodies include the American Association of Medical Colleges (AAMC), Accreditation Council for Graduate Medical Education (ACGME), Accreditation Council for Continuing Medical Education (ACCME), and American Board of Internal Medicine (ABIM).

³⁸ Buchanan V., McGovern J., et al., Letter to Dr. Thomas Nasca, ACGME CEO, re: Nutrition Education in Medical Training, 4/25/24

Figure 1. Modifiable causes of death in the United States. Source: JAMA. 2018;319(14):1444-1472. doi:10.1001/jama.2018.0158/

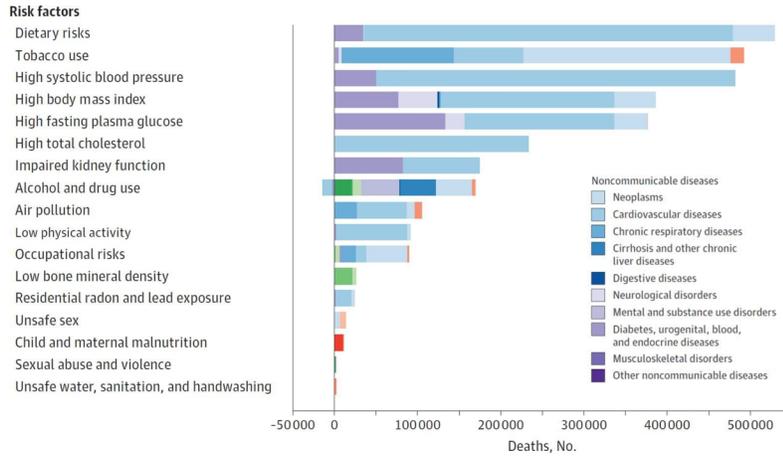


Figure 2. Dietary intakes of Americans compared to goals (Dietary Guidelines for Americans). Source: https://www.dietaryguidelines.gov/sites/default/files/2021-11/DGA_2020-2025_CurrentIntakesSnapshot.pdf

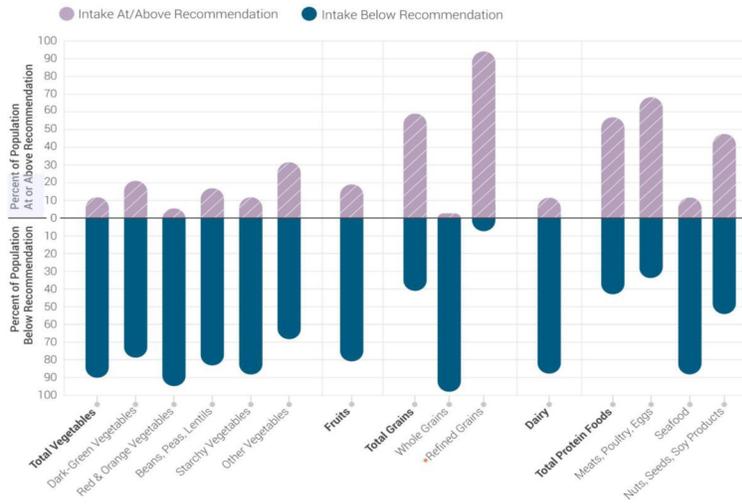


Figure 3. Estimated health effects, costs, and net savings of providing medically tailored meals to the approximately 6.3 million eligible Americans with high-risk, complex medical conditions and limited activities of daily living. Source: <https://tuftsfoodmedicine.org/true-cost-fim-case-study-report/>

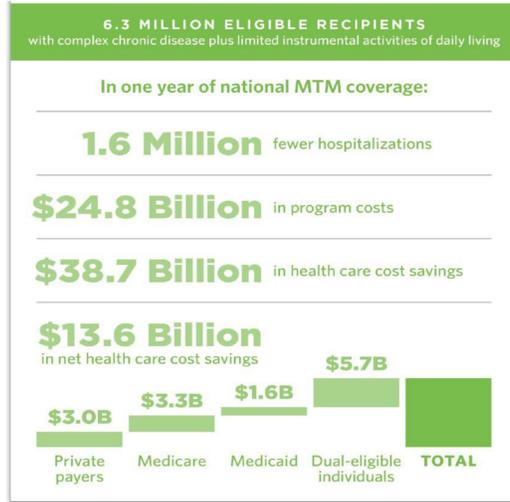


Table 1. FY 2023 and FY 2024 Funding for Offices within the NIH Office of the Director. Source: Division of Program Coordination, Planning, and Strategic Initiatives (DPCPSI) Budget Summary (Dollars in Thousands)

	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Office of the DPCPSI Director	28,426	28,426	41,026	12,600
Office of Behavioral & Social Sciences Research	40,845	40,845	40,845	0
Office of AIDS Research	67,589	67,589	67,806	217
Office of Research on Women's Health	77,557	77,557	153,909	76,352
Office of Disease Prevention	17,873	17,873	17,873	0
Office of Dietary Supplements	28,500	28,500	28,500	0
Office of Data Science Strategy	85,000	85,000	85,000	0
Office of Research Infrastructure Programs	309,393	309,393	259,393	-50,000
Office of Nutrition Research	1,313	1,313	1,313	0
Common Fund	735,001	735,001	722,401	-12,600
Total	\$1,391,497	\$1,391,497	\$1,418,066	\$26,569

https://officeofbudget.od.nih.gov/pdfs/FY25/insti_center_subs/27-OD_FY25_CJ_Chapter.pdf

Mr. BUCHANAN. Thank you.
Dr. Hyman, you are now recognized.

**STATEMENT OF MARK HYMAN, M.D., FOUNDER, INSTITUTE
FOR FUNCTIONAL HEALTH**

Dr. HYMAN. Thank you, Mr. Chairman, and members of the committee for the opportunity to testify before you today. My name is Dr. Mark Hyman. I am the chairman of the food fix campaign. I am the co-founder and chief medical officer of Function Health, the fastest growing consumer health platform in America empowering people to live 100 healthy years through data driven healthcare.

As both a doctor and a concerned citizen, I am very grateful for your focus on food and the chronic disease epidemic facing our nation. I especially wish to thank you, Vice Chair Buchanan, for your leadership in establishing the bipartisan preventative health and wellness caucus with Congresswoman Moore. It is a critical step in addressing the human and economic burden of chronic disease.

And like you, I am deeply committed to reversing America's chronic disease epidemic by addressing its root cause: Our modern ultraprocessed diet. Unlike healthy foods, ultraprocessed foods are high in sugar, starch, refined oils. They often contain industrial ingredients, such as preservatives, emulsifiers, artificial flavors, colors, and sweeteners. Also, they have a long shelf life and are fast to prepare and eat but with devastating consequences.

Nutritious food has the power to make us healthier, but processed food drive the chronic diseases that are the leading cause of death and disability in the U.S. today. 60 percent of Americans have at least one chronic disease. 40 percent have two or more.

93.2 percent of Americans are metabolically unhealthy? What does that mean? It means they have high blood pressure, high blood sugar, abnormal cholesterol, are overweight, or have had a heart attack or stroke. That means 6.8 percent of Americans are not metabolically unhealthy. And one in ten Americans has prediabetes or type two diabetes, including one in four teenagers.

The culprit is what we consume. About 60 percent of our diet is ultraprocessed foods, which are new to nature foods. They are not really food by the definition of food. And among children, the share of their diet, this ultraprocessed food, is 67 percent. For every 10 percent of your diet that is ultraprocessed food, your risk of death goes up by 14 percent. It is the number one killer globally.

Ultraprocessed foods also impose a huge burden on our healthcare system. Since 2000, national healthcare spending has ballooned from \$1.3 trillion to \$4.9 trillion, but although we are spending more and more, we are getting sicker and sicker. We rank 30th in the world in key healthcare metrics, like infant mortality, and last among developed nations.

We are 48 in life expectancy. I think Cuba is higher than us. We account for 16 percent of the global cases of COVID deaths, even though we are only 4 percent of the world's population. Why? Because COVID kills the chronically ill and obese.

Fortunately, there is a solution. It is harnessing the power of eating more nutritious foods. The fact is that most diabetic chronic diseases are preventable, and as Senator Frist said, even reversible

if we change our diet. And that is the food fix campaign's singular goal.

Now, fortunately, there is mounting research that proves that food is both the cause and the cure for most of our chronic disease epidemic, yet doctors do not learn about nutrition nor is their healthcare system reimbursed for treating patients with the most scientifically effective tool to reverse chronic disease.

Food. Take Janet, if we can show her picture here. This is Janet, who was a minister from Ohio, came to our center at the Cleveland Clinic. She had obviously severe obesity, type two diabetes, on insulin, heart failure, hypertension, fatty liver, failing kidneys, on her way to a heart and liver transplant. Her annual co-pay for medication was \$20,000. After three months, she reversed all of her diseases and was off insulin and all her medications. This is something we learn is not possible in medical school, because we don't learn about how to use food as medicine. And this is Janet a year later. She lost 116 pounds and got her life back.

The data clearly demonstrate that we cannot only prevent type two diabetes, but we can reverse it. Data show with a ketogenic diet that 60 percent of people can have their diabetes completely reversed, 100 percent reduced or eliminate their medication at a savings of \$6,000 per patient after the cost of the program. If scaled across Medicare, this would save over \$90 billion a year.

Now, here are ways you can address the problem. First, I want to applaud Chairman Buchanan of the committee for including in the American Medical Innovation Investment Act a medically tailored meals demonstration in Medicare. Now, under this incredible demonstration program, qualified beneficiaries would receive medically tailored, home delivered meals and medical nutrition therapy.

In the future, the standard of care can be further incentivized with a Medicare add-on payment for nutrition focused treatment.

Second, we must train tomorrow's clinicians in the science and nutrition and its roll in causing and curing chronic disease. In medical school I learned nothing about nutrition.

40 years later, my daughter, a fourth-year medical student, also received zero nutrition education. We can change that by setting minimal competency requirements in nutrition in all federally funded medical schools and graduate medical education.

And finally, I encourage the committee to consider a novel but proven direction, and I believe this could change so much about what is wrong with our country. We all know that change in diet and physical activity can reduce the risk of developing type two diabetes by 58 percent.

New research clearly demonstrates that type two diabetes is not only preventable but reversible, and that is why I encourage you to establish a national diabetes reversal program to address the single biggest driver of disease and cost in our healthcare system.

In closing, I want to thank you all for all you are doing to solve America's chronic disease epidemic. This is a national emergency and it demands a national bold response. We know that food is medicine, and together we can build a healthier and more productive and safer future.

Thank you.

[The statement of Dr. Hyman follows:]



House Ways and Means Health Subcommittee

Written Statement of Mark Hyman, M.D.

September 18, 2024

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify before you today. My name is Dr. Mark Hyman, Founder and Senior Advisor to the Cleveland Clinic Center for Functional Medicine and Chairman of the Food Fix Campaign.

As both a medical professional and concerned citizen, I am truly grateful for your focus on the food crisis facing our nation. I have had the opportunity to speak with many of you about this critical issue, and I am so impressed by the depth of your knowledge and your determination to fix our broken food system. I especially wish to thank you, Vice Chair Buchanan, for your impressive leadership. Your work to expand nutrition education in America's medical schools is vital to a healthier future, and your establishment with Congresswoman Moore of the bipartisan Congressional Preventive Health and Wellness Caucus has generated tremendous excitement in our community and across the country.

Like you, I am deeply committed to reversing America's chronic disease epidemic. How? By addressing its root cause: our ultra-processed diet, which is high in sugar and starch. I am doing this through my work at the Cleveland Clinic, *The Doctor's Farmacy* (a podcast with over 300 million downloads), my fifteen *New York Times* best-selling books on health and nutrition, and the Food Fix Campaign, an education and advocacy initiative dedicated to strengthening America's health, economy, and security by fixing our food system from field to fork.

Today, our modern ultra-processed, refined sugar and starch diet comprises 60% of our calories.¹ Unlike healthy foods, ultra-processed foods are high in sugar and starch, refined oils, and contain industrial ingredients – what I call “Frankenfoods” – such as preservatives, emulsifiers, and

artificial flavors, colors, and sweeteners.² It's important to note that many of the industrial ingredients that are added to processed foods are untested for safety at all and prohibited in other countries due to their documented harm to human health.³ In fact, countries like Singapore consider the use of harmful chemicals in food products to be a crime punishable by hefty fines and even prison sentences.⁴

Ultra-processed foods are so prevalent today they account for about 80% of all the food products sold in grocery stores,⁵ and 73% of our total food supply.⁶ Nutritious food has the power to make us healthier, but ultra-processed foods are the number *one* cause of the chronic diseases that are the leading cause of death and disability in the U.S., including cancer, heart disease, type 2 diabetes, dementia, mental illness, autoimmune disease and more.⁷

The food industry will argue that ultra-processing gives their food products a longer shelf life and makes them more convenient to serve. But is shelf life and ready-to-eat use worth putting human health and our economy in peril? The reality is any "convenience" we may experience now is overshadowed by the enormous cost our people and nation suffer for years to come.

The statistics are chilling. Today, 60% of American adults have at least one chronic disease, and 40% have two or more.⁸ Nearly 75% of American adults are overweight, and 42% are obese.⁹ Even our children are suffering, with more than 40% of them overweight and more than 20% obese.¹⁰ These conditions were practically unheard of in children in my generation and prior, and they reduce our children's life expectancy by up to 14 years.¹¹ They also impact our economic future, as they make people become lifetime patients of the medical system and reduce our global competitiveness. Obesity also threatens our national security because most young Americans are unfit to serve in our due to conditions including overweight and obesity.¹²

Even worse, 93.2% of Americans are metabolically unhealthy and suffer from high blood pressure, high blood sugar, abnormal cholesterol, are overweight, or have suffered a heart attack or stroke.¹³ In addition, more than half of our population has pre-diabetes or diabetes, and 26.4% of Medicare fee-for-service (FFS) enrollees had a diabetes diagnosis in 2022.¹⁴ Seven times more Americans have type 2 diabetes than in 1980¹⁵, and more than half of all Americans are at

increased risk of heart attacks, strokes, dementia, kidney failure, liver failure, limb amputations, and death.¹⁶

Some may attribute these conditions to genetics, but the data say otherwise. Obesity, for example, has increased more than 300% over the past six decades – from 13% to 43%.¹⁷ Did our genetics change in that time? No – our diet and lifestyle did.

This is a national emergency. The government needs to mobilize science, health care, and policy to address the catastrophic health of our citizens and its social and economic impact on the United States.

Fortunately, we know what to target: the culprit is what we consume. About 60% of our diet is ultra-processed food – among children, the share is 67%.¹⁸ To put this in perspective, for every 10% of our diet that is ultra-processed food, the risk of death increases 14%.¹⁹ In fact, diet now exceeds smoking as the number one cause of disease and death, globally accounting for 11 million deaths a year.²⁰

The direct cost of healthcare for diet-related chronic disease is staggering. According to CMS, our nation's 2023 health care bill was \$4.8 trillion or one in five dollars of our GDP, more than twice per capita than any other nation.²¹ More than 75% of Medicare funds is spent on the 40% of beneficiaries who have been diagnosed with four or more chronic conditions, which are either caused or exacerbated by the modern American diet and lifestyle. In 2018 alone, Medicare spent \$800 billion of its \$1.1 trillion expenditures for chronic conditions that are primarily caused by diet and lifestyle.²²

Simply put, this financial burden is simply unsustainable. And though we spend far more on healthcare than other nations, we are seeing increasingly worse health outcomes. We rank 30th in the world and *last* among developed countries in objective health care metrics including infant mortality.²³ We are 48th in life expectancy²⁴, and for the first time in history, our life expectancy is declining year over year. The US comprises about 4% of the world population but accounted for 16% of the cases and deaths from COVID-19.²⁵ Why? Our nation is severely metabolically

unhealthy and burdened with chronic disease which drove our hospitalizations and deaths. The data show that 63% of all hospitalizations and deaths from COVID-19 could have been prevented by a healthy diet and appropriate nutritional support (something as accessible as vitamin D), meaning that as a nation, we may have been able to save trillions of dollars.

As harrowing as these facts are, most diet-related chronic diseases are preventable, and in many cases, even reversible. But, realizing this potential means changing how we approach food and medicine. Today, *we do not practice evidence-based medicine in America. Instead, we practice reimbursement-based medicine.* To translate, practitioners aren't incentivized to treat based on what science proves to be successful, but rather what has been approved for reimbursement – a model which leaves the medical establishment decades behind the latest scientific consensus. I cannot underscore the importance of this more strongly: we compensate our medical providers according to predefined billing and diagnostic codes, rather than objective health metrics that demonstrate progress and recovery. The perverse incentives in health care reimbursement drive more, not better care. Doctors and hospitals are paid for providing more services, more medication, more surgery, not better health care outcomes or lower healthcare costs.

The data are clear: food – not medication – can reverse type 2 diabetes. Eating whole real food is not simply helpful in **preventing** disease, it is the most effective **treatment**, for the most costly and debilitating diseases facing Americans. And yet, our funding reveals an obvious priority asymmetry: we pay around \$1 billion for nutrition services a year for type 2 diabetes and an extra \$85 billion in additional medications for patients with diabetes ... an 85-fold difference that represents a lost opportunity to invest in reversing a curable disease that costs America \$412 billion a year.²⁶

In sum, the loss of human, social and economic capital as a result of today's diet and medical model is staggering.

Fortunately, there is a solution: harnessing the power of eating more nutritious foods. The Food Fix Campaign is focused on addressing the systemic challenges in the food system – with one of

the clearest being the fact that nutrition education or services are not integrated into the U.S. healthcare system.

Our current medication-centered approach to chronic disease is like mopping up the floor while the sink overflows. *We are spending time and treasure on the consequences of our health crisis without addressing its root cause.* The solution is not more access to health care, better disease management, or lower drug prices, all necessary but not sufficient. The solution is addressing the root cause. Scientists are now calling upon governments to address what they call the “commercial determinants of health” – the role that multinational corporations have in driving our chronic disease epidemic, including the production, price-setting, and targeted marketing of ultra-processed foods, sugary drinks, and the medication those foods make necessary.

In other words, it’s time that we turn off the sink. Utilizing the science of lifestyle and functional medicine, we can address the root causes of illness. That is because lifestyle and functional medicine uses *food as medicine* to prevent, treat, and even cure chronic disease. In other words, food need not only be the cause of what ails America – it can be the cure, too.

This isn’t theory – it’s fully documented science.

As just one of many examples, a healthcare platform is using nutrition therapy with a ketogenic, very low carbohydrate diet for patients with type 2 diabetes. In a clinical trial, 60% of participants achieved diabetes reversal after one year of following their nutritional ketosis protocol. At the one-year mark, 94% of participants who were using insulin at the start of the trial were able to reduce or completely eliminate insulin use. Additionally, 67% of all diabetes-specific medications were either reduced or discontinued. Specifically, 100% of insulin users were able to reduce their insulin dosage by more than 50%, and a large percentage completely eliminated the need for insulin.²⁷ To be clear there is no medication or combination of medications that can achieve these results. Rather than focusing on chronic disease “management” (a euphemism for medication) as a way to reduce health care costs, but wouldn’t it be better to focus on reversing those diseases altogether?

This health program has demonstrated significant cost savings for patients and the healthcare system. One study indicated an annual healthcare cost reduction of approximately \$5,000 per patient due to reduced medication needs and fewer diabetes-related complications. Extrapolated to the 28% or 18.2 million Medicare beneficiaries with type 2 diabetes, this scalable solution would save \$91 billion a year.

Not only are these extraordinary outcomes, but they were also accompanied by declines in depression, pain, inflammation, and healthcare costs commonly associated with obesity, diabetes, and other diet-related chronic conditions.

Here's the key: the same outcomes documented by such nutrition-focused models can be achieved across our nation – *if Congress takes action to implement nutrition training, pilots, and reimbursement within our health programs*. Doing so would generate profound results for America's clinical and economic health. And the men, women, and children you represent will be the direct beneficiaries.

I know because my patients are living proof that better health and lower costs are possible through nutrition. Take my patient, Janet, for example. When Janet came to me, she was a 66-year-old severely obese woman who ate ultra-processed food her whole life. She had type 2 diabetes, was on insulin, had multiple stents, heart failure, and a failing liver and kidneys. She was on her way to a kidney and heart transplant. And her co-pay for medications alone was \$20,000 a year.

Within a very short time of starting on an unprocessed, anti-inflammatory whole food diet with low starch and sugar and higher fat, Janet was off her insulin. In just three months, she had reversed her diabetes, heart failure, and high blood pressure, and her kidney and liver function returned to normal. She lost 43 pounds and got off all her medication. In a year she lost 116 pounds and got her life back, enabling her to continue her work as a minister.

Dr. Drema Hill from Greenbrier County, West Virginia, is another example of the power of Food as Medicine. Dr. Hill serves as a vice president in the School of Osteopathic Medicine, West Virginia's largest medical school. Under my program, Drema was able to change her diet, lose

nearly 150 pounds, get off more than a dozen medications, and experience vastly improved health. She is now helping others at the community level and is ensuring medical students are educated about nutrition in order to make them better physicians!

These are not miracles. Instead, they're made possible by applying the latest science of food as medicine. There is no drug that can accomplish these results. Only healthful food can. We know how to prevent chronic illness by focusing on its root cause – food.

One of the clearest ways to make progress is by addressing the silos dividing medical care and nutrition that is failing Americans with chronic diseases. Towards that end, I would like to offer the following proposals for your consideration:

First, we need to increase federal investment in proven strategies that prevent and treat chronic disease. Today, physicians have few if any incentives to incorporate nutrition into their medical practice, despite the central role that nutrition and diet play in the cause and cure of our epidemic of chronic disease. In Medicare, for example, the small number of programs addressing nutrition are extremely limited in scope and under-utilized. In addition, physicians and health care systems are generally being paid for performing more procedures, not for delivering greater value by achieving better health outcomes and reducing health care costs. This imbalanced approach leads to more pain, suffering, early mortality, and higher costs for everyone.

As a result, I want to applaud Chairman Buchanan and the Committee for including in the *American Medical Innovation and Investment Act* a Medically Tailored Meals Demonstration in Medicare. The demonstration would “test a payment and service delivery model under which selected hospitals provide medically tailored home-delivered meals” to qualified individuals “to improve clinical health outcomes and reduce the rate of readmissions.”

Under this exciting demonstration program, qualified beneficiaries would receive medically tailored home-delivered meals that meet most of their daily nutritional needs. They would also receive medical nutrition therapy from skilled clinicians including physicians, registered

dietitians or other nutrition professionals, or clinical social workers. Best of all, beneficiaries would not pay cost-sharing for the services.

Over time, I encourage the Committee to explore adding other innovations to integrate nutrition into health care through innovations, such as patient assessment, produce prescriptions, and medically tailored meals as well as proven group shared medical lifestyle change programs such as Functioning for Life developed at the Cleveland Clinic Center for Functional Medicine. After all, approximately 240,000 seniors see a physician or nurse every weekday – and the vast majority of them will leave *without* a prescription for the healthy food they need to heal and thrive. This Committee can change that by prioritizing nutrition in the treatment of chronically ill Medicare beneficiaries.

Additionally, it is vital to incentivize nutrition-focused clinical care for patients with chronic diseases via such means as a Medicare nutrition add-on payment for participating physicians and hospitals. In this manner, more clinicians will assess patients' suitability for using food as medicine, offering patients the option to take control of their own health rather than automatically defaulting to conventional and costly medication and institutionalization.

Second, we must fully train tomorrow's clinicians about the power of nutrition and ensure they are reimbursed for its use. Patients respond very well to nutrition-centered care, but too few providers know how to deliver it. When I went to medical school, there was no focus on the impact of food on our health. Forty years later, my daughter, a 4th year medical student, has received no nutrition education, either. Although there is clinical consensus that 7 of the 10 leading killers are preventable, diet-driven chronic diseases, most medical schools don't require a single course in nutrition.

We can fix this problem by setting minimal competency requirements in nutrition as part of the federal government's \$17 billion funding of graduate medical education and require nutrition classes and functional medicine in federally funded medical schools.

Finally, I would like to encourage the Committee to consider additional models that are already delivering much-needed progress. For example, the National Diabetes Prevention Program (DPP) has been a valuable tool in reducing the risk of type 2 diabetes, particularly among high-risk populations. The program, which focuses on lifestyle interventions like diet and physical activity, has been shown to reduce the risk of developing diabetes by 58%. As a result, I propose a National Diabetes *Reversal* Program be explored in which diet and lifestyle interventions are used to bend the curve of this dreaded chronic condition.

In closing, I would like to applaud you for all you are doing to solve America's chronic disease crisis. Chairman Buchanan and Committee Members, our chronic disease epidemic is a severely neglected national emergency that is almost entirely preventable and curable. It demands vigorous and urgent action.

We know that Food IS Medicine. Thanks to your vision and efforts, we can build a future in which it is used as exactly that. Thank you.

- 1 <https://bmjopen.bmj.com/content/6/3/e009892>
- 2 <https://www.health.harvard.edu/blog/what-are-ultra-processed-foods-and-are-they-bad-for-our-health-2020/09/18/605>
- 3 <https://harvardpublichealth.org/policy-practice/processed-foods-make-us-sick-its-time-for-government-action/>
- 4 https://www.sfa.gov.sg/docs/default-source/legislation/sale-of-food-act/51web_saleoffoodact1.pdf
- 5 <https://ballardbrief.byu.edu/issue-briefs/the-overconsumption-of-ultra-processed-foods-in-the-united-states>
- 6 <https://www.medrxiv.org/content/10.1101/2022.04.23.22274217v2.full.pdf>
- 7 <https://www.bmj.com/content/384/bmj-2023-077310>
- 8 https://chronicdisease.org/wp-content/uploads/2022/04/FS_ChronicDiseaseCommentary2022FINAL.pdf
- 9 <https://www.cdc.gov/nchs/fastats/obesity-overweight.htm>
- 10 <https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity>
- 11 <https://www.nih.gov/news-events/news-releases/nih-study-finds-extreme-obesity-may-shorten-life-expectancy-14-years>
- 12 <https://www.military.com/daily-news/2022/09/28/new-pentagon-study-shows-77-of-young-americans-are-ineligible-military-service.html>
- 13 <https://now.tufts.edu/2022/07/05/only-7-american-adults-have-good-cardiometabolic-health>
- 14 <https://www2.ecwdata.org/documents/10280/19099065/medicare-charts-chronic-conditions.pdf>
- 15 <https://www.cdc.gov/diabetes/data/statistics-report/index.html>
- 16 <https://www.cdc.gov/chronic-disease/about/>
- 17 <https://usafacts.org/articles/obesity-rate-nearly-triples-united-states-over-last-50-years/>
- 18 <https://jamanetwork.com/journals/jama/fullarticle/2782866>
- 19 <https://dceg.cancer.gov/research/who-we-study/nih-aarp-diet-health-study#overview>
- 20 [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(19\)30041-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)30041-8/fulltext)
- 21 <https://www.reuters.com/business/healthcare-pharmaceuticals/us-healthcare-spending-rises-48-trillion-2023-outpacing-gdp-2024-06-12/>
- 22 <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet>
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- 25 <https://www.cnn.com/2020/06/30/health/us-coronavirus-toll-in-numbers-june-tmd/index.html>
- 26 <https://diabetes.org/newsroom/press-releases/new-american-diabetes-association-report-finds-annual-costs-diabetes-be>
- 27 <https://www.virtahealth.com/research>

Mr. BUCHANAN. Thank you.
Dr. Peters, you are now recognized.

**STATEMENT OF ANNE PETERS, M.D., SENIOR SCHOLAR USC
SCHAEFFER INSTITUTE**

Dr. PETERS. Thank you. Mr. Chairman, Mr. Vice Chairman, and honorable members of the subcommittee, thank you for the opportunity to testify about how we can create incentives to better prevent and treat chronic disease. I am Dr. Anne Peters, professor of medicine—clinical medicine at the University of Southern California and senior scholar at the USC Schaeffer Institute. The views I express are my own.

Chronic diseases are a growing health and economic burden. By 2030 cumulative chronic disease costs could reach \$42 trillion. The staggering figure underscores the urgent need for our shifts in our approach to healthcare. As a diabetes specialist, I have spent my life devoted to preventing disease and its complications. I have written papers, books, and guidelines to help others understand the need for preventative healthcare. Lifestyle modifications, newer medications, and wearable technologies can help reduce the risk for diabetes, but access is disparate and largely dependent on socioeconomic factors.

Most primary care providers don't have the time or tools to help people achieve sustained lifestyle change. Our healthcare system understandably pays surgeons a premium for performing heart surgery or removing a leg, but doctors like me don't get paid much for preventing cardiovascular disease or an amputation. The misalignment of priorities is at the core of our chronic disease crisis.

I have treated many thousands of patients, some in affluent Beverly Hills and some in underserved East Los Angeles. The disparity in outcomes is stark and heartbreaking. My Beverly Hills patients live to become really healthy 80 and 90-year-olds. I can't remember when my last patient from this community lost their vision, had an amputation, or started on dialysis. Almost none have heart attacks or strokes. But in east L.A. I see patients every week in their 20s and 30s who have developed life-altering preventable diabetes complications, blindness, kidney failure, the loss of a limb. These patients rarely live to grow old.

What is especially heartbreaking is that this is preventable. Our research has shown that if we provide these patients the resources they need, we can improve their outcomes. Everyone benefits from preventive health care. The data support that prevention is worth our investment. Schaeffer research predicts that the social return on investment from treating adults with moderate obesity is more than 15 percent per year. Recent scientific advances suggest it may be possible to slow the aging process and delay the onset of chronic diseases. This approach could extend healthy lifespans and compress illness into a shorter period at the end of life.

Interventions include new therapies for newer degenerative diseases and addiction, medications to reduce cardiovascular risk factors, integration of wearable technologies and blood-based cancer screening. Even moderate success in delaying aging could yield enormous benefits. One analysis found that by slowing aging by just 2.2 years could reduce the incidents of major diseases by 7 to

12 percent and save over \$7 trillion in healthcare costs over 50 years.

To realize these benefits, we need policy changes that incentivize prevention and health. Some of our recommendations include reimbursing physicians for patient outcomes, encouraging multi-year insurance contracts, ensuring innovators are paid a reasonable rate of return, and implementing value-based reimbursement models.

In conclusion, the challenges posed by chronic diseases are immense, but so is the opportunity before us. With strategic investments and policy changes, we can usher in a new era of health and longevity for all Americans. We need to remove existing barriers and change our priorities, but there is no one size fits all approach to achieving long-term sustained behavior change. Citizens need to be flexible and responsive to individual needs. My experience is that it can be done in nearly all clinical settings with the right resources, education, and dedication. Thank you for your attention to this critical issue.

[The statement of Dr. Peters follows:]



Testimony of Anne L. Peters, M.D.

Professor of Clinical Medicine
Keck School of Medicine of USC
Senior Scholar

Leonard D. Schaeffer Institute for Public Policy & Government Service
University of Southern California

Before the
U.S. House Committee on Ways and Means
Subcommittee on Health

Hearing on "Investing in a Healthier America: Chronic Disease Prevention and Treatment"

September 18, 2024

Key Points:

- **Chronic diseases are a growing health and economic burden:** Conditions like obesity, diabetes, heart disease, cancer, and Alzheimer's are becoming increasingly prevalent, driving up healthcare costs. By 2030, cumulative chronic disease costs could reach \$42 trillion.
- **Obesity is at the core of the chronic disease crisis:** New obesity treatments show promise, with potential for significant health improvements and cost savings. Medicare coverage of obesity treatments could generate \$4 trillion in social value to Americans over three decades.
- **Prevention and early intervention are critical:** Comprehensive treatment of chronic conditions like obesity and diabetes, especially when initiated at younger ages, can yield substantial long-term health and economic benefits. The social return on investment from treating adults with moderate obesity is estimated at more than 15% per year.
- **Delaying aging could have enormous benefits:** Scientific advances suggest it may be possible to slow the aging process and delay the onset of multiple age-related chronic diseases simultaneously. Even modest success in delaying aging could yield enormous health and economic benefits.
- **Policy changes are needed to incentivize prevention and health:** Recommendations include reimbursing physicians for patient outcomes, encouraging multi-year insurance contracts, ensuring innovators are paid socially desirable returns, creating regulatory and reimbursement incentives for preventive interventions, and implementing value-based reimbursement models.



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Chairman Buchanan, Ranking Member Doggett, and Honorable Members of the Subcommittee, thank you for the opportunity to testify today about how we can create incentives to better prevent and treat chronic disease. My name is Dr. Anne Peters, and I am a Professor of Clinical Medicine at the Keck School of Medicine of the University of Southern California (USC). I am also a Senior Scholar at the USC Leonard D. Schaeffer Institute for Public Policy & Government Service. The views I express today are my own and do not represent those of the University of Southern California or the USC Schaeffer Institute.

My colleagues at USC Schaeffer and I have conducted research on the value and economics of prevention for well over a decade. I also speak today as a recipient of the American Diabetes Association Outstanding Physician-Clinician Award and the Laureate Award for Public Service from the Endocrine Society, having helped pioneer efforts to diagnose, prevent and treat diabetes in a variety of socioeconomic settings.

Chronic Disease in America

For decades, our medical system has been set up to fight disease, and we've largely succeeded in developing effective treatments and cures.⁽¹⁾ Americans now enjoy both longer and healthier lives as result of both medical advances and public health measures. However, we now face a new challenge - the rising tide of chronic diseases threaten to overwhelm our health system and erode quality of life for millions of Americans. Conditions like obesity, diabetes, heart disease, cancer, and Alzheimer's disease are becoming increasingly prevalent as our population ages.⁽²⁾

Not only are the health consequence of chronic disease large; so are the costs of treating them. Chronic disease is the leading driver of the nation's \$4.5 trillion in annual health care costs.⁽³⁾ Without changes to our approach, these costs are projected to continue rising. One study estimated that by 2030, cumulative chronic disease costs could reach \$42 trillion.⁽⁴⁾

Treating the Obesity Epidemic

At the heart of this chronic disease crisis in the United States is the growing obesity epidemic. Obesity is associated with increased risk of more than 200 other diseases, including heart disease, diabetes, cancer and dementia.⁽⁵⁾ Tackling the high and rising rates of obesity is a pressing public health issue: According to modeling by the USC Schaeffer Center, the average American adult will soon have obesity, despite decades of public health efforts.⁽⁶⁾

Minority populations have been particularly hard hit. Black and Hispanic individuals experience higher rates of severe obesity compared to white individuals, translating into higher rates of chronic diseases among Black and Hispanic populations.

Fortunately, new obesity treatments are proving to be increasingly effective, which has substantial value for the individual patient and society.

Much of the debate has focused on the price of these medications. Less attention has been placed on the savings derived from improved health and reduced complications. My USC Schaeffer Center colleagues estimate that if Medicare covered obesity treatments, the program would see \$700 billion in offsetting medical savings over the following three decades.

And this calculation, while useful for budget scoring purposes, misses the key point. There would be enormous benefits in terms of population health. Valuing that health appropriately, they find that Medicare coverage of obesity treatment would generate \$4 trillion in social value to Americans.⁽⁶⁾ And, if private insurers followed Medicare's lead, the value would be even greater: \$1.5 trillion in Medicare cost offsets and \$6.7 trillion in cumulative social benefits.⁽⁶⁾

Treating the Diabetes Epidemic

Much of these savings come from preventing diabetes. Almost 15% of U.S. adults have diabetes, making it one of the most prevalent chronic conditions and inseparable from the obesity epidemic. Among Medicare beneficiaries, the rate increases to more than one-in-four.^(7,8)

As a diabetes specialist my life has been devoted to preventing disease and its complications. As a professor of medicine, I have given lectures around the world and written papers, books and guidelines to help others understand the need for preventive healthcare.

There are proven ways to prevent and substantially reduce the risk of diabetes: diet, exercise, stress and other lifestyle factors can be modified. New wearable technologies like continuous glucose monitors can provide physicians with substantial data. But access is disparate and dependent largely on socioeconomic factors.

But most primary care doctors don't have the time to speak with their patients about prevention or possess the tools to help people achieve sustained lifestyle change. Our healthcare system pays surgeons a premium for performing heart surgery or amputating a leg. But doctors like me get paid very little for preventing cardiovascular disease or the development of a foot ulcer.

I know from experience that spending time with patients works. I personally have treated thousands of patients, some in affluent Beverly Hills and some in underserved East Los Angeles. My Beverly Hills patients live to become healthy 80- and 90-year-olds. I can't remember when my last patient lost their vision, had an amputation or started dialysis, the most common complications of diabetes. Almost none have heart attacks or strokes.

But in East LA I see people every week in their 20's and 30's who have waited too long and have now developed life altering, preventable complications from their diabetes—blindness, kidney failure, the loss of a limb. These patients rarely live to grow old, and if they do they suffer many complications of their disease. What is especially heartbreaking is it is preventable. My research has shown that if we provide these patients the resources they need, teach them about nutrition and exercise, and provide appropriate technology we can improve their outcomes. Everyone benefits from preventive healthcare.

The data support the premise that prevention is worth our investment. Schaeffer researchers have also modeled the value of preventing diabetes, finding there is significant long-term health and economic benefits from comprehensive treatment of chronic conditions like obesity and diabetes, particularly when initiated at younger ages and for those with moderate forms of the disease. Schaeffer modeling predicts that the social return on investment from treating adults with moderate obesity is more than 15% per year.⁽⁹⁾ I am not an economist, but I am told that is more than double the real rate of return of the S&P 500 since 2000.⁽¹⁰⁾ And, just like the S&P is a good investment, so too is incentivizing early intervention and prevention strategies is critical.

Delaying Aging in Sickness

Investments in prevention go beyond metabolic health. Increasing rates of chronic disease, fueled by rising rates of obesity and gains in life expectancy, positions us to be an ever-sicker population. But age may be a modifiable risk factor. As such, rather than solely targeting specific diseases, an increased focus on understanding and modifying the underlying biology of aging itself is warranted.

Recent scientific advances suggest it may be possible to slow the aging process and delay the onset of multiple age-related chronic diseases simultaneously. This approach holds tremendous potential to extend healthy lifespans and compress illness and disability into a shorter period at the end of life.⁽¹¹⁾

Researchers have made significant progress in understanding the hallmarks of aging and identifying potential interventions to slow these processes. For example:

- Incretin therapies may directly help reduce rates of Parkinson's and Alzheimer's disease and potentially help with smoking cessation and alcohol abuse.⁽¹²⁾
- Use of current and developing medications to reduce lipids and other cardiovascular risk factors.⁽¹³⁾
- Integrating wearable technologies into systems of behavior modification and disease surveillance.⁽¹⁴⁾
- Use of blood-based cancer screening to change the paradigm for diagnosing and treating malignancy

Preliminary economic modeling indicates that even modest success in delaying aging could yield enormous health and economic benefits. One analysis found that slowing aging by just 2.2 years could reduce the incidence of major diseases by 7-12% and save over \$7 trillion in healthcare costs over 50 years.⁽¹⁵⁾

Policies That Incentivize Paying for Health and Prevention, Rather Than Sickness

As a physician treating diabetes patients in both affluent and underserved communities, I have seen firsthand how social and economic factors profoundly impact health outcomes. Fortunately, there are policy solutions that could bend the curve towards investing in health:

- **Physicians could be partially reimbursed for incremental outcome improvements:** Understanding the multi-faceted causes of sickness in a patient, including social, economic, mental and biological, takes time. Most physicians, and especially those treating patients with chronic conditions, do not have the time to invest in the patient fully. Furthermore, an increasingly large share of our time is spent updating EHRs, filling out prior authorization and denial paperwork from insurers and other administrative tasks that are not about patient health. Reimbursing physicians for the outcomes for the patients, while reducing the administrative burden of payment, should be a priority.
- **Multi-year contracts for insurers:** Incentivizing multi-year insurance contracts, especially at large employers who have a consistently long-tenured staff, would incentive their bottom line towards prevention and health, rather than paying for treating sickness.
- **Innovators must be paid socially desirable returns:** This is crucial to incentivize continued innovation in areas with high societal impact (16) Ensuring that innovators are paid socially desirable returns for their investments in biomedical research and development can help us find new solutions to promoting prevention.
- **The field is currently tilted against prevention and cures:** Lifestyle factors like physical activity have been shown to substantially reduce mortality risk, prevent multiple chronic conditions and improve health. (17) But innovation incentives are not currently set up to foster creative ways to get populations active.
- **Value-based reimbursement and flexible regulatory approaches would substantially help:** These arrangements must allow for the ability to change both price and labelling as long-term evidence emerges. For example, a three-part pricing strategy developed at the Schaeffer Center would allow for a low initial price as real-world evidence is collected. Once evidence emerges, the price could increase (or decrease) to correspond with the value of the new treatment. After a period of time, new entrants and generic competition would bring the price down. (18,19)

Conclusion: These changes are vital if we are going to tackle high prevalence diseases

Currently, our healthcare system is tilted towards treating diseases rather than preventing them or finding cures. This short-term focus can lead to higher overall costs and poorer health outcomes. By rebalancing our approach to favor prevention and cures, we can potentially reduce the long-term burden of chronic diseases on individuals and the healthcare system.(1)

The policy recommendations I've suggested are designed to create a more balanced and forward-thinking approach to healthcare and biomedical innovation. By ensuring that innovators are appropriately rewarded for their investments, we can encourage continued research and development in areas that have the potential for significant societal impact, such as treatments that delay aging or prevent chronic diseases.

The implementation of value-based reimbursement and flexible regulatory approaches is crucial for promoting innovation in areas where the full benefits of a treatment may not be immediately apparent. For instance, a drug that delays the onset of Alzheimer's disease might show modest short-term benefits but significant long-term value. By allowing for price and labeling adjustments as new evidence emerges, we can create a system that more accurately reflects the true value of these interventions over time.(18)

The challenges posed by chronic diseases are immense, but so is the opportunity before us. With strategic investments and policy changes, we can usher in a new era of health and longevity for all Americans. Thank you for your attention to this critical issue. I look forward to your questions.

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Mr. BUCHANAN. Thank you.
Dr. Rinaldo, you are now recognized.

**STATEMENT OF FRANCESCA RINALDO, M.D., CHIEF CLINICAL
INNOVATION OFFICER, SENIOR CARE ACTION NETWORK
(SCAN) HEALTH PLAN**

Dr. RINALDO. Chairman Buchanan, Ranking Member Doggett, and distinguished members of the subcommittee, thank you very much for the opportunity to testify today. My name is Dr. Francesca Rinaldo. I am a physician scientist with expertise in clinical research and healthcare delivery and I am the chief clinical innovation officer and corporate medical director of SCAN Health Plan. I focus every day on improving the quality of life for vulnerable older adults.

I began my career training in surgery at Stanford University. I observed that my older adult patients often experienced poor outcomes, not only because of the high burden of chronic disease and functional impairment, but also due to insufficient support in addressing social determinants of health.

Recognizing the need to address these critical factors to provide more comprehensive care for patients, I paused my surgical career. For two years, as a postdoctoral research fellow at the Stanford Clinical Excellence Research Center, I focused on innovative ways to improve care delivery and outcomes for older adults by addressing the intersection between chronic disease and social determinants of health.

I co-developed a high value care model for late life integrating the most effective solutions from both academia and industry. This model addresses factors such as social isolation, functional impairment, and loss of independence while aligning the patient's health goals and value to the care that is delivered.

After leading the clinical strategy for a national network of in-home caregivers, I took on my current role at SCAN where I use my background to keep our members healthy and independent. SCAN Health Plan, one of the nation's largest nonprofit Medicare advantage plans, serves nearly 280,000 older adults across five states.

Almost 50 years ago a group of older adult activists we affectionately call the 12 angry seniors were unable to access needed services. Frustrated, these seniors formed the mission driven organization that became SCAN. In its infancy, SCAN was a network of services and programs, such as meal delivery, home repair, medical centers, transportation, housing support, and more. To understand SCAN's origin is to understand our purpose today.

In an industry dominated by large for-profit health clients, we believe that Medicare beneficiaries and taxpayers benefit from a robust presence of nonprofit plans. Our financial incentives center entirely around the beneficiary. Payments made to SCAN are directed towards high value benefits and fair compensation to our providers. Nonprofit plans like SCAN are accountable to our communities resulting in a better understanding of member needs and tangible investment in these communities.

The results of this approach translate to high quality care. For 11 years in a row, SCAN has received a rating of four stars or

higher from CMS. Thanks to the flexibilities of Medicare advantage, SCAN is incentivized to provide preventative care which leads to fewer expensive and unnecessary acute care services like emergency department visits.

For example, we reduce or remove cost sharing on high value services like primary care and prescription drugs that keep chronic diseases in check. SCAN also stressed to design benefits that emphasize wellness. One such benefit is meals and nutrition. We recognize that access to nutritious culturally tailored meals along with targeted nutritional counseling is essential for managing chronic diseases.

In 2023 SCAN delivered 41,000 meals per month under several programs we offered. These include post-acute meals which provide delivered meals following a hospital stay, chronic condition meals, which are tailored both nutritionally and culturally to support chronic condition management, and long-term services and support meals for our dual members who are the most vulnerable in the communities we serve. Other examples of benefits to prevent disease are detailed in my written testimony.

Congress has recognized that beneficiaries with chronic diseases face nonhealthcare challenges by creating special supplemental benefits for the chronically ill. However, the chronically ill are not the only patients who face social risk factors. Low income beneficiaries face similar challenges. To meet their need as well, SCAN believes that Congress should expand SSBCI eligibility to include dual eligible beneficiaries, part D low income subsidy recipients, and other low income beneficiaries often referred to as the near poor who face many of the same barriers as those living below the poverty line.

Fortunately, legislation to make this change has been put forward. SCAN commends Representatives Blumenauer and Bilirakis for introducing the Addressing Whole Health in Medicare Advantage Act. Congress should pass this bipartisan legislation as soon as possible.

Thank you for examining this important topic today. SCAN's 12 angry seniors would be proud that the work they undertook five decades ago is being continued by this important committee. I look forward to taking your questions.

[The statement of Dr. Rinaldo follows:]

TESTIMONY OF FRANCESCA RINALDO, MD, PHD
Chief Clinical Innovation Officer and Corporate Medical Director
SCAN Health Plan

Before the
Health Subcommittee of the Ways and Means Committee
of the
U.S. House of Representatives

On

Investing in a Healthier America: Chronic Disease Prevention and Treatment

September 18, 2024

Introduction

Chairman Buchanan, Ranking Member Doggett, and distinguished members of the subcommittee, thank you for the opportunity to testify today.

My name is Dr. Francesca Rinaldo. I am a physician-scientist with a background and expertise in clinical research and health delivery. I currently serve as the Chief Clinical Innovation Officer and Corporate Medical Director of SCAN Health Plan, where my focus is on improving the quality of life and cost of care for vulnerable and frail older adults.

I began my healthcare career training in general surgery at Stanford University, where I had the privilege of caring for older adult patients across various surgical specialties. Over time, I observed that older adult patients often experienced poorer outcomes – not only because of their higher burden of chronic disease and functional impairments, but also due to insufficient support in addressing social determinants of health. These factors, rooted in my patients' homes and environments, were critical drivers of their overall health outcomes. Yet, as a frontline clinician, I did not feel that I had the tools nor the knowledge to address them.

Recognizing the need to address these critical factors, and to provide more comprehensive care for my patients, I decided to pause my surgical career. I spent two years as a post-doctoral research fellow at the Stanford Clinical Excellence Research Center, where I focused on finding innovative ways to improve care delivery and outcomes for older adults by addressing the intersection between chronic disease management and social determinants of health.

During this time, my co-fellows and I developed a high-value care model for Late Life, integrating the most effective solutions from both academia and industry. This model addresses

key factors such as social isolation, functional impairment, loss of independence, and the importance of delivering goal-concordant care: care that aligns with the patient's personal health goals and values.

This experience inspired me to take on the role of Chief Medical Officer in the private sector, where I led the clinical strategy for a national network of in-home caregivers. As part of our work, our team was deployed to provide in-home support services as a supplemental benefit to Medicare Advantage (MA) members: supporting patients through care transitions, empowering them to better manage their chronic diseases, and proactively identifying and addressing clinical and social risk factors within the home.

These experiences, along with my desire to continue to improve healthcare delivery for older adults at scale, eventually led me to my current role at SCAN, where I continue to use my background to keep our members healthy and independent.

My remarks will briefly cover SCAN's background and history, SCAN's approach to preventing and addressing chronic disease through high-value supplemental benefits and clinical interventions, and recommendations to policymakers. SCAN serves mainly older adults, so my comments will focus on this population.

SCAN Background

SCAN Health Plan is a mission-driven, not-for-profit, Medicare Advantage plan. Almost 50 years ago, in Long Beach, California, a diverse group of older adults we affectionately call the "Twelve Angry Seniors" were unable to access the services they needed to age safely at home in their communities. Frustrated, the Twelve Angry Seniors formed the organization that became SCAN:

the Senior Care Action Network. In its infancy, SCAN was a network of services and programs, from meal delivery to home repair to medical centers, transportation, housing support, and more.

I offer this background because to understand SCAN's origins is to understand our current mission and operations. Today, SCAN Health Plan is one of the nation's largest not-for-profit MA plans, serving more than 280,000 Medicare beneficiaries in California, Arizona, Nevada, New Mexico, and Texas. SCAN specializes in serving vulnerable and frail older adults. We offer a variety of Special Needs Plans (SNPs), including the only Fully Integrated Dual Eligible (FIDE) SNP in California.

In an industry increasingly dominated by large, for-profit health plans, we believe that both Medicare beneficiaries and the American taxpayer benefit from a robust presence of non-profit plans in the MA marketplace. Our financial incentives center entirely around the beneficiary. Payments made to SCAN by CMS are directed toward high-value benefits for our members and fair compensation for our providers. Non-profit plans like SCAN are accountable to our communities, resulting in a better understanding of our members' needs, culturally congruent and sensitive care, and tangible investment in local communities. The results of this approach translate to consistent, high-quality care. For eleven years in a row, SCAN has received a four-star or better rating from the Centers for Medicare & Medicaid Services (CMS).

SCAN's Approach to Preventing and Managing Chronic Disease

When the Twelve Angry Seniors founded the Senior Care Action Network in 1977, their priorities were to manage the process of aging gracefully, keeping patients in their homes

instead of in a facility, and preventing and managing chronic illnesses. So, in a system that all too often encourages “sick care,” as Chair Buchanan has said, SCAN is proud to be a leader in healthcare.

Our mission now, 47 years after our founding, is still to keep seniors healthy and independent. Thanks to the flexibilities present in the MA program, SCAN and other plans are both able and incentivized to provide preventive care. For example, SCAN can reduce or remove cost-sharing on high-value services like primary care and prescription drugs that keep chronic diseases in check. Meanwhile, our financial incentive is clear: more preventive services, more upfront interventions, mean fewer expensive and unnecessary acute care services, like emergency department trips or extended hospital stays.

Beyond these structural advantages of Medicare Advantage, SCAN takes great pride in how our benefit design and clinical interventions prevent disease when possible.

Benefit Design

As this committee knows, MA plans are required to offer all benefits, except for hospice, that are provided under fee-for-service Medicare. In addition, MA plans may offer supplemental benefits not covered by fee-for-service. These benefits may include reduced cost-sharing, health-related benefits such as transportation to a doctor’s appointment or in-home nurse support to prevent falls, and targeted benefits that address social risk factors – like nutritious meal delivery. Most plans, including SCAN, offer some combination of these three benefit types.

However, as SCAN's CEO Dr. Sachin Jain has written, to gain market share, some plans in recent years have begun offering prospective members benefits that may be attractive during open enrollment but do little for people when they need care. This is not SCAN's approach.

At SCAN, we strive to design benefits that are not only appealing due to their affordability and accessibility but also because they emphasize wellness. By focusing on preventive care, we aim to keep our members from needing costly, acute care whenever it is avoidable.

One such benefit category SCAN is proud to provide to our members is meals and nutrition. SCAN is a strong advocate of "Food as Medicine." We recognize that access to high-quality, culturally tailored, nutritional meals and targeted nutritional counselling is essential for managing chronic diseases. In the case of diabetes, for instance, we have engaged with meal partners to offer appropriate diabetic meals and nutritional counselling to our members at no additional cost to them.

In 2023, SCAN delivered 41,000 meals per month to our members under several different programs we offer (many members may qualify for more than one type of meal benefit). These programs include:

1. Post-acute meals, which enable members to receive daily meals delivered to their homes for four weeks following a hospital stay.
2. Chronic condition meals, which are tailored both nutritionally and culturally to support chronic condition management. Members receive 84 meals annually to support their health needs.

3. Long Term Services and Supports (LTSS) meals for our Dual Special Needs Plan members.

These members, who are among the most vulnerable in the communities we serve, receive home-delivered meals regardless of their health conditions.

Supplemental benefits can also address barriers to care, like an inability to physically reach a provider. SCAN offers transportation benefits to physician appointments and to other settings where members can obtain healthcare services. For example, in 2023, SCAN members took almost 320,000 rides to access primary care, dialysis, physical therapy, and specialty medical services. SCAN also provides thousands of rides a month to grocery stores and senior centers. For those members who, for whatever reason, would prefer to stay home for their care, SCAN has curated a substantial suite of supplemental benefits. For example, we provide unlimited telehealth for urgent care needs and behavioral health support through video-based therapy and psychiatry. We also offer an online program with a series of mental activities designed to strengthen attention, memory and other skills. And, of course, to deal with inevitable technical barriers, SCAN offers a 24/7 telephone support line with experts who can answer whatever health-related technology questions our members may have.

Clinical Interventions to Prevent & Treat Chronic Disease

Beyond offering benefits that promote wellness and address both clinical and social risk factors, SCAN entities also provide direct care to members through our Institutional Special Needs Plan (I-SNP), Embrace, as well as through other care delivery assets that SCAN developed as strategic investments. These initiatives address gaps in the healthcare value chain, creating lasting impacts on older adults' health and independence, while also driving innovation in senior care.

Our focus is on meeting the diverse needs of a wide range of older adult populations, ensuring that clinical excellence remains at the core of our mission.

For Instance, Homebase Medical complements primary care providers by offering wraparound, home-based services that support the management of clinically complex patients. These services facilitate smooth care transitions, streamline care coordination for effective chronic disease management, and deliver preventive care directly in the home.

Take, for example, a recent Homebase Medical patient, a 91-year-old with hypertension and congestive heart failure. This patient has experienced multiple hospitalizations and readmissions over the course of the year. Homebase stepped in to provide counseling for the patient, and to their family caregiver, on dietary changes to prevent heart failure exacerbations. Homebase coordinated care with the treating cardiologist to closely monitor the patient's condition and adjust medications as needed. I am pleased to report that, thanks to these additional layers of support, the patient has not been hospitalized in several months. For an older adult patient, whose cognitive and functional status can decline significantly with every hospital stay, this is a major victory.

Between our health plan and our provider lines of business, SCAN does everything we can, within current laws and regulations, to help our members avoid and manage chronic diseases. However, we know that we could do so much more with the help of this Committee and the entire Congress.

Congress Can Improve Preventive Care for Vulnerable Populations

Congress recognized, as part of the Bipartisan Budget Act of 2018, that Medicare beneficiaries with chronic diseases face non-healthcare challenges that directly influence their health outcomes. Food insecurity makes it difficult to live with heart disease or diabetes. Air pollution exacerbates asthma. Social isolation affects one's mental health – especially in those with depression and anxiety. To address these social risk factors, Congress created Special Supplemental Benefits for the Chronically Ill, or SSBICI. These supplemental benefits permit MA plans to invest in targeted benefits that lead to better outcomes and lower costs.

People with chronic diseases are not the only patients who face social risk factors. Low-income beneficiaries face similar challenges. For instance, public housing units and residents are overrepresented in neighborhoods with poor air quality.¹ Lower income households purchase less healthy foods than higher income households.² Lower income households spent 30% of their post-tax income on transportation in 2022, the highest of any income bracket.³ Lower income households reported encountering more roaches and rodents, both of which often carry disease, than higher income households.⁴

¹ Chakraborty, J., Collins, T. W., Grineski, S. E., & Aun, J. J. (2022). Air Pollution Exposure Disparities in US Public Housing developments. *Scientific Reports*, 12(1), 9887. <https://doi.org/10.1038/s41598-022-13942-3>

² French, S. A., Tangney, C. C., Crane, M. M., Wang, Y., & Appelhans, B. M. (2019). Nutrition Quality of Food Purchases Varies by Household Income: The SHoPPER Study. *BMC Public Health*, 19(1), 231. <https://doi.org/10.1186/s12889-019-6546-2>

³ Bureau of Transportation Statistics (2024). The Household Cost of Transportation: Is It Affordable? *U.S. Department of Transportation*. <https://www.bts.gov/data-spotlight/household-cost-transportation-it-affordable>

⁴ Sellner, M. & Wicht, J. (2021). Residents of 14 Million Housing Units Reported Seeing Roaches, 14.8 Million Saw Rodents in Last 12 Months. *United States Census Bureau*. <https://www.census.gov/library/stories/2021/04/how-many-american-homes-have-pests>

To fully meet the needs of some of Medicare’s most vulnerable beneficiaries, SCAN believes that Congress should expand SSBCI eligibility to include 1) beneficiaries dually eligible for Medicare and Medicaid, 2) beneficiaries who receive the Part D low-income subsidy, and 3) beneficiaries who are neither duals or LIS-eligible but are still considered low income – often referred to as the “near poor,” who face many of the same barriers to care experienced by those living below the poverty line.⁵

Fortunately, legislation to make this change is pending before this committee and the Energy & Commerce Committee. SCAN commends Representative Earl Blumenauer, a member of this Subcommittee, and Representative Gus Bilirakis for introducing the “Addressing Whole Health in Medicare Advantage Act” or H.R. 5746. SCAN urges Congress to enact this bipartisan legislation as soon as possible to meet the needs of Medicare’s most vulnerable beneficiaries.

In Conclusion

For my entire career, I have worked to address the ways that older adult care is insufficient. As a surgeon, I cared for seniors at what was often one of the most challenging moments of their lives. As a post-doc at Stanford, I developed a model of care to align healthcare services with a patient’s personal health goals and values. In the private sector, I helped deliver a home health supplemental benefit to MA members. And finally, here at SCAN, I combine my own experiences with the spirit of our Twelve Angry Seniors that still guides this organization. I look

⁵ Roberts, E. T., Glynn, A., Cornelio, N., Donohue, J. M., Gellad, W. F., McWilliams, J. M., & Sabik, L. M. (2021). Medicaid Coverage ‘Cliff’ Increases Expenses and Decreases Care for Near-Poor Medicare Beneficiaries. *Health Affairs (Project Hope)*, 40(4), 552–561. <https://doi.org/10.1377/hlthaff.2020.02272>

forward to taking your questions about how our non-profit, mission-driven organization provides high-quality, high-value, care to our members.

Mr. BUCHANAN. Thank you.
Dr. Gearhardt, you are now recognized.

STATEMENT OF ASHLEY GEARHARDT, PROFESSOR OF PSYCHOLOGY, FOOD AND ADDICTION SCIENCE AND TREATMENT, UNIVERSITY OF MICHIGAN

Dr. GEARHARDT. Chairman Buchanan, Ranking Member Doggett, and distinguished members of the committee, thank you for the opportunity to participate in today's hearing. I have been on the faculty at the University of Michigan for 12 years and I serve as a professor of psychology and the director of the food and addiction science and treatment laboratory.

I earned my doctoral degree in clinical psychology from Yale University specializing in addictive disorders, obesity, and disordered eating. Additionally, I am a licensed clinical psychologist with experience treating individuals with substance use disorders, obesity, and compulsive overeating.

Since the 1980s the United States has witnessed a sharp rise in diet-related diseases. Diabetes rates have doubled and the prevalence of obesity has tripled. Type two diabetes in children, which was almost unheard of in the 1980s, is now projected to quadruple within 40 years. Diet-related cancers are also now increasing, particularly among younger generations. Obesity and diet-related diseases disproportionately affect rural communities and black, Hispanic, and Native Americans which exacerbates existing health disparities. This public health crisis affects economic viability, workforce productivity, healthcare cost, and military readiness.

A significant contributor to the rise of chronic health issues in America is the changing food environment. From the 1980s to the late 2000s, tobacco companies like RJ Reynolds and Phillip Morris became the biggest producers of processed food in the world. Internal tobacco industry documents demonstrate strategies designed to develop and sell cigarettes were applied to processed foods and beverages, such as adding flavor additives developed for cigarettes into children's sugar sweetened beverages and intentionally targeting children and racial ethnic communities in their marketing.

Consequently, the modern food supply has been significantly shaped by the tobacco industry's expertise and maximizing profits from highly appealing products. The result has been an American food and environment dominated by ultraprocessed foods and beverages that have been optimized to maximize palatability and consumer appeal. These products are industrial formulations with high levels of added sugar, saturated fats, and additives that enhance taste and texture while reducing sensitivity to satiety signals. Common examples include candy, sugar sweetened beverages, frozen pizza, and salty snacks.

The average American now consumes over 57 percent of their calories from ultraprocessed products, and this is even higher in youth. Introduction of these ultraprocessed products has displaced nutrient rich minimally processed foods contributing to poor physical, mental, and cognitive health. Many of these ultraprocessed products share characteristics similar to recognized addictive substances. They deliver unnaturally high doses of rapidly absorbed

carbohydrates and fats effectively triggering reward mechanisms in the brain.

Research shows that sugar, fat, and ultraprocessed foods can activate the brain's reward system. It is similar magnitude to nicotine and ethanol. These products enhanced with additives and coupled with texture and flavor modifications resemble addictive substances like cigarettes making them difficult to resist despite harmful health consequences.

More than 280 studies estimate that 14 percent of adults and 12 percent of children would meet the criteria for an addictive disorder based on their intake of ultraprocessed foods. This prevalence has doubled in individuals with obesity. If addictive mechanisms are being triggered by ultraprocessed foods, this may be an overlooked reason why it can be challenging to reduce their intake, even in the face of life threatening health conditions like diabetes.

A participant in my lab described her ultraprocessed food addiction in the following way. I can't even be in the same vicinity as a doughnut store or any type of doughnuts because I will finish a dozen all by myself, and I am a type two diabetic, so that could kill me, and I know that and I know I shouldn't be eating all of those. I shouldn't be eating one, let alone a whole dozen, but for some reason, I just can't stop.

A multiprong strategy is necessary to reduce excessive intake of ultraprocessed products to improve American health. First, evidence-based strategies that have been successful and could be considered on a broader level including taxes on ultraprocessed food and beverages and front of path nutritional and warning labels.

Second, restricting misleading health claims and marketing of unhealthy products to children, especially on social media, is another important strategy to reduce the risk of diet-related disease in children.

Third, policy should aim to make healthy minimally processed foods convenient and affordable, particularly for economically disadvantaged groups who face the greatest challenges.

Lastly, investment in scientific research on the health impacts of ultraprocessed food is essential alongside preventive measures focused on youth to promote lifelong healthier eating habits.

In conclusion, the food and beverage industries have designed many ultraprocessed products to be nearly irresistible leading to rising chronic disease levels and significant public health cost. It is crucial that we address systematic factors contributing to these issues and invest in strategies that promote healthier eating habits and health for all. Thank you.

[The statement of Dr. Gearhardt follows:]

**Written Testimony before the U.S. House of Representatives Committee on Ways and
Means Health Subcommittee Hearing on “Investing in a Healthier America: Chronic
Disease Prevention and Treatment”**

Ashley N. Gearhardt, Ph.D.

Professor of Psychology

University of Michigan

September 18, 2024

Introduction

Chairman Buchanan, Ranking Member Doggett, and Distinguished Members of the committee: thank you for the opportunity to participate in today's hearing. To start, I will briefly outline my qualifications to speak as an expert at today's hearing. I earned my PhD in clinical psychology from Yale University, specializing in addictive disorders, obesity, and disordered eating. I have been on the faculty at the University of Michigan for 12 years, currently serving as a professor of psychology and the director of the Food and Addiction Science Treatment laboratory. Additionally, I am a licensed clinical psychologist with experience treating individuals with substance use disorders, obesity, and compulsive overeating.

Through my clinical experiences, I have gained a firsthand understanding of how hard people are working to try and get control over their eating behavior. I saw that even when people were faced with life threatening health conditions, they often still failed to reduce their intake of highly appealing foods despite being motivated to change. My research has been built on the parallels between what I observed in the clinic and my scientific training on how certain substances can trigger addictive processes that keep people stuck in compulsive and destructive patterns of consumption. In my program of research, I use multi-method approaches to explore the neurobiological, psychological, and behavioral factors that contribute to compulsive overeating across the lifespan. I have published over 175 peer-reviewed articles, including in prestigious outlets like the *JAMA Psychiatry* and *British Medical Journal*.

Rates of Diet-Related Disease in America

Since the 1980s, the United States has witnessed a sharp rise in diet-related diseases. In the last 40 years, the amount of diabetes doubled (1) and the presence of moderate-to-high risk obesity tripled in adults (2). In children, the rise in diet-related disease has been even more

striking. In the 1980s, Type II diabetes in children was almost unheard of, but the Center for Disease Control and Prevention now projects that the rate of this disease will quadruple in children within 40 years (3). Cancer is also a major concern for younger Americans. The rates of 17 out of 34 types of cancer are increasing in younger generations, particularly cancers related to obesity and diet (e.g., colorectal cancer) (4). Obesity and diet-related diseases disproportionately impact rural communities and African Americans/Blacks, Hispanics, and Native Americans, worsening existing health disparities (5, 6). Poor diet-related health also impacts economic viability, reducing workforce productivity and increasing healthcare costs (7). Additionally, it poses a threat to our military readiness, as a less healthy population may not meet the physical standards required for service (8). There is an urgent need for comprehensive strategies to address and mitigate diet-related health issues and health inequities.

The Role of Tobacco Companies in the Modern Food Environment

A major contributing factor to the rise of chronic health issues in America is the changing food environment. In the 1970s and 1980s, the tobacco companies RJ Reynolds and Philip Morris bought processed food and beverage companies, including Kraft and General Foods (9, 10). When Philip Morris merged Kraft and General Foods in 1987, it became the largest processed food corporation in the world (9, 10). Although the tobacco industry sold off many of their holdings in this arena by the late 2000s (9, 10), they had already impacted the nature of the American food supply. Internal tobacco industry documents demonstrate they took strategies designed to develop and sell cigarettes and applied them to their processed food and beverage products (9, 10). This includes putting flavor additives developed to enhance the palatability of cigarettes in their leading children's sugar-sweetened drinks and increasing marketing strategies that targeted children and racial/ethnic minorities (9, 10). For example, Philip Morris's beverage

division developed children-focused loyalty programs, based on a similar program used to promote Marlboro cigarettes, where purchases of sugar-sweetened beverages were exchanged for child-focused gifts and sweepstakes (9, 10). Between 1988 to 2001 products from tobacco-owned food companies were more likely to have products with hyper-palatable combinations of carbohydrates, fat, and salt compared to those from non-tobacco owned companies (11). However, by 2018, non-tobacco owned food companies had increased the level of hyper-palatable ingredient combinations to a level that compared with tobacco-owned companies (11). As a result, the modern food supply has been significantly shaped by the tobacco industry's expertise in maximizing profits from highly appealing products.

The Rise of Ultra-Processed Foods and Beverages

This has resulted in the dominance of ultra-processed foods and beverages in the American diet that have been optimized to maximize palatability and consumer appeal (12, 13). These ultra-processed products are industrial formulations manufactured by deconstructing foods into their component parts, modifying them and recombining them with a myriad of additives (14-16). Common examples of ultra-processed products are industrially created candy, sugar-sweetened carbonated beverages, instant noodles, frozen pizza, and salty snacks (15). Beyond providing calories, the resulting ultra-processed products have little resemblance with nutrient-rich minimally processed foods (e.g., fruit, vegetables) and are a major source of added sugar and saturated fats in the American diet (17, 18). The unnaturally high level of palatability-inducing nutrients (fats, sugars, carbohydrates and/or sodium) in many ultra-processed products trigger reward signals and reduce sensitivity to satiety signals (12, 19). Ultra-processed products also often contain flavor additives and texturizers that enhance taste and the feel of the product in the mouth (14-16). The structure of these products is also altered and important nutrients (e.g.,

fiber) are removed to make them easier to consume and digest (15, 16). Finally, the preservatives in many ultra-processed products allow them to stay shelf-stable and come in convenient ready-to-heat or ready-to-eat packages (14-16), which makes them highly appealing to busy Americans.

The introduction of ultra-processed products into the food supply tends to result in the displacement of health-promoting, minimally processed foods (20). Epidemiological research estimates that the average American adult now gets the majority of their calories (57%) from ultra-processed products while intake of nutrient-rich minimally processed foods like fruits, vegetables, and legumes is decreasing (13). This estimate is even higher for youth. From 1999 to 2018, a global team of epidemiologists found that the percentage of energy consumed from ultra-processed products increased from 61.4% to 67.0% in children 2 to 19 years old (21). Rural communities and communities of color are more likely to be 'food deserts' that lack grocery stores with access to fresh food and instead have higher concentrations of retailers that predominantly sell ultra-processed products (22, 23). Individuals with food insecurity who lack consistent access to nutritious foods are further targeted for the marketing of ultra-processed products. For example, stores in neighborhoods with high Supplemental Nutrition Assistance Program (SNAP) enrollment are four times more likely to advertise or display ultra-processed beverages on the days when payments are distributed (24). Due to structural inequities, African Americans/Blacks, Hispanics, Native Americans and Americans who live in rural areas are more likely to rely on the SNAP program (25, 26) and, therefore, experience additional exposure to unhealthy food marketing. Thus, while an ultra-processed food environment affects all Americans, individuals living in rural communities, communities of color, and those who struggle to afford nutritious food face an environment that makes it even harder to maintain a healthy diet.

A converging body of research highlights the potential ramifications of diets composed mostly of ultra-processed products (27). High levels of ultra-processed food and beverage intake is implicated in higher risk for physical health conditions like heart disease and obesity, but also mental health conditions like anxiety and depression (27). In older adults, high levels of ultra-processed food and beverage intake predicts accelerated cognitive decline and dementia (28, 29). In a controlled randomized crossover trial, a team of researchers at the National Institute of Health found that being given a diet high in ultra-processed foods relative to minimally processed foods over a two-week period was associated with an increased daily intake of 500 calories and a two-pound weight gain (30). This occurred despite the ultra-processed and minimally processed meals being matched on the overall calories available to participants (30). Thus, the high levels of ultra-processed food and beverages in the American diet are a major cause for concern across physical, mental, and cognitive domains.

There are Strong Parallels between Addictive Substances and Ultra-Processed Foods

Ultra-processed products exhibit characteristics similar to those of well-recognized addictive substances. Most addictive substances are created by processing natural substances (e.g., fruit, leaves) into a new product that delivers a heightened dose of a reinforcing ingredient (e.g., ethanol, nicotine) into the body (31). Speed of absorption is also important and the more rapidly the reinforcing ingredient is absorbed the more likely the substance is to be addictive (32, 33). All addictive substances activate the mesolimbic dopamine system, which is key to the reward and motivational mechanisms that go awry in addiction (34, 35). For example, cigarettes are created by processing naturally occurring tobacco leaves through drying and curing into products that can be smoked to rapidly deliver high doses of nicotine into the body. The nicotine in cigarettes is further amplified by flavor enhancers, such as sugar, cocoa, and menthol, which

create brand-specific taste and flavor profiles (36, 37). These tastes and flavors become repeatedly paired with the delivery of nicotine and become salient drivers of smoking behavior in their own right (36, 37). The cigarettes that result from this processing are highly addictive and can lead people to continue smoking even when facing life-threatening health conditions, like heart disease and lung cancer (38).

Similarly, many ultra-processed products are created by processing naturally occurring substances (e.g., fruits, grains, vegetables) into products that deliver unnaturally high doses of rapidly absorbed carbohydrates and/or fats. Refined carbohydrates, like sugar, and fat are highly reinforcing ingredients and they are effective at activating reward mechanisms in the brain (31, 39-41). While many minimally processed foods contain either carbohydrate (e.g., fruit) or fat (e.g., nuts, meat), the combination of both is rare in nature (39). In contrast, ultra-processed foods often deliver high levels of both refined carbohydrates and fats. This combination has a supra-additive effect in activating neural reward systems (40). Evidence exists that sugar, fat, and ultra-processed foods can activate mesolimbic dopamine in the brain at similar magnitudes as nicotine and ethanol (42-47). Additives further amplify ultra-processed products by coupling industry created flavors and textures with the delivery of refined carbohydrates and added fats (15, 16). Thus, these ultra-processed products with high levels of refined carbohydrates and fats are highly rewarding processed substances that share many commonalities with addictive substances like cigarettes (31).

Ultra-Processed Food Addiction

Many people demonstrate classic symptoms of addiction when consuming ultra-processed foods including a loss of control over intake, intense cravings, and continue consumption despite physical or emotional problems (48). We developed the Yale Food

Addiction Scale to apply substance addiction criteria to the intake of such products (e.g., chocolate, soda, pizza) (49). The Yale Food Addiction Scale has been extensively validated and is a widely used measure in the field with over 1000 citations and translations available in over a dozen languages (50). Multiple studies have identified that people report consuming ultra-processed products high in refined carbohydrates and/or fats in an addictive manner, but not minimally processed foods like fruits, vegetables, and legumes (51-53). Dietary intake studies confirm that individuals who meet “food addiction” consume higher levels of ultra-processed products, but lower levels of minimally processed foods (54, 55). Thus, I will refer to the construct measured by the Yale Food Addiction Scale as ultra-processed food addiction in the remainder of my testimony.

Although ultra-processed food addiction is not currently an officially recognized diagnosis by the American Psychiatric Association, the science on this topic has grown quickly. Systematic reviews of over 280 studies from 36 different countries estimate the prevalence of ultra-processed food addiction to be 14% in adults (56), which is similar to the prevalence of alcohol and tobacco use disorder (e.g., 14% for alcohol and 18% for tobacco) (57, 58). The estimated prevalence of ultra-processed food addiction is twice as high (28%) in adults with obesity (56). Particularly relevant to the current hearing, ultra-processed food addiction has been associated with a more than five times greater likelihood of Type 2 diabetes even when adjusting for sex and age (59).

Below is a quote from a participant who was interviewed for a research study in my lab about their experience with ultra-processed food addiction.

“I can't even be in the same vicinity as [donut store] or any type of donuts, 'cause I will finish a dozen all by myself and I'm type 2 diabetic. So, that could kill me, and I know

that and I know that I shouldn't be eating all those. I shouldn't be eating one, let alone a whole dozen. But for some reason I just can't stop eating them.”

In children, the estimated prevalence for ultra-processed food addiction based on a systematic review of the literature is 12%, which surpasses the prevalence of other substance addictions at this stage of development (60). Children are typically protected against exposure to addictive substances through policy initiatives (e.g., marketing restrictions, age limits on purchases), but exposure to ultra-processed foods for children in America is a daily occurrence (21). There is also evidence that ultra-processed food addiction is important for older Americans. In collaboration with Michigan Medicine, my lab recently conducted a study on ultra-processed food addiction in the National Poll of Healthy Aging. This is a nationally representative poll of over 2000 older adults between the ages of 50 and 80. In this poll, 13% of participants met the criteria for a clinically significant ultra-processed food addiction, which was associated with a greater likelihood of reporting being overweight and in poorer physical and mental health (61). Finally, individuals with food insecurity that lack adequate access to nutritious food are more than three times more likely to meet the criteria for ultra-processed food addiction with chips, soda, chocolate, pizza, and ice cream being identified as the most addictive foods (53).

Taken together, this scientific body of evidence suggests that addictive processes play an important role in contributing to patterns of ultra-processed food intake implicated in poor health (39, 62). If addictive mechanisms are being triggered by ultra-processed foods, this may be an overlooked reason why it can be challenging to reduce intake of ultra-processed foods even in the face of health conditions like diabetes.

What Can Be Done to Address this Problem?

A wide range of potential approaches are available for consideration to reduce excessive intake of ultra-processed foods and improve the health of Americans. The history of addressing addiction epidemics suggest that no singular approach will be sufficient to address complex public health issues like the obesity and diabetes epidemic. However, multi-pronged strategies have been effective and similar approaches are being implemented globally to combat the health consequences associated with ultra-processed products. Evidence-based examples include ultra-processed food and beverage taxes and mandatory or voluntary reformulation of the food supply (39). Front-of-pack nutritional and warning labels would provide essential information to consumers about the health consequences of available foods and beverage options. Many nutrient-poor foods aimed at children display health-related claims on their packaging (63), which is confusing to parents trying to make healthy choices for their children. Implementing restrictions on misleading health claims (particularly for nutrient-poor products targeted at children) is essential for promoting healthier diets. Many countries are implementing restricting the marketing of unhealthy food products to children (39) or at the least reducing tax incentives for the advertising of unhealthy foods and beverages (64). This is an important equity issue as Black/African-American and Hispanic children are exposed to more unhealthy food advertisements than non-Hispanic white children (65). Food marketing toward children is increasingly spreading to social media, including the promotion of unhealthy products by paid children influencers (66). Given that social media marketing can be highly personalized based on user metrics and data, it will be essential for policies to protect children from food marketing in this sphere. Convenience is another factor that drives reliance on ultra-processed foods. Many Americans are juggling multiple competing demands on their time, including, child and elder care. This is particularly true for economically disadvantaged Americans who may have

additional time constraints, like multiple jobs or reliance on public transit. Individuals who are Black/African American, Hispanic, or Native American are more likely to be economically disadvantaged in America (67) and, thus, face these additional obstacles to eating a healthier diet. Creative policy solutions are needed to make healthy options composed largely of minimally processed foods convenient and affordable irrespective of financial circumstances. Greater investment is needed to advance the scientific understanding of how ultra-processed products negatively impact health and engage addictive mechanisms to guide the development of effective solutions. Finally, another key point learned from the tobacco addiction epidemic is that prevention efforts can be far more cost effective than relying solely on treatment (68). Targeting prevention efforts on youth, especially, can be particularly helpful to shape lifelong health promoting behaviors (68).

Eating is necessary for survival. We each make numerous food-related decisions every day all while surrounded by grocery stores, restaurants, gas stations, convenience stores and advertisements that promote ultra-processed products. The food and beverage industry has engineered these products to be irresistible, which has resulted in substantial profits for these companies. However, the burden of these costs (e.g., rising rates of disease, mental distress, medical costs) falls on the rest of us. It is essential that we address the systemic factors that contribute to the rising levels of chronic disease and invest in an American food supply that promotes health for all.

Table 1. Diagnostic Criteria for Substance Use Disorders

DSM-5 Diagnostic Criteria for Substance Use Disorders(48)
Consumption of larger amounts and/or over longer time than intended
Persistent, unsuccessful attempts to cut down
Significant time spent obtaining, using, or recovering from effects
Cravings (i.e., intense almost irresistible urges for the substance)
Interference with role obligations at work, school, or home
Use despite social or interpersonal problems
Important activities given up or reduced
Use in physically hazardous situations
Continued use despite physical and/or psychological consequences
Tolerance (i.e., needing more and more of the substance to get the desired effect)
Withdrawal (i.e., experiencing psychological and/or physiological symptoms when reducing intake)

Note. Individuals meet the diagnostic threshold for a substance use disorder in the Substance-Related and Addictive Disorders section of the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM 5) by endorsing at least 2 of the symptoms above plus clinically significant functional impairment or distress(48). Severity of substance use disorders determined by the number of symptoms endorsed (mild 2-3 symptoms; moderate 4-5 symptoms; severe 6-11 symptoms).

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Mr. BUCHANAN. Thank you. Appreciate all of our witnesses.

We will proceed now to the questions and answers with our members. Let me just start out why I am such a big believer personally, because many years ago, probably eight, ten years ago, I happened to walk into Whole Foods, and I am always looking for the new diet, like a lot of people, and you realize those diets up and down and it is another bust and everybody's got ten stories.

But I picked up a book by Dr. Fuhrman and it just said the equation in there. It was very simple, and it was simply the top of the equation was nutritional quality in the food. You have got to figure out what that is. Sometimes that is difficult. Underneath that equation was the calories. So the thought was what is the most nutritional food with the fewest calories. That changed my life, because you don't have to worry about going up and down like a yoyo in terms of your weight all the time. You just stay on the program.

Now, my grandkids give me a hard time. I have got one back there, number ten, actually checking this out, but my point is, you know, you realize they are saying papa, you can't do that or you can't do this, but my whole thing of trying to bring that point to you is that is why I am such a big fan that food is medicine. It clearly made a big difference for me.

Dr. Frist, I thought what we would do is start with you. Maybe you can expand on that a little bit more. As I am thinking about Medicare now, here, you know that. You have dealt with it for a lot of years. I am in the Sarasota region, Manatee County, Tampa region, and we have a lot of seniors and all of them count on Medicare, but at the same token, I want to figure out just—just over this year, first time ever, we went over a trillion dollars. How can we apply some of these principles to help educate people to maybe take a little better care of themselves?

I had a guy, a doctor that I went to, and he said it was another thing on a little different thing. Some things stick with me, because it works for me. He said, you know, they come in, they're from the Midwest to the Northeast, come in our area and they are, you know, 70, 75 years old. They're on four or five pills, six pills. He said how would you like to get off of half of those? He said doc, I can't get off there. He said, no, seriously, how would you like to get off half? He said what are you talking about?

I want you to start walking two miles a day, five days a week, and when you can do that for 30 days, you come see me and I will take you off half of the garbage you are on. It is not that it is all garbage. But my point is there is something to be said for that as well.

What is your thoughts? We are spending over a trillion dollars. You know, we have got the debt and the deficit. You brought that up. I am obviously very concerned about that, but I am also concerned about, you know, healthcare, where all this is going, how we start bending the curve on some of the costs, because we are paying more and more and we are getting less and less. I think everybody pretty much is, especially in the last ten years, so what are your thought?

Mr. FRIST. Thank you, Mr. Chairman, and I think that is really the overriding question. Given where we are today in 2024, what is different than when I was on that side of the dais, and in 2003

we did the Medicare Modernization Act. And what is neat about it is in just listening to the panel, we are in such a better position today in terms of the science itself of whether it is understanding addiction based all the way from opioid disorder back to sugar today in terms of the science itself and in terms of what works and what doesn't work.

In 2003, which was the last big modernization of Medicare, we invented Medicare advantage to manage patients better. It has had its ups and downs and I am sure people—some are for it and against it, and all, but the whole idea of being able, for a group of the population, to help manage—let them make their choices, making the healthy choice, the easy choice requires data. It requires information. We have underinvested in this country in IH funding for prevention and specifically for food. Only 5 percent of the NIH budget goes to nutrition prevention, yet we are saying uniformly that it is a root cause, a root cause of this burden of disease that we have to deal with today.

In 2003 we had value-based care introduced. Our outcomes were readmissions to a hospital, death. These really—that is all the points that we have. Now with the science, we have a number of end points to apply. We have social determinants of health. We have the importance of food, of transportation, of access, of prevention itself. That is number one.

Number two, we have Medicare advantage about half the Medicare population, and then we have the non-Medicare advantage fee for service. I think the committee can continue to make it more uniform in terms of what is expected in terms of nutrition. Social determinants of health, there are four or five that are now recognized in 2024 today, the social determinants themselves that are required in hospitals, that can be expanded to the outpatient arena not just for Medicare advantage, but also for the nonmedical determinants.

And then lastly, I think conceptually we need to follow the patient in Medicare as we look at Medicare policy and not the plan and not just the traditional outcomes, but follow the patient over time. That takes data. Good science up front. We have underinvested in the past. And then applying that science in an evidence-based way in realtime going forward. With that it becomes true public health, both crisis, but a public health problem. Not just addressing the end points of admissions, what happens in the hospital, whether or not you die of a heart attack, but actually what you are eating and the impact it is having and the preventative aspects of moving forward.

Mr. BUCHANAN. Dr. Hyman, what is your thoughts on that with the idea we are spending over a trillion dollars? We are spending more money than we have ever spent and going in the wrong direction in terms of healthcare. Two percent. Pick a number. Obesity of adults, 20 percent with children. That is wrong. That is sad. We can do a lot better. What are your thoughts on that?

Dr. HYMAN. Thank you, Mr. Chairman, I think this is a very important issue because as Senator Frist said, we now have the science, and the science and the data are clear that we can solve this chronic disease epidemic by focusing on its root causes. I prac-

tice root cause medicine. Some people call it functional medicine, systems medicine, network medicine. It doesn't matter. The key is what is the root cause.

In America we mop up the floor while the sink overflows. How do we turn off the faucet so we deal with the root cause? The problem, which is the food that is driving the chronic disease epidemic. And I think there's a lot of numbers the government can pull. Many of them were mentioned here by the panel. I think a deep understanding of food is medicine is very important. I think most people still don't comprehend that food is not only something that can be used for prevention of disease, but for the treatment of disease and that it often is a better treatment.

Medication. Medication has a role. It is important. It is not that we want to get rid of it. But we have to understand what is the actual right treatment for a patient? Just like this patient Janet from Ohio, she lost 116 pounds and reversed all her diseases. This is not something you can do with medication. She was already getting the best medication from the best healthcare system in the world, and yet she wasn't getting better.

And I have seen this over and over in clinical practice. We have demonstrated this in our research at the Cleveland Clinic. There is many, many data points we have in the cited literature that by applying the science included as medicine that we can transform biology.

And for those of you who try to understand what does that mean, what does food is medicine mean, it is not just a metaphor. Food is literally a code that you are eating. Every molecule in the food you are eating translates into changes in your biology, in your gene expression, your immune system, your brain chemistry, your microbiome, your hormones. They are all regulated by the molecules you eat. And if they are molecules that produce health, it creates health. If they are molecules that produce disease, you get sick.

And the molecules that we are eating in America are not actually food. Food by the definition in the Webster dictionary is something that promotes the growth and health of an organism. By definition, most of what America is eating in ultraprocessed food is not food. It actually does the opposite. It promotes disease.

So I think understanding how do we make nutrition central to healthcare? How do we reimburse for it? I say in my written testimony that we don't have evidence-based medicine. We have reimbursement-based medicine. How do we move to more evidence-based treatments? In fact, every professional association, American Heart Association, National Heart and Lung and Blood Association, I mean, from the NIH, the American Diabetes Association, all recommend lifestyle therapy as the first line therapy for treating high blood pressure, for diabetes, for heart disease, and yet it is not done in healthcare because it is not reimbursed. If tomorrow doctors were paid to do the right thing, not the thing which they get paid to do, this would change very quickly.

So I think the medically tailored meals program, prescriptions, incentivizing nutrition services and payment services for physicians in healthcare is critical. I think reforming our medical education system, I think the Federal Government's had \$17 billion for pro-

viding medical education. None of it comes with any ties or recommendations for—including nutrition services. I think some of the work we have done and you have done, Mr. Chairman, has helped change that, and the ACJ—the American College of Graduate Medical Education is now going to provide nutrition competency as part of their training.

And I think that we have an opportunity to do some really bold things through CMMI and medical demonstration programs like a diabetes prevention—sorry, like a diabetes reversal program, which has never done been before.

Mr. BUCHANAN. Doc, let me ask you, both of you, if someone said 30 years ago, I hate to bring up these stories, but some things have an impact on you. You're a heart doc. You said that 50 percent of people that have their first heart attack don't see the next day.

Dr. HYMAN. That is right.

Mr. BUCHANAN. I don't know if that's true or not, but that's what I was told.

Dr. HYMAN. That is right.

Mr. BUCHANAN. I thought to myself how do you not have the first heart attack to begin with? What can we do about that? So I want to—in terms of prevention, I am just looking at how much we are spending, and only three percent of dollars are allocated for federal dollars for prevention. That makes no sense. It is kind of like lung cancer and these other things. If you don't do the test, you get into a lot more expense. I can't afford to eat that way. Some ways you can't afford not to.

Dr. HYMAN. Yeah.

Mr. BUCHANAN. You are the heart doctor. What are your thoughts about this whole idea of prevention and three percent?

Mr. FRIST. I think from the policymaking standpoint—first of all, it is not just government. This is to empower individuals to make the healthy choice, the easy choice is when they think policy needs to actually do. So we need to, A, support the science. Get as much evidence as we possibly can. The 3 percent figure is exactly right. The 5 percent figure I gave for funding about nutrition research so we really know what works short-term, mid-term, long-term. We are going to actually have to increase that body of knowledge.

The testing in this committee has done superb work in passing legislation to increase the testing early on, the diagnostic testing, which is unbelievable. I think—which is fantastic, because if you are not testing, you are not going to pick it up early.

And then from the old days, or my days, and where we are really with Medicare today, we do well in terms of treating the heart attacks and the diabetes. It is really expensive. To lower that expense we are going to have to get from the testing, make sure people who have a positive test actually get the treatment themselves. And that means that there are real opportunities for and you this committee to make sure that yes, A, you get the test and you have moved in that direction. The acute care system today, the chronic needs system needs to be improved systematically, but there is a gap in between the two to make sure if you get that particular test you actually get the ultimate treatment that you need at a point in time, and that gives opportunities for these newer technologies

like telemedicine that after COVID we realized are so important to bring people into the system. That is where I think a lot of the policy opportunity is today.

So first, the evidence is—the food is medicine is crystal clear today. What we need to do is be able to build that body of knowledge over time. Have policy actually set the guiderails, and then recognize that the private sector, the nonprofit, which SCAN is a beautiful model of, and the for-profit sector to be able to accomplish the reality of what the policymakers intend all working hand in hand.

Dr. HYMAN. Yeah. I—if I could add, I would just underscore Senator Frist's point about nutrition research. The NIH spends \$48.6 billion on research every year. \$121 million is spent on nutrition research, a fraction of that, and yet it is the single biggest driver of all the diseases that all the institutes at the National Institute of Health are studying, and that needs to change in order to actually further study this problem.

And I also think that we have an opportunity to really rethink our whole approach to treating disease, not just preventing it. I think prevention is important, but 5 percent of the population accounts for 50 percent of the costs in Medicare, and focusing on that group will create the best ROI and I believe what the CBO will create a potential scoring that allows this legislation to pass.

I think it is essential that we think about things a little bit differently. Prevention is important. We need to figure out how to do public health campaigns, we need public health measures that include nutrition, education to the public, addressing the food marketing. The U.K. just banned food marketing to kids from—during the day, front of package labeling to help educate consumers like they do in most countries in the world. They are far ahead of us in policy. And there seem to be changes that benefits their population, and yet we are not addressing these things in a serious way. And I think this, as I said in my testimony, is a national emergency and it needs to be treated as that. I hope the next President will declare such an emergency and put a focus on it, as we did for COVID, whether we did it right or wrong, we had a focus on it and we put resources to it and we put efforts of the government behind it, and I think that is the kind of effort it is going to require.

Mr. BUCHANAN. Thank you. Mr. Doggett from Texas.

Mr. DOGGETT. Thank you very much. Dr. Gearhardt, I was struck by your testimony on the challenges consumers face in maintaining a healthy lifestyle. While we should make these healthier foods more affordable and convenient, many consumers will still select the ultraprocessed. Can you elaborate on how these products trigger addictive habits.

Dr. GEARHARDT. My pleasure. Thank you for the question. Addictive substances are things that man makes by taking often a plant or a fruit and processing it and altering it so it rapidly delivers a reinforcing agent into the brain and into the body. We don't really—we haven't really evolved to care whether we are getting enough nicotine or getting enough ethanol, but we come out of the womb liking sugar, needing fat, needing enough calories. And so now our food science technology has advanced so rapidly that they

are able to make very cheap irresistible foods that amplify the rewarding nature in the brain, and we just have really never evolved to be protected from that.

And when we look at a food supply where this is the dominant source of calories in most groceries that when people see the brands or smell the smells of the Cinnabon in the airport, it triggers such an intense desire in the brain that even if you see the salad or the very sad looking apple at the airport, it is hard to make that choice, even if you might know it is healthy for you.

And so I totally agree that we want to make the healthy choice the easy choice, and we also need to help people not be so aggressively targeted and tempted by these ultraprocessed products that are designed to maximize craveability, hit your bliss point, and make you want more and more and more.

Mr. DOGGETT. What can we do about it legislatively?

Dr. GEARHARDT. Yeah. Legislatively there is a lot of options and most of them come from the tobacco history. That is one of our biggest public health wins in decades, and we did that both by educating the consumer about the risks of tobacco, making that really clear through labeling and warning labels, but also curtailing industry practices that were questionable, like the targeting of children from marketing.

Right now there is actually tax write-offs for food companies to advertise their products to children. There is tax breaks for that. And so there is this big concern that we could do things like change the economic incentives towards healthier foods, restrict marketing to children, look at our school lunch programs, and think about how do we make sure that the healthiest food is what children are getting from the beginning. And that is particularly important for our most economically disadvantaged Americans where we are all feeling time poor and crunched. We really need to think about how does this fit into their life in a way that is achievable to help sustain a healthier future?

Mr. DOGGETT. Thank you and thanks to all the witnesses, but I have just been summoned to the floor, so I will try to get back and hear some of the other questions. Thank you.

Chairman BUCHANAN. Mr. Smith, you are recognized.

Mr. SMITH. Thank you, Mr. Chairman.

And certainly thank you to our witnesses.

I think this is an important topic that we want to take on. Chronic disease prevention and treatment I think is actually one of the biggest challenges we face, as has been mentioned, certainly within the government payment context and Medicare, Medicaid especially.

And, despite incredible success in research to help us better understand the causes of chronic disease alongside the billions of dollars invested in public health, overall rates of chronic disease have steadily increased.

Alarming, some 129 million Americans, more than half of adults in our country, have at least one major chronic disease, such as heart disease, cancer, diabetes, obesity, or hypertension. With nearly 90 percent of the \$4.1 trillion America annually spends on healthcare going to treat chronic diseases, finding a way to reverse

the trend is vital for our future, both for individuals and our country as a whole.

While there are no easy solutions to the problem, it is clear more needs to be done to encourage people to actively manage their health in the form of regular care and prevention. The cornerstone of prevention is access to primary care and a strong relationship with the primary care provider.

Primary care access is a serious challenge in rural districts like mine, which is why I have introduced legislation like the Critical Access Hospital Relief Act and the Rural Health Clinic Burden Reduction Act to support our frontline providers.

We can also leverage successes in better coordinating care through utilization of accountable care organizations, or ACOs. In fact, earlier this year, I introduced the ACO Assignment Improvement Act, which would make participation in an ACO even more accessible by allowing physician assistants and nurse practitioners providing primary care and services the ability to assign their patients to an ACO without an extra doctor's visit.

There is also significant opportunity to improve on the treatment side of the equation. Lack of treatment flexibility and outdated payment policies can often simultaneously cost Medicare more money and make it more difficult for patients to manage their conditions.

Uncertain future payment terms can also discourage providers from investing in innovative new technologies which can more accurately diagnose chronic conditions and catch problems at earlier stages. The absence of a long-term reimbursement strategy also threatens breakthroughs in access to care, like telehealth expansions.

Most seniors were not able to connect virtually with their primary care provider for routine consultations and telehealth services prior to flexibilities developed during the COVID pandemic. Despite the popularity of these services among patients and providers alike and one of the largest access to care expansions in recent history, effectively all COVID-era telehealth flexibilities are set to expire at the end of this year.

While House committees have marked up various extensions, not even a short-term extension has been enacted, and both patients and providers still lack long-term certainties for the telehealth services they have come to rely on.

Dr. Peters, I know you have a lot of experience working to address health disparities for those with diabetes. And I was wondering, how has greater access to telehealth services helped people manage their diabetes, especially in rural and underserved areas?

Dr. PETERS. Well, it has made a tremendous difference, because in diabetes we now have the wearable continuous glucose monitors, and those transmit the data to the cloud. So I actually don't have to have you in front of me. I can just look at your data and make decisions.

And so we have been doing programs in our clinic where we just give everybody continuous monitors. And I can really improve outcomes. And that is both synchronous and asynchronous telemedicine. And we have a tracking system. We have remote monitoring.

We check patients every day. And it really has helped enormously in my ability to reach those patients.

Not everybody, however, in our clinic has access to the ability to telemedicine. So we all worked all the way through the pandemic in person. But people who can access telemedicine, it is tremendously beneficial, and I would be so sad to see it go away.

Mr. SMITH. Thank you. I appreciate that insight.

Dr. Rinaldo, based on your experience with Medicare Advantage, how would you say plan design can better incentivize patients to build stronger relationships with their primary care providers and suggestions you have there?

Dr. RINALDO. Yes, absolutely. So, in our benefit design, we often eliminate or reduce costs for preventive care services like primary care visits, especially those that are related to chronic condition management.

So, for example, we have our chronic condition special needs plans related to cardiovascular disease, diabetes, and end-stage renal disease.

And, specifically, for example, for our diabetic members, we provide services and benefits that include no-cost insulin and low-cost other drugs, no-cost diabetic supplies and no-cost diabetic self-management training.

For our cardiovascular disease members in our Heart First Plan, we provide zero-dollar cardiologist visits as well as low-cost cardiac and pulmonary rehabilitation, and we provide no-cost primary care visits for these patients as well.

Mr. SMITH. Very good. Thank you.

I yield back.

Chairman BUCHANAN. Dr. Wenstrup, you are recognized.

Mr. WENSTRUP. Thank you very much. And thank you all for being here. I have long said since I have been in Congress, especially on health issues when we have these hearings, we need to hear from those wearing the white coats, not just the ones writing the white papers. It makes a big difference. The people that are actually treating patients.

And, you know, we have done a lot, and especially as our Doctors Caucus here, in addressing these issues. You are preaching to the choir with us. It is others whom we have to convince of things. You know, I am glad I live in a country with safety nets, but we have got to make sure they are working.

And, you know, in medicine, as you all know, there is the risk of bad luck. No one necessarily knows why they got the glioblastoma. But there is also the risk of bad behavior, and that we can have something to do with. You know, when we talk as a government here, we talk about success being how many people you have enrolled in a program, and they are not checking whether the program is really working or not.

Instead of looking at, hey, we have got more people healthy than ever before in America, wouldn't that be great? You know, our goal, we keep talking about being the healthiest nation on the planet. And we can't do things, like in SNAP, okay, I am glad we have programs to feed people that can't feed themselves, but what are we feeding them?

And, you know, they say things like, rather than focusing on nutrition, they focus on calories. And, when we say, “Well, we should restrict it, and these are the foods that people should be able to get in these programs,” and the response we get up here, “Well, rich people get to buy those foods, so that is not fair.” Well, life isn’t fair, but we are trying to make life better.

And so, you know, just talk about obesity. I was doing an interview about a year and a half ago, and it was like it is terrible; there is such a stigma against obesity. And I said, “No, the stigma is against those who want to talk about it.” And we are turning that around.

That is changing, and it is thanks to all of you and some people here. You know, with the Army, I was teaching a class, the Performance Triad, and it was about sleep, activity, nutrition, right? And we talked about—and it was referenced here. We can keep people alive for a long time in this country. Can we keep them healthy for a long time? And, even those with chronic diseases, can we make you as healthy as you possibly can, so you can live the best life that you might be able to?

So I am just grateful you are all here. And I just want to share some things. You know, I said for a long time, I said, yeah, we reward the doctor that does a coronary bypass graft but not the doctor and the patient that prevent it from ever happening, right? We got to look at those types of things, and that is what really success is.

And what are the root causes? You talk about social determinants of health. We had a Rural and Underserved Task Force, because rural and underserved areas, they got the same problems, basically.

So, I mean, I had a patient one time, diabetic, end-stage renal disease, neuropathy, trying to prevent him from ulcerating over and over again. And he says to me, “I can’t come to you anymore because they changed my bus schedule.” And I said, “Well, I am going to change my schedule then so you can get in here.” Those are things we have to address, you know, at the local level and whatever.

And, Dr. Rinaldo, I was thinking, we have one of our hospitals, when I went to their free clinic, they also have a food bank with nutritious food there. So they said more people show up for their appointments because they know they are going to leave with food.

And so we had another really nice FQHC, and a new large food bank was going in next door. I said, “Build a sidewalk.” Well, they did, and they put a gazebo in. I said, so people do that. I said, “You know what else you might do in here, though, is have local employers post jobs that they have available.” But all of these things are very holistic and grounded.

And I do have some good news. When we talk about school, I have always complained we didn’t get much on nutrition or vitamins, and I did that studying on my own when I was in medical school. But Xavier University is starting a new D.O. school, and they are doing it because the D.O.s tend to gravitate toward primary care, and we need more primary care. And I talked to the new dean about prevention, and I said to him, “What about nutrition?” He showed me his white board that was right behind me,

and he has that right in with biochemistry. I said, "Well, that will make biochemistry a lot more interesting, so I am glad that you are doing that."

So it is being recognized, and I think we have to keep beating that drum. But you are right; food as medicine, prescribe—you know, we do that. That is what nutritionists do. That is what dieticians do. You know, this is your prescription for what you need.

So I don't have a question for you, because you all got it figured it out, and I am out of time. But I only have an undergraduate degree in psychology, but that is one of the root causes too. And I can stay away from ice cream. If I have one bite, there is going to be two.

I yield back. Thank you.

Chairman BUCHANAN. Mr. Thompson, you are recognized.

Mr. THOMPSON. Thank you, Mr. Chairman. Thank you for having the hearing today, and thank you to all the witnesses who came.

I was thinking about some things going on in my district while you were giving your testimony. I have got some gardening programs at schools, and it is amazing to see the kids not only take an interest in it but learn to love nutritious food that have come from those gardening.

I was over visiting one of the Sutter Health Hospitals in my district last week and saw a pretty interesting food nutrition class program that they have to educate their patients, which was heartening to see.

Adventist Health in my district is a big proponent of the Blue Zones, and they are pushing this. And it is all the things that we all know we need to be doing, but then we also know there are other problems.

I have food desert areas in my district where you can't get good food. If you know that you need to have it and want to get it, it becomes very, very difficult to purchase it. And, as we all know, that the ultraprocessed foods are cheap. They are easy to get, and, as you all have said, it triggers certain desires to eat more of those. And that is just not a good thing.

And I wish that you could give us some idea how to fix those things because we have been trying to deal with the food deserts forever. The advertising issues that you raised, good luck fixing that. You know how difficult it has been to deal with the private sector and advertising pharmaceuticals, driving consumers to drive crazy their doctors to prescribe the things that they see on television.

So it is a tough one to deal with. And the education is good, but this is not new. You know, we learned about nutritious eating habits when I was in grade school. But there are so many distractions and so many alternatives that taste good and trigger those desires.

So I would be really interested in figuring out how we could figure out some policy that on both sides of this dais we could work on to get us to a more healthy population.

Dr. Gearhardt, in your testimony, you discuss the impacts of a diet full of ultraprocessed foods. You mentioned this type of diet leads to physical diseases, heart disease, obesity, and also anxiety and depression.

I mentioned earlier that Adventist Health in my district is a proponent of the Blue Zone Project, which focuses a lot on food, food as medicine, eating, eating healthy. And I would be interested to know if you know about that program and your thoughts about that and how we could maybe mimic that in other areas to get people to eat a more healthy diet.

Ms. GEARHARDT. My pleasure. I am not familiar with that specific Blue Zone program, but I am familiar with the research on Blue Zones. And that is looking at places around the world where people are living the sorts of lives that we are talking about here, long-term health—

Mr. THOMPSON. That is what Adventist is trying to push is to create these opportunities—

Ms. GEARHARDT. Meaning that environment.

Mr. THOMPSON [continuing]. And push people towards those types of eating habits.

Ms. GEARHARDT. I think that is really so essential, because we are talking so much here on the individual, and it is important to equip individuals with this knowledge about healthy eating and ways they can live better lives.

And then I look at—I grew up in rural Ohio. And, when I go home, we don't have a grocery store anymore. We are farmers. My dad is a farmer. But the food that we are creating is actually the ingredients that go into processed foods, and the rates of obesity and diabetes are going up so dramatically.

And so taking these environmentally focused initiatives where we are setting it up for the individual where they can thrive in ways that are achievable for them I think is really key. Because we have talked a lot about food deserts, but there is also the food swamps.

So, if you have the one grocery store, but you have to walk past the 20 different convenience stores that are promoting this soda and the salty snack that is activating that reward system, that desire system of your brain over and over and over again to get to that more expensive, less convenient food; it is probably not going to work that well for most people. So those upper level approaches seem to be really key.

Mr. THOMPSON. Thank you.

That was a fast clock, Mr. Chairman. I yield back.

Chairman BUCHANAN. I want to recognize Dr. Murphy, but I do want to say I am so glad we have got two very bright, capable doctors that are on our team here too. So Dr. Murphy is one of the two.

Dr. MURPHY. Somewhere else. I didn't know what you were talking about.

Thank you, guys, for coming. You know, sitting here looking up what ultraprocessed foods were, the staff in this place is going to go crazy when we get rid of the energy drinks, because that is the number one that they put on. And then I saw vegan meat. How about that? How about that, guys, because that is going to toss back.

But, thank you, guys. I think there is full recognition on this committee that food is medicine. The real question is, how do we get—and, you know, when I tell a patient—and I still see pa-

tients—to stop smoking, to do this, do that—and if you write a prescription, they are going to go to the drugstore and fill it. The next time they go to the grocery store, eh, may think in their mind, but are they going to do something different?

And so there is a point of coercion where you have to have some of these foods. I look back. You know, when I grew up in junior high school and high school, you didn't have soft drink things in the gym or in the cafeteria. You didn't have any of that. You got water or milk, or sometimes you got that, you know, purple juice or whatever that you had.

But it is a change. We have also taken exercise out of our schools. The Presidential Fitness Program has gone away. So this combination with food, because exercise is healthy also.

So I want to pare down on one of our more really at-risk communities, and those are folks on Medicaid and on SNAP. I sadly enough see a lot of end-stage renal patients, a lot of folks who have faced diabetes, a lot of folks who have hypertension, et cetera, et cetera.

But we don't have anything really in SNAP that says, "You have to eat nutritious food." And, if I am in the grocery store and I am looking behind and I am looking, you know, God forbid I just try to hide my potato chips. I have done better. I promise you I have done better.

But it is time that we actually did that, because those are at a higher risk population. Those are the ones who end up costing the system more. Those are the ones whose longevity is decreased.

So what do we do with SNAP? How do we fix this? How do we then say, "Look, this is for nutritious food; it is not for soda; it is not for chips; it is not for cookies," in a way that still gives people choice?

Because, remember, at the end of the day, it is personal choice. You can't force them to take a medicine. You can't force them to eat a food, especially stewed broccoli.

But, anyway, so I am interested, Dr. Frist and Dr. Hyman and anybody else on the committee, how do we deal with SNAP? How do we say, "This is for folks for nutritional assistance, but it is nutritional assistance; it is not caloric assistance."

Dr. FRIST. I will start, and Dr. Hyman can add to intelligently.

The farm bill is underway. And, again, this is multi-jurisdictional. This is sort of changing behavior that is new. Obesity was not a problem 50 years ago. The diabetes too, you know, the effect we have today was not a problem.

So it is fixable. And I think what you have heard beautifully, I think, as we have presented, it is a creation of industry in large part.

Dr. MURPHY. Sure.

Dr. FRIST. The industry that—and I am, you know, out with business for-profit. I am out with capitalism. I am out there all the way. But it is an industry that is out to sell, to make a profit on food.

And the science today—and we are—most of us or all of us are scientists of some sort. The science today allows us to manipulate chemicals that are no longer really food that hit the brain.

Dr. MURPHY. Right. If I can—I am sorry, just our time is short.

How do we fix SNAP? I know these things really trigger our brain. How do we fix SNAP?

Dr. FRIST. Yeah. Let me go quicker to it. And so you have heard me say to make the healthy choice the easy choice. But people on SNAP don't really have—many people on SNAP don't have the choice, because if you see a sugary beverage or a fruit drink, both of which have lots of added sugar to it—

Dr. MURPHY. Sure.

Dr. FRIST [continuing]. Versus an alternative, that is not really a choice because of the addiction of the brain itself.

Dr. MURPHY. Right.

Dr. FRIST. So SNAP itself, what is it, 20, 30 percent goes to sugary beverages.

Dr. MURPHY. Yeah, yeah.

Dr. FRIST. That is the killer. That is the cause of chronic disease today. So I do feel—this is personal, based on my policymaking like you and health—that we should limit—these are taxpayer dollars—that as a choice, since we know it is an addictive choice.

Now, you can look to the WIC program. I think the WIC program is ahead of the SNAP program, and I would look to the WIC program and adopt some of that at the SNAP level.

Dr. MURPHY. I think it is important. My time is just about expired. And, you know, somebody said this may be very paternal, telling you what to do, what to do, but this is an at-risk population. There oftentimes are food deserts without a doubt.

But, if we don't start putting some personal responsibility and if people aren't going to be able to do that and they are—good lord, you know, I have seen 2-year-old kids come in as a patient with their mother drinking a Mountain Dew. You know, we have to put some responsibility, because they are going to have so many deleterious effects in the weeks and years to come.

Real quick, Dr. Hyman.

Dr. HYMAN. Just quickly, I think we need to put the N back in SNAP. Nutrition security, not just food security. Not just calories but also nutrition that drives health and wellness. I think incentives for purchasing healthy food have been demonstrated to be effective. And disincentives for purchasing unhealthy food, that can be built in.

I think that focusing on nutrition security as well as food security is essential, and I think people want it. I think people on SNAP would benefit, and the data show clearly that those who get the incentives for good food and disincentives for unhealthy food actually create better health outcomes and better overall health for the people who are doing this.

Dr. MURPHY. Yeah. I mean—

Dr. HYMAN. There are models for this.

Dr. MURPHY. Absolutely.

Dr. HYMAN. There is actually a program at the Indian Health Service I think in Native American reservations, which is like SNAP. And they get a choice between whole foods or SNAP, and they often choose whole foods, which they have on the reservations. We can expand that to the rest of the Nation.

Dr. MURPHY. Thank you, Mr. Chairman. I yield back.

Chairman BUCHANAN. Mr. Hern, you are recognized.

Mr. HERN. Thank you, Mr. Chairman, for having this important meeting. You know, as a person who actually lived on food stamps many years ago when I was young, and four siblings younger than me lived on food stamps, we had this debate about what can food stamps buy today.

SNAP, let's call it what it is. And there is a debate about, as one of my colleagues said, is that, "Well, the rich people get this." There was a time when that wasn't so. I remember standing in line with my mother, and she would buy some of these things that we are saying are just for everybody now, and I would have to take them back.

You know, you are always getting called by your middle name when your mother is trying to get your attention. And she would say, "Kevin Ray, you can't buy that, and so you got to put it back."

And so there was a time when we cared about nutrition a lot in our families as we were trying to move people onto their feet.

So I have got a series of questions. Dr. Hyman, when I saw you this morning, I said, "Usually I have a big diatribe, then I ask like two questions real hurriedly and use all my time."

But, you know, we do have a nexus, and it is kind of a real tough situation. You all are giving us a problem. And Dr. Murphy said this a minute ago. We hear these problems all the time, but nothing is getting solved. It is getting worse. And that has got to be extraordinarily frustrating. I know you are, because we talked last night and again today.

So I am just going to run through some questions. So you have given us the numbers on obesity, what it is in the United States and how it has continued to grow.

So my question is, are we still measuring the—we get hung up on things being measured differently today than they were 10, 20, 30 years ago. Are we still measuring obesity the same way today that we did 10, 20, 30 years ago?

Dr. HYMAN. Yes, it is defined as—overweight as a body mass in excess of 25 or more. Obese is 30 or more. And, when I graduated medical school, there wasn't a single State with an obesity rate over 20 percent.

Now there is not a single State with an obesity rate under 30, and most are well over 40; 42 percent is the national rate. By 2030, it is estimated that one in two Americans will not be overweight but obese.

Mr. HERN. So you are saying that we have not changed the numbers to make the problem look worse?

Dr. HYMAN. No. The definition is the same. I mean, we can talk about BMI as a valuable metric or not, because body composition turns out to be more important. If you are someone like the Rock, you are a big guy; your body mass index is very high. It doesn't mean you are overweight. It means you have a lot of muscle.

So the definitions are not as clear, but I think the problem we are facing is one of a metabolic dysfunction, which has to do with insulin resistance, which is driven by sugar and starch in our diet. And that is what is driving most of the chronic disease, from heart attack to strokes to cancer and diabetes.

Mr. HERN. While I am not a doctor—I didn't mean to interrupt you, but while I am not a doctor like my two esteemed colleagues

here, you know, I spent a lifetime in business and understanding human nature and was pretty successful at it, and I am pretty successful still to this day.

And there are a lot of really smart people if I could do things for you, I would, but I can't. So we have to incentivize people.

Dr. HYMAN. That is right.

Mr. HERN. In my world of business, we all work in the same models. We all have businesses. But the ones who are really, really successful understand what motivates people to be better in themselves. They don't have to be the most educated, but they can be the best themselves.

And it has got to be extraordinarily frustrating, because you all see the end game. If you don't, you are not going to live as long, friends, if you are obese. It is just not going to happen, or if it is, you are living on borrowed time.

So we are trying to tell people this, but it doesn't change anything. It is only getting worse, as you all have all described. So why is that? Why do people want to live shorter lives?

You know, in a day and age when things are instant gratification, we have to figure out how to incentivize people even beyond their own knowledge or capability, because we know that is going to be good for them. And that is where we need to move into what, are the solutions?

We deal with taxes on this. We deal with tariffs. We deal with all the problems, but it takes a special transition into what are the solutions to this? You can regulate every single business out of the food business.

I spent 35 years in McDonald's, very proud of it. My kids can't gain weight, but they are very active, very athletic, stayed busy all the time. We didn't let them sit on the couch watching video games. They were working daylight to dark, which meant we were as well.

But there is a part to this. One of the fastest growing places in the world on density of restaurants is China. Every major brand that we would demonize that you all did it openly in the United States today are in China, because China wants them there. But Chinese people are very active. They walk a lot. They are high-density populations that are walking a lot.

So there are a lot of opportunities here for us to incentivize this. I am a business guy. I like to figure out solutions. I am an engineer. I like solutions. I get the problem. You guys have written tons of books. You have written tons of documents.

So we don't have an information problem of describing the problem. Everybody in the world knows the United States is obese. Now we have got to move to the resolution, the solving of this.

You have some great examples. We have got to figure out we are going to put a study together and have some businesspeople get involved in fixing this situation. I have got some really great ideas I shared with you last night. I am going to move on it, because who better than a guy who spent 35 years in McDonald's to find a solution to obesity? So I think it is a great place to go.

I want to say thank you all, because it is a big deal. We are spending trillions of dollars. We spent trillions of dollars on the symptoms, but we are not solving the problem.

So thank you, Mr. Chairman, thanks for bringing this up. I know it is a passion of yours. And thank you all for your hard work.

Chairman BUCHANAN. Ms. Sewell.

Ms. SEWELL. Thank you, Mr. Chairman.

I want to thank all of our witnesses here today. Lowering the disproportionate rate of chronic diseases in my district in Alabama has long been one of my top priorities. As a representative of the historic Civil Rights District that includes the towns of Birmingham and Montgomery, my hometown of Selma, I am sensitive to the necessity to increase health equity and lower the rates of chronic diseases for most of America's most vulnerable populations.

Today's hearing presents an opportunity to discuss the need for a comprehensive approach to health policy that addresses the social determinants of health. I heard that from a lot of our witnesses today. It is no secret on this committee that citizens in States like mine experience some of the poorest health outcomes of any State in the country.

In Alabama, 67 percent of the people are living with a chronic disease. That means seven out of 10 people in my district and in my state have at least one chronic disease diagnosis.

Without creating and supporting policies that would address the structural socioeconomic and environmental factors that lead to poor health outcomes, we will continue to experience high rates of chronic diseases. This is why I am a champion of the John Lewis Equity in Medicare and Medicaid Treatment bill, alongside my colleague, Senator Cory Booker.

Under the current law, CMMI is not required to consider social determinants of health, such as the patient's environment, transportation or lack thereof, education, socioeconomic status when implementing and testing new payment models.

This seems to me to be absurd. This lack of consideration for social determinants of health incentivizes health providers to pick patients who will produce favorable clinical outcomes. This oversight leaves women, rural citizens, black and brown people on the sidelines when it comes to developing a payment model. And that is just not fair nor is it equitable.

I would like to invite my colleagues who have not signed onto H.R. 3069 to ensure experts at the Federal Office of Rural Health Policy and other agencies to weigh in on new payment models in Medicare that focus on social determinants of health.

Dr. Peters, can you speak to how important addressing the social determinants of health is for improving healthcare outcomes in underserved communities, like the urban and rural communities that I represent in Alabama?

Dr. PETERS. I appreciate what you are doing. And I can tell you that social determinants of health is something that haunts me to some degree all the time, because I am so aware of the lives of my patients and how difficult they are.

And so often the best doctor for their diabetes is a social worker, because the social worker can help them deal with how to find food or how to get transportation.

And then we specifically have been very successful and we have done programs in our area, like the DPP as well as Look AHEAD, which is a study of weight loss and the treatment of type II diabe-

tes, because my team, my educators come from the community. They work with the community. We have focus groups. We give the community the kind of care and—

Ms. SEWELL. And support that it needs.

Dr. PETERS. Yes, that they need. And then we have peer groups. And so I am really sensitive to the need for communities to engage in trying to help us help them. But, if you give them resources—and then, of course, you have got to give them access to the kinds of medications they need to help them.

Ms. SEWELL. And access to the kinds of nutritional food—

Dr. PETERS. Yes.

Ms. SEWELL [continuing]. That we want them to eat. And then it's sort of an odd thing to say that you have a choice when you don't live within walking distance or even driving distance to a supermarket that has fresh fruits. It is a false narrative to think that somehow they are not going to get the sugary canned fruit if they, you know, try and—

Dr. PETERS. That is how we succeeded in Look AHEAD was we give them meal replacements. And we were successful at sites at Stanford and Yale and wherever else because we actually gave them food. And we gave them—I mean, at that point, it wasn't such great food, but nonetheless you can do it. And I really wanted to make it something that the—

Ms. SEWELL. That you could scale out.

Dr. PETERS [continuing]. Is food.

Ms. SEWELL. No, I hear you. Listen, I feel very fortunate. In my district, we have amazing partners like the Live HealthSmart program sponsored by the University of Alabama-Birmingham that has committed to addressing social determinants of health, if that means a mobile unit that goes around and provides meal replacements or the like.

But the Live HealthSmart program is an example of the type of work this committee should be supporting. The program is committed to removing barriers in education, in good nutrition, physical activity, as well as prevention and wellness.

My constituents have benefited from the Mobile Food Market that has provided access to healthy food options in 25 of the communities that I represent. In addition to providing access to healthy food, the program also revitalizes communities and neighborhoods by building parks and walking paths to encourage physical activity.

I say this to say that we have to focus on social determinants of health and really tackle them if we really are to address chronic diseases. And that may mean that we have to spend some money on the front end on prevention, but then we make it up I would assume on the back end by having less folks with chronic diseases and, you know, long-term death.

So I hope that our committee, Mr. Chairman, will take this hearing and really broaden it to social determinants of health and how our committee can address that.

Thank you, sir.

Chairman BUCHANAN. Mr. Moore, you are recognized.

Mr. MOORE. Thank you, Chairman, for holding this important hearing. Preventing chronic disease should be one of the most im-

portant things we do on this committee. And I appreciate the witnesses for being here today.

Look, folks, we have a problem in this country. Forty-two percent of Americans have two or more chronic diseases. Treatment for chronic disease such as cardiovascular disease, diabetes, cancer and obesity cost Medicare and Medicaid \$384 billion annually. Chronic diseases are a substantial burden on our health system, our economy, and they are obviously a detriment to patients.

More than 40 percent of children are now considered overweight, and more than 20 percent of them are obese. Instead of a society-wide initiative to get kids outside, off screens, on a healthy diet of fruits, vegetables, macros, you name it, we have pediatric clinical guidelines recommending prescription drugs.

We are the richest, most competitive, most innovative country on Earth, and yet our life expectancy is going down. According to CDC, only two in five young adults are both weight eligible and adequately active enough for military service. Our healthcare spending is the leading cause of inflation and one of our biggest debt drivers, but the bottom line is our outcomes are not improving. The system isn't working. We have to do better.

Dr. Peters, in your testimony, you discuss the importance of aligning payment incentives toward payment for health and prevention rather than sickness. Congress has taken several steps over the years to work towards this goal in the Medicare program, through Medicare Advantage and ACOs.

What additional ways can we incentivize value-based or outcome-driven care in the commercial market to prevent the development of chronic diseases?

Dr. PETERS. Well, I think that is a tough issue and obviously one that requires people have consistent access to care through their insurers and maybe creating plans where people have insurance that lasts over longer periods of time.

But I think we need to take some of these things that are best practices that you have heard about and try to use those and put them in other settings, such as the DPP program, which we know has been shown to work for prevention of diabetes, and then maybe augment it and try to help using some of the newer technologies and tools that we have that might make it easier for people to understand the impact of food and nutrition on their lifestyle.

And I think there are more sort of technical answers that my economist pals at the Schaeffer Center could also give you to answer that question more fully.

Mr. MOORE. Senator Frist, anything to add to this?

Dr. FRIST. No. I think the commercial market. The challenge there, of course, is the fact that there is a lot of spinning from plan to plan to plan. So we do need to figure out how to get the data to be able to follow patients over time in order to be able to measure what interventions work and to measure outcomes.

Value-based care is outcomes sort of divided by cost itself. Traditionally, those outcomes have been things like re-admissions, coming to the emergency rooms. We need to move that back upstream and look at things like the root causes, the public health model of root causes like food itself. We just didn't set it—Medicare was not set up that way, and we need to change that over time.

And we have not looked at, truly since 2018, the BBA, we have not really looked at food and nutrition as a root cause today the way that we should do in the dual eligible population, the population of Medicaid and Medicare, those 12 million people. We have not changed anything.

That is where much of the chronic disease, about half a trillion dollars is. And it is a little bit beyond the jurisdiction of this committee, and it is to challenge the way Congress has committees organized.

But that overlap of Medicare and Medicaid dual eligible 12 million people, half a trillion dollars, much of the chronic disease, we need to have integrated care there. And that is where the value-based care will have its greatest impact.

Mr. MOORE. Narrow that down to me. In your mind, legislatively, what can Congress do? It wasn't set up this way. Medicare wasn't set up this way. And to change it requires a catalyst.

Dr. FRIST. Yes.

Mr. MOORE. Because we just let it continue on in perpetuity, and it is the most obnoxious thing that I deal with back in Congress. What can we actually do to create some change on this?

Dr. FRIST. Yeah. I mean, a really simple thing, having sort of again been on that side. I would set up a hearing very quickly. What I just said about the dual eligibles is beyond your jurisdiction. And this is health versus healthcare.

Much of what we talk about is healthcare. We are talking about health, which comes into the social determinants themselves.

So the first thing I would do is set up an integrated hearing between the two appropriate committees in the House to look at those 12 million people—I just told you it hasn't been changed in 5 years—and say, how do we get an integrated model of health and healthcare and value-based care, and have that discussion for the first time in Washington, D.C., in our government.

Mr. MOORE. Thank you.

Dr. Hyman, quickly, you have led the charge on food as medicine. How do we incentivize better diet through healthcare without the mandates?

Dr. HYMAN. Well, I think a lot of it has to do with knowledge and education. I have been shocked at how little people, even educated people, know about what to eat or what not to eat. I think that is a result of the confusing amount of information in the media and in science. Nutrition science is funded 12 times more by the food industry than by the NIH.

I think one of the key strategies to work around is behavior change. And I think this is something that we do know a lot about, because, at the end of the day, it is about behavior change and how do you incentivize that.

And we discuss the social determinants of health. I learned from Paul Farmer, who treated TB and AIDS in Haiti using not better medications or surgery, but by using the power of community health workers to help people change their behaviors.

And I scale this model to the Saddleback Church in Orange County, California, with Rick Warren, where we got 15,000 members of that church to do a lifestyle change program in small groups, not run by a doctor, not run by a nutritionist or any

healthcare provider or health coach, just a curriculum that was supported by the church in little groups every week.

They lost a quarter of a million pounds in a year and transformed their lives without medications, ended up, you know, reducing hospitalizations. We scaled that to Cleveland Clinic, where we created a Functioning for Life program. And we showed that we have three times better outcomes, the same patient with the same diagnosis with the same doctor, simply by using the power of group therapy.

Janet, I mentioned to you, she was in a group program, a lifestyle change program. If we reimbursed for things that work and behavior change strategies, it is really around understanding the nature of these social models, of these social models of change.

And I think the Blue Zone is an example. They are a natural environment, and I have been there. I wrote a book called "Young Forever" about the Blue Zones, where they live in ways that automatically create health. They automatically eat healthy food. They automatically have to move, because they live in rugged environments. They automatically have social connection and meaning and purpose in their life. These are the things that drive longevity, not genes.

And so those are things that we can replicate. You are more likely to be obese if your friends are overweight than your family is overweight. You are 171 percent more likely to be obese if your friends are overweight than if your family is, 40 percent.

So this is something we actually can do and reimburse. So the reimbursement for these group social lifestyle change programs I think is a very important thing that we can implement.

Mr. MOORE. Appreciate that. Thank you.

Chairman BUCHANAN. Thank you.

Mrs. Miller, you are recognized.

Mrs. MILLER. Thank you, Chairman Buchanan.

And thank all of you all for being here today. And, Senator Frist, it is nice to have you back.

Thank you for taking your time to be here to help educate us and to testify on such an important issue. It is extremely personal to me and my constituents, because I am from West Virginia. And West Virginia has the highest rate of diabetes, COPD, and kidney disease in the country.

This is nothing to brag about, but it is something that constantly guides my work and the work of healthcare providers in my home state.

One effort that I have been very impressed by is the Food is Medicine program at Marshall Health Network that is in my own hometown of Huntington. The Food is Medicine program screens patients for food insecurity and social needs, provides medically indicated food assistance, and encourages nutritious food utilization.

And this approach to chronic disease management has been working wonders for patients in our state. There is a Medically Indicated Food Box program in the tiny little town of Lavalette, which is led by a community health worker. And it recently showed that all 61 patients participating in the program have gotten their blood pressure under control.

Similar food assistance programs provided to dialysis and oncology patients with food insecurity have improved nutrition and outcomes as well.

Dr. Hyman, you have dedicated your career to the notion that food plays a huge part of managing chronic disease. Can you speak a little bit more on some of the benefits of getting patients on track for healthier living?

Dr. HYMAN. Well, it is quite astounding. You know, I have been practicing this way for 30 years, and I would say that food is the most powerful tool in my toolkit as a doctor for a broad range of diseases.

Obviously, diabetes but many other things. Mental health we know is directly related to diet, that ultraprocessed food has been linked to depression, anxiety, behavior changes in kids and adults.

We know from clinical trials, for example, in other countries where they swap out healthy food for the junk food, that depression rates are dramatically reduced. We know for autoimmune diseases, for neurodegenerative diseases—for example, dementia, which is one of the most costly diseases because of the effect on caregivers and loss of productivity, it is now called type III diabetes—because of the effect of insulin resistance and sugar on the brain.

So, across the spectrum of chronic disease, not just the ones we typically think of, like heart disease and diabetes and hypertension, but even cancer is primarily driven by sugar and starch in our diet. The main cancer is colon cancer, breast cancer, prostate cancer, pancreatic cancer. And these cancer rates are rising. We are seeing it in younger and younger members of our population, in 30-, 40-year-olds.

Mrs. MILLER. Repeat that, that statement right there.

Dr. HYMAN. We are seeing cancer in younger and younger people in our country, which is staggering to me, in their thirties and forties.

Mrs. MILLER. Yes.

Dr. HYMAN. And the real driver is our diet. And, until we come to terms with this fact as a country, we are going to not only threaten the health of our Nation. We are challenging our economy. Of the \$4.9 trillion, 40 percent of that bill is footed by the federal government in one program or another. It is 30 percent of our federal budget. It is completely unsustainable, and most of it is almost preventable.

So, if we tackled this intelligently, coherently, and looked across policies that have to be done, as Senator Frist said, across different committees and across different jurisdictions, whether it is Medicare reform, whether it is food labeling, front-of-package label from the FDA or addressing the problems of food marketing to children or addressing the problems at SNAP or looking at our dietary guidelines or nutrition research funding.

There are so many levers to pull as we try to sort of change this tsunami that is coming at us. It is almost as an invisible threat, because when we graduated medical school this wasn't a problem.

Mrs. MILLER. No, it wasn't.

Dr. HYMAN. And, you know, I am old but not that old.

Mrs. MILLER. I would like to move on a little bit as well, because chronic lifestyles in patients, we also need to listen to the cli-

nicians, because they have a big role to play here, just with screening and education and identifying the chronic diseases and how to manage them.

Studies have overwhelmingly showed us that the screenings for diabetes, cholesterol, chronic kidney disease, and cancers can be the difference in anybody's health journey.

I introduced a bill called the Chronic Kidney Disease Improvement in Research and Treatment Act to address these issues just for kidney disease. And my bill would expand the Medicare annual wellness benefit to include kidney disease screening for seniors, as many patients do not know that they have kidney disease until it is too late.

The bill would also increase access to the Medicare kidney disease education benefit so that physicians, as you all are, can help teach patients more about managing their disease and any of the comorbidities that they may have and not know.

And so I am happy to have voted in favor for—and she is already gone, but the Nancy Gardner Sewell Medicare MultiCancer Early Detection Screening Coverage Act—earlier this year, my dear friend Terri, about her mother—which would help screening with cancer for Medicare patients to ensure that they have the best information about their health that they could.

Now, Dr. Peters, you have done tons of work surrounding preventive care for chronic diseases.

Can you speak to the clinical benefits of increasing education and screening so that patients are more informed about their options?

Dr. PETERS. I think those are incredibly powerful tools, because if you don't know you have a risk you are not going to go find out and see if you can do anything about it.

But education alone in many areas, particularly with diabetes, isn't enough. You need to couple that with treatment. And treatment, frankly, should start with lifestyle. And so I see all of it as part and parcel of the same process.

But education is necessary so people realize that they must do something. And I think that people go into these weird states of denial. And I am not a psychologist, but they will see family members who are blind or on dialysis, and they won't go get tested because they are too afraid to find out they have the same disease.

So I think it is a—you know, you can get educated. We have done programs with the churches. We have done programs with the schools. There are all sorts of ways that you can get this out here.

Mrs. MILLER. I have to yield back my time. You all, thank you so much.

Dr. HYMAN. Can I make a comment?

Mrs. MILLER. Is he allowed to make a comment?

Chairman BUCHANAN. Quick.

Dr. HYMAN. Just quick. I think screening is really important. I think we wait too late. We are reactive, not proactive in medicine. And it is part of why I cofounded a company, Function Health, to allow people access to their own biological data without having to go through insurance or doctors.

For 499, they get 110 biomarkers that track all these things, from kidney function to cardiovascular health to metabolic health, and diagnostics that are not done at your annual physical.

And we are so behind the times. Senator Frist wrote an incredible paper that was in the Journal 20 years ago that talked about how long it takes for science to become clinical practice. And I think early screening and detection is important. It is essential. And I think it is something that should be looked at very carefully as something we can motivate our Medicare patients to do as well as our citizens in general to do early screening and detection.

Mrs. MILLER. Thank you so much. Thank you all.

I yield back.

Chairman BUCHANAN. Ms. Chu, you are recognized.

Ms. CHU. Dr. Gearhardt, thank you so much for your testimony. I am a clinical psychologist myself, so it is always wonderful to see another clinical psychologist. And I was heartened to hear about your firsthand experience working with those who are struggling with life-threatening health conditions.

As we talk about access to nutritious foods and their role in preventing and treating chronic illness, I am especially concerned about how this issue is impacting our Nation's seniors.

Roughly 7 million older adults are struggling with food insecurity, which ultimately leads to poorer health outcomes, lower nutrition intakes, and mental health issues, including eating disorders.

While eating disorders are often thought of as a young person's disease, eating disorders in older adults have a mortality rate of over 20 percent. If left untreated, eating disorders can lead to heart failure, diabetes, and other serious chronic illnesses.

That is why I have introduced a bill with Congress Member Fitzpatrick called the Nutrition CARE Act, which would finally provide medical nutrition therapy services for individuals diagnosed with an eating disorder on Medicare.

Medical nutrition therapy is an evidence-based medical approach to treating chronic conditions through an individualized plan, but the service is not covered under Medicare for eating disorders treatment.

Dr. Gearhardt, given the rising concerns about over-processed foods and their impact on chronic illness, how can medical nutrition therapy help to ensure that seniors on Medicare receive adequate nutrition to support long-term health and well-being?

Ms. GEARHARDT. Thank you for bringing up this really important issue. Eating disorders are often very overlooked broadly, despite them having some of the highest mortality of any mental health conditions.

And, overwhelmingly, when we look at eating disorders, the sorts of foods that seem to trigger this loss of control over intake and intense cravings are these ultraprocessed foods, that overwhelmingly these are the sorts of foods that people binge on and crave irresistibly.

And, often, when we can actually nourish people and help them reconnect with food and also their body by helping them realize what it feels like to feel full and to feel nourished by the sort of real minimally processed foods we are talking about today, that can make a big difference.

We did a poll with the Institute for Health Policy and Innovation at the University of Michigan with a nationally representative sample of older adults. And, looking at that addictive profile of hav-

ing that addictive relationship with ultraprocessed foods, we found that one out of every four women 55 and older would have met with a diagnosis of an addiction if that substance was an ultraprocessed food. This is associated with worse physical and mental health and social isolation.

So I think the more we can get our older adults access to healthy nutritious food in a convenient, affordable way will really benefit us across multiple domains.

And we referenced here today dementia, Alzheimer's. I don't think we have fully seen the consequences of our diet on our cognitive well-being, because it is only my generation that has lived their whole life in a predominantly ultraprocessed food environment. And so I think this is going to continue to grow as we age into older and older cohorts unless we do something now to address our food environment.

Ms. CHU. Thank you for that.

Dr. Gearhardt, I also want to highlight the rise of another chronic illness, addiction and substance use disorder. This crisis is worsening like other chronic illnesses. And it is a long-term condition that requires ongoing management and takes an extreme toll on physical and mental health.

As we discuss strategies to combat chronic disease development, it is critical that we help leverage social support systems, such as friends, families, and peer groups to encourage and maintain healthier behavior.

So that is why I have worked with my colleague on this committee, Congressman Adrian Smith, to introduce the PEERS in Medicare Act. A peer support specialist is a person with lived experience who has been trained to support those who struggle with mental health, psychological trauma, or substance abuse. And they supplement mental health professionals as part of the care team struggling with substance abuse or mental health disorders.

Our bill would require Medicare to cover peer support services at rural health clinics, federally qualified health centers, community mental health centers, and certified community behavioral health clinics.

Dr. Gearhardt, can you say something about the utilization of these kind of specialist peers who can help individuals better manage their mental and physical health conditions?

Ms. GEARHARDT. Absolutely. I have had the opportunity to treat individuals with substance use disorders, particularly at the VA Hospital in Ann Arbor. And I can't tell you how essential peer-led support groups that have really flourished in the context of addictive treatment, like 12-step programs, can play such an essential role.

We see that behavior change is really more effective when it is supported by other people, and you feel like you are part of a group and a social network who supports you. These sorts of mental health conditions aren't just short term. They are often lifelong changes.

And we don't have enough mental healthcare providers in the United States, particularly in rural areas, to provide the sort of chronic care that is needed to help people sustain these behavioral changes.

Peer supports can help people connect to others who understand what they are going through, reduce stigma, and promote lifelong change in a way that is affordable and accessible, and especially areas that are underserved by mental health professionals.

Ms. CHU. Thank you. I yield back.

Chairman BUCHANAN. Mrs. Steel, you are recognized.

Mrs. STEEL. Thank you, Mr. Chairman. And this is a really important issue, and thank you to all the witnesses coming out today.

You know, usually I don't eat junk food like this, and I stopped in the middle of this because we are talking about nutritious food. So thank you.

And then, you know, Dr. Frist, I was invited to your office when you were a Senator, and Secretary Chao and a few of us had dinner, and we discussed about this too. So thank you so much for coming out today.

Currently, 129 million people in the U.S. have at least one major chronic disease, and an increasing proportion are dealing with multiple chronic diseases. This creates a personal impact and a substantial effect on our entire healthcare system.

We all must look at ways of addressing chronic disease, and I believe part of the problem is lack of access. To prevent chronic disease, I agree it is important that we must work to improve convenient access to high-quality and nutritious food that I always eat at home. Only come to committee meetings like this that I ended up eating some junk food, but—

And, to manage chronic disease, I believe Congress has the ability to put patients and doctors back in charge of healthcare.

Last year, our committee passed the Telehealth Expansion Act, which would ensure access to telehealth services for those with high-deductible health plans and health savings account. This will improve access to affordable care and increase patients' choice. Congress must immediately pass this bill before the policy expires by end of this year.

I also thank the committee for including the SPEAK Act in our most recent telehealth markup, which will address language barriers in managing chronic diseases.

Another way we can manage chronic diseases is through innovative plans, including special needs plans. Today, we have a key witness from my district who has designed a unique plan for seniors who have severe and disabling chronic condition.

And, Dr. Rinaldo, can you walk me through how SCAN developed the programs for these specific groups of seniors? What kind of requirements from CMS do special needs plans need to comply with in order to target specific diseases?

Dr. RINALDO. Thank you, Representative Steel.

SCAN is proud to offer multiple special needs plans for members with chronic conditions. As I mentioned previously, three plans that we offer are Balance, Heart First, and VillageHealth.

Balance is our special needs plan for our diabetic members, where they receive no-cost insulin and low-cost drugs, no-cost diabetic supplies and no-cost diabetic self-management training.

We also have Heart First, which offers zero-dollar cardiology visits as well as low-cost cardiac and pulmonary rehabilitation.

And, for our members with end-stage renal disease, we offer no-cost nephrology visits as well as a nurse that works with the patient, their family members, and their providers to basically coordinate their care and ensure they are receiving the highest value from those services.

For all of our chronic condition plans, CMS requires that we create a model of care that is specifically tailored to that chronic condition, which the agency then approves. We also train all of our in-network providers on this model of care to ensure they are delivering the highest quality care that is in line with the model.

And, finally, CMS also requires all special needs plans to conduct health risk assessments, which we use as a powerful tool to uncover the social determinants of health that are driving outcomes for our members.

So, in addition to having chronic diseases, they may also have transportation or food insecurity, and we can address those things by adding wraparound services like free rides and home-delivered meals to assist in their clinical trajectory.

Mrs. STEEL. Thank you. Just yesterday, my bill to expand telehealth access for people with limited English proficiency passed on the House floor. And, in your testimony, you mentioned that SCAN's benefit design gives patients 24/7 access to telehealth services.

Can you speak further about how Medicare Advantage special needs plan benefits allow SCAN to offer wraparound benefits of patients to improve their overall health, and could you share how your supplemental benefits address the cultural needs of your members, especially for those nonspeaking English beneficiaries?

Dr. RINALDO. Thank you for the question. SCAN really shares your commitment to ensuring that people with limited access and especially limited English proficiency have access to services and care whenever they need it. That is why we, along with our partners, have developed benefits and services that include 24/7 care through a telehealth benefit, and we continue to improve and add to these capabilities for our members with English—limited English proficiency so that they may obtain care.

This includes partnering with our telehealth providers, which have clinicians that represent the communities that they serve, including primarily English and Spanish speakers. They also have an interpretation service that they can use to offer over 300 languages to members who call in who don't speak those languages.

And then on the health plan side we have member service advocates who offer assistance to members in languages like Korean, Mandarin, Cantonese, and Vietnamese, and we are continuing to ramp up recruiting for this additional staff going into our open enrollment period.

Mrs. STEEL. Thank you. Actually, my time is up, so thank you so much for your answer, and you know what? If you want to put more information into it, then you can just send them to us.

Thank you very much, Mr. Chairman. I yield back.

Mr. BUCHANAN. Mr. Davis, you are recognized.

Mr. DAVIS. Thank you, Mr. Chairman.

Let me thank all of you for your testimony and the insightful information that you have provided. As I listen, I was thinking about

the district that I represent, which is a very diverse district. In our city, we name areas based on where people live and how they got there, so I represent Greektown. I represent Chinatown. I represent Little Italy. I represent Brownsville. I represent city and suburbs. I represent upscale and low income. It seems to me that some—there are huge gaps in health status in my district, as much as 25, 30 points in some lineups.

And it seemed to me that the health status that stands out the most in terms of differentials is between districts or areas that are low-income and areas that are not as low-income. And, of course, many of the groups have a tendency to have diets based upon hereditary factors and, of course, also based on income.

Dr. Gearhardt, could you share some thoughts relative to how do we—I have been around health conversations now for about 40 years. We have essentially the same ones that we had when I started. Could you share some thoughts? How do we really deal effectively with this?

Dr. GEARHARDT. My pleasure. And I think your instincts are accurate, what we see in the data that health and how it shows up really has a lot to do with your zip code and how much money you have and how much time you have to spend on food. I think, you know, I've been really struck by our panel and how much we are kind of agreeing a lot about there is real nourishing food and then there is hyper-engineered ultraprocessed foods that are making us ill.

And I think that hasn't been reflected in our policies, in our communication to the American public and FDA labeling and USDA guidelines. And kind of a little bit of an elephant in the room is that there is a multi-billion dollar processed food and beverage industry that is really who is benefiting and profiting off of the current status quo. We know very little about how these ultraprocessed foods and beverages are being designed in a way that make it hard for us to eat for our health.

The industry will say we are trying to maximize "craveability" and use a sense of nourishment so people want to eat more and more and more, but all of that information is kind of locked behind closed doors. So I think if there was an agreement in government policy with places like the FDA and USDA, taxation that really focused on we know what real nourishing foods are, fruits and vegetables, beans, legumes, and we know the sorts of foods that are making us ill and we made that clear and in a system that promoted access and affordability for all people, it would really make a difference.

There is a lot of targeted racial and ethnic marketing. We know that children who are black and Hispanic and who are economically disadvantaged are exposing—are exposed to more ultraprocessed food and beverage ads than their more well-resourced non-Hispanic white counterparts. We are not all living in the same food environment. And so we have to do things to kind of even the playing field so everybody has the same access to nourishing food and aren't being targeted in ways that make it very challenging to resist these products that have been designed to tempt you.

Mr. DAVIS. Let me just end by, I guess, health education, health awareness, health promotion probably is as much help to these individuals understanding that ultimately it is them to a degree that is going to have to take much of the responsibility for their being and their health. So I thank you, Mr. Chairman.

Mr. BUCHANAN. Thank you.

Mr. DAVIS. I yield back.

Mr. BUCHANAN. Mr. Fitzpatrick, you are recognized.

Mr. FITZPATRICK. Thank you, Chairman Buchanan, for holding this very important hearing on investing in a healthier America by evaluating chronic disease prevention and treatment. Our nation invests less than three percent of our overall health expenditures on prevention services. All the while, there are 1.7 million people that die from chronic diseases each and every year, many of which are preventable.

Moreover, about 42 percent of Americans have two or more chronic diseases, and as members of Congress, we should be prioritizing and investing in prevention and living healthier lives, hence the purpose of today's hearing.

This is also one of the reasons why I co-led the introduction of the Personal Health Investment Today Act, also known as the PHIT Act alongside our colleagues Representative Kelly, Representative Panetta, Representative Hood, Representative Sewell, and Representative Boyle. This bipartisan, bicameral legislation encourages physical activity and incentivizes healthier living by allowing Americans to use a portion of the money saved in their pretax health savings account, HSAs, and flexible spending accounts, FSEs, toward qualified sports and fitness activities.

Mr. Chairman, I would like to submit for the record a letter sent to our committee as well as an attachment both from the Health and Fitness Association on the benefits of physical activity for preventative health and chronic disease reduction.

[The information follows:]

HEALTH & FITNESS ASSOCIATION

September 18, 2024

The Honorable Jason Smith
Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable Richard E. Neal
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Chairman Smith and Ranking Member Neal,

On behalf of the Health & Fitness Association (HFA) and our member organizations, I would like to submit this letter for the record regarding the House Ways and Means Health Subcommittee hearing titled Investing in a Healthier America: Chronic Disease Prevention and Treatment. We strongly believe that increasing access to physical activity is one of the most effective investments Congress can make in preventive health for all Americans.

HFA is the leading trade association dedicated to enhancing mental and physical health in the United States by increasing access to physical activity. Our organization represents over 55,000 health and fitness businesses, which contribute over \$22 billion to the economy each year and employ more than 434,000 workers. Most importantly, our members help patrons live healthier lives, strengthening immune systems, increasing productivity, and enhancing overall happiness, all of which lead to positive public policy outcomes such as the reduction of overall healthcare costs.

The chronic disease crisis in America is well-documented, with conditions such as diabetes, heart disease, and obesity imposing staggering health and economic burdens on our country. Physical inactivity is a significant contributor to these diseases. According to the CDC, nearly 80% of U.S. adults do not meet the recommended levels of aerobic and muscle-strengthening activities, despite the clear benefits of exercise in preventing and managing chronic conditions. Research shows that regular physical activity reduces the risk of chronic diseases, improves mental health, and lowers healthcare costs. In light of these findings, Congress must take steps to encourage greater physical activity across all age groups.

We urge the Committee to consider the passage of the Personal Health Investment Today Act (H.R. 1582), which would be a critical step toward enabling Americans to invest in preventive physical activity. The PHIT Act would allow individuals and families to use pre-tax dollars from Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs) to cover fitness-related expenses, such as gym memberships, exercise classes, and youth sports fees. By

making fitness more affordable, this legislation would empower millions of Americans to prioritize their health, thereby reducing the long-term costs of chronic disease treatment.

The need to incentivize youth sports participation is particularly pressing. The rising costs of youth sports in the United States are pricing many families out of these essential activities. The average cost of participating in a single youth sport can exceed \$900 annually, with costs climbing significantly higher in competitive leagues. This creates barriers for families and leads to lower participation rates, depriving children of the physical, mental, and social benefits of sports. Passage of the PHIT Act would help lower these barriers by making youth sports more affordable, fostering healthier habits in children that can last a lifetime.

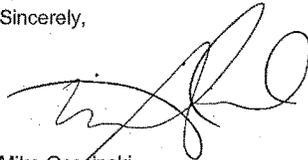
Public support for the PHIT Act is overwhelming. Recent polling conducted by the Health & Fitness Association in 2023 found that 86.5% of Americans believe Congress should allow HSAs and FSAs to cover fitness-related expenses, with bipartisan support—82.3% of conservatives and 91.6% of progressives favoring the bill. Additionally, over half of Americans (50.8%) say they would use these accounts for fitness-related expenses, and 58% report they would be more likely to exercise regularly if the PHIT Act were passed.

The public also recognizes the broader societal benefits of the PHIT Act. More than 74% of Americans support the bill, knowing it could save taxpayers over \$30 billion annually through improved public health outcomes. By investing in fitness, Congress has the opportunity to reduce the financial burden of preventable diseases and ensure more Americans live healthier, more active lives.

As you consider policy solutions to address chronic disease prevention, we strongly encourage the passage of the PHIT Act. This forward-thinking legislation will not only reduce healthcare costs but will also help Americans of all ages, backgrounds, and income levels engage in physical activity to improve their health and well-being.

Thank you for your leadership on these important issues. We look forward to working with you to promote healthier lifestyles for all Americans.

Sincerely,



Mike Gosdinski
Vice President of Government Affairs
Health & Fitness Association

Cc: Members of the U.S. House Ways and Means Committee

Attachments: Physical Activity for Preventive Health and Chronic Disease Reduction.pdf

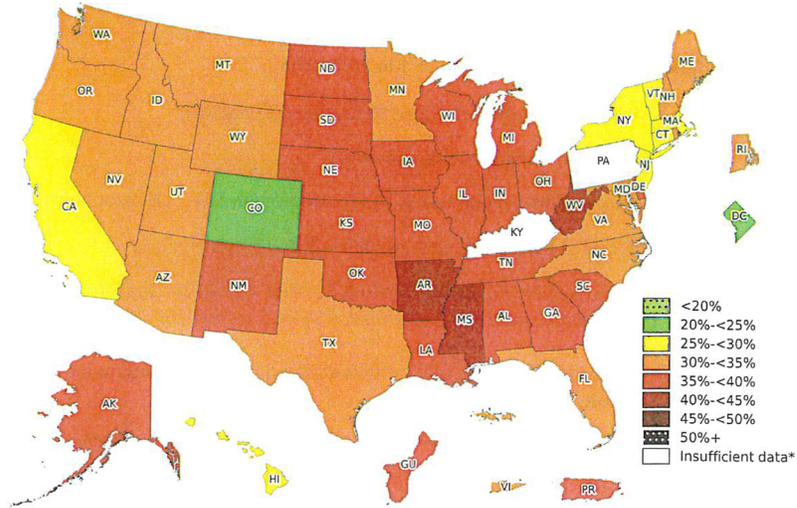
United States House Committee on Ways & Means

Health Subcommittee Hearing on Investing in a Healthier America: Chronic
Disease Prevention and Treatment, September 18, 2024

Resources in Support of Investing in a Healthier, More Active America

- I. [Prevalence of Self-Reported Physical Inactivity Among U.S. Adults by State & Territory](#)
- II. [Prevalence of Obesity Among U.S. Adults by State](#)
- III. [Key Facts on Physical Inactivity in the United States](#)
- IV. [The Benefits of Physical Activity for Brain Health](#)
- V. [Infographic: Health Benefits of Physical Activity for Adults 65 and Over](#)
- VI. [Infographic: Health Benefits of Physical Activity for Adults](#)
- VII. [Infographic: Health Benefits of Physical Activity for Children](#)
- VIII. [Background on Personal Health Investment Today \(PHIT\) Act](#)
- IX. [Executive Summary on Consumer Polling Data for PHIT Passage](#)

Prevalence of Obesity Among U.S. Adults by State



Source: [U.S. Centers for Disease Control & Prevention](#)

Key Facts on Physical Inactivity in the United States

Physical Inactivity

➤ **Physical inactivity contributes to 1 in 10 deaths**

Source: [U.S. Centers for Disease Control & Prevention](#)

➤ **Physical inactivity drives healthcare costs**

- Inactivity costs the entire U.S. healthcare system \$84.7 billion annually
- The cost to the public health system is \$39.9 billion annually

Source: *Deloitte Economic Health & Societal Wellbeing: Quantifying the Impact of the Global Health & Fitness Sector - Global Report (2022)*

➤ **The loss of productivity due to insufficient physical activity reduces annual GDP by \$142 billion**

Source: *Deloitte Economic Health & Societal Wellbeing: Quantifying the Impact of the Global Health & Fitness Sector - Global Report (2022)*

➤ **64.9 million Americans (ages 6+) are totally inactive**

Source: *Sports & Fitness Industry Association, 2024 Sports, Fitness, and Leisure Activities Topline Participation Report*

➤ **Disparities exist across income levels**

- The inactivity rate is 13.1% in households with annual income greater than \$100,000
- The inactivity rate is 38.2% in households with annual income less than \$25,000

Source: *Sports & Fitness Industry Association, 2024 Sports, Fitness, and Leisure Activities Topline Participation Report*

➤ **Race/ethnicity disparities exist among inactivity rates for adults outside of work**

- Non-Hispanic Asian: 20.1%
- Non-Hispanic White: 23%
- Non-Hispanic American Indian/Alaska Native: 29.1%
- Non-Hispanic Black: 30%
- Hispanic or Latino/a: 32.1%

Source: [U.S. Centers for Disease Control & Prevention](#)

The Benefits of Physical Activity for Brain Health

Outcome	Population	Benefit	Acute	Habitual
Cognition	Children ages 6 to 13 years	Improved cognition (performance on academic achievement tests, executive function, processing speed, memory)	●	●
	Adults	Reduced risk of dementia (including Alzheimer's disease)		●
	Adults older than age 50 years	Improved cognition (executive function, attention, memory, crystallized intelligence,* processing speed)		●
Quality of life	Adults	Improved quality of life		●
Depressed mood and depression	Children ages 6 to 17 years and adults	Reduced risk of depression Reduced depressed mood		●
	Adults	Reduced short-term feelings of anxiety (state anxiety)	●	
Anxiety	Adults	Reduced long-term feelings and signs of anxiety (trait anxiety) for people with and without anxiety disorders		●
	Adults	Improved sleep outcomes (increased sleep efficiency, sleep quality, deep sleep; reduced daytime sleepiness, frequency of use of medication to aid sleep)		●
Sleep	Adults	Improved sleep outcomes that increase with duration of acute episode	●	

- > "Acute" refers to an effect that happens immediately after a session of moderate to vigorous physical activity
- > "Habitual" refers to an effect that is consistent with regular sessions of moderate to vigorous physical activity

Source: [U.S. Department of Health and Human Services. Physical Activity Guidelines for Americans, 2nd edition. Washington, DC: U.S. Department of Health and Human Services; 2018.](#)

Health Benefits of Physical Activity

FOR ADULTS 65 AND OLDER



IMMEDIATE

A single bout of moderate-to-vigorous physical activity provides immediate benefits for your health.

Sleep
Improves sleep quality



Less Anxiety
Reduces feelings of anxiety



Blood Pressure
Reduces blood pressure



Emerging research suggests physical activity may also help boost immune function.

Nieman, "The Compelling Link," 201-217.
Jones, "Exercise, Immunity, and Illness," 317-344

LONG-TERM

Regular physical activity provides important health benefits for chronic disease prevention.



Brain Health
Reduces risks of developing dementia (including Alzheimer's disease) and reduces risk of depression



Heart Health
Lowers risk of heart disease, stroke, and type 2 diabetes



Cancer Prevention
Lowers risk of eight cancers: bladder, breast, colon, endometrium, esophagus, kidney, lung, and stomach



Healthy Weight
Reduces risk of weight gain



Independent Living
Helps people live independently longer



Bone Strength
Improves bone health



Balance and Coordination
Reduces risks of falls



Source: Physical Activity Guidelines for Americans, 2nd edition

To learn more, visit: <https://www.cdc.gov/physicalactivity/basics/basics/health-benefits-of-physical-activity.html>

June 2023

Health Benefits of Physical Activity for Adults

IMMEDIATE

A single bout of moderate-to-vigorous physical activity provides immediate benefits for your health.

LONG-TERM

Regular physical activity provides important health benefits for chronic disease prevention.

Sleep
Improves sleep quality

Brain Health
Reduces risks of developing dementia (including Alzheimer's disease) and reduces risk of depression

Less Anxiety
Reduces feelings of anxiety

Heart Health
Lowers risk of heart disease, stroke, and type 2 diabetes

Blood Pressure
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Cancer Prevention
Lowers risk of eight cancers: bladder, breast, colon, endometrium, esophagus, kidney, lung, and stomach

Emerging research suggests physical activity may also help boost immune function.
 Nieman, "The Compelling Link," 201: 217.
 Jones, "Exercise, Immunity, and Illness," 317-344.

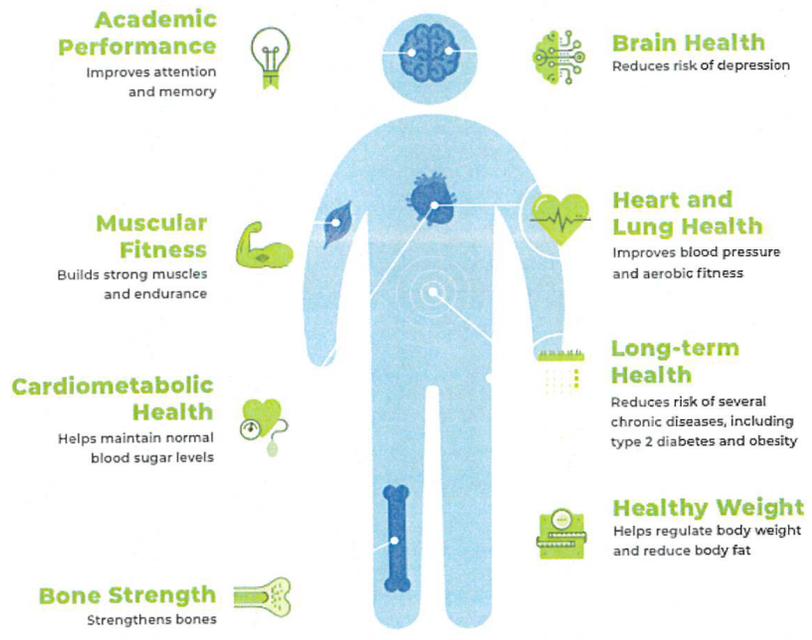
Healthy Weight
Reduces risk of weight gain

Bone Strength
Improves bone health

Balance and Coordination
Reduces risks of falls

Source: *Physical Activity Guidelines for Americans*, 2nd edition
 To learn more, visit <https://www.cdc.gov/physicalactivity/basics/adults/health-benefits-of-physical-activity-for-adults.html> August 2020

Health Benefits of Physical Activity FOR CHILDREN



Source: Physical Activity Guidelines for Americans, 2nd edition

To learn more, visit: <https://www.cdc.gov/physicalactivity/basics/adults/health-benefits-of-physical-activity-for-children.html>

October 2021

Personal Health Investment Today (PHIT) Act

Bill Information
H.R. 1582

Republican Staff:
Quinn Ritchie
Rep. Mike Kelly (PA-16)
quinn.ritchie@mail.house.gov

Democrat Staff:
Seamus McKeon
Rep. Jimmy Panetta (CA-19)
seamus.mckeon@mail.house.gov

Industry Coalition:
Mike Goscinski
VP of Government Affairs
Health & Fitness Association
mgooscinski@health&fitness.org

The Personal Health Investment Today (PHIT) Act allows individuals to use funds from pre-tax accounts, including flexible spending accounts (FSA) and health savings accounts (HSA), to pay for physical activity expenses, such as gym memberships, fitness equipment, and youth sports fees. This will ensure that Americans receive favorable tax treatment for investing in activities that directly benefit their own or their children's physical and mental health.

What PHIT Does

- Amends Internal Revenue Code to treat physical activity as preventative healthcare covered under allowable FSA/HSA spending, similar other health related items like glasses, over the counter products..
- Allows a medical care tax deduction for up to \$1,000 (\$2,000 for a joint return or a head of household) of qualified sports and fitness expenses per year.
- Limits spending to youth sports and physical activity, including fitness facility memberships, physical exercise or activity programs, or equipment for a physical exercise or activity program.

PHIT Facts

Over 90 Million Americans currently utilize HSAs/FSAs with an eligible household income of \$57,000 a year. Yet, many are apprehensive to utilize these tax-free savings due to a fear of miscalculating yearly expenses. PHIT serves as a key educating tool showing tangible expenses.

Endless nonprescription items sold by retailers, drug stores, and suppliers are eligible expenses yet the undisputable preventative health benefits of physical activity are not due to IRS treatment.

Approximately half of all FSA users forfeit a combined \$400-500 million each year, reverting funds back to employers that could be used on qualified preventative health benefits of physical activity and youth sports.



Americans Overwhelmingly Support the PHIT Act and are More Likely to Exercise if Passed

Polling conducted by the Health & Fitness Association (HFA) in late 2023 highlights the untapped potential of Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs) to promote physical activity and improve public health. Today, over 90 million eligible Americans utilize these accounts through their employers. However, many hesitate to fully utilize these tax-free benefits, often due to concerns about miscalculating expenses. As a result, 58.2% of beneficiaries spend less than \$1,000 annually from their accounts, while over a third (34.7%) leave at least \$1,000 unspent by the end of the year. This forfeiture results in a combined \$400 to \$500 million returning to employers every year—something nearly 9-in-10 users (88.4%) are unaware of.

Given the level of underutilization, it's not surprising that Americans overwhelmingly support expanding the scope of HSAs and FSAs to cover fitness-related expenses under the proposed PHIT Act. An overwhelming 86.5% say Congress should allow these accounts to help pay for exercise and fitness costs, with strong bipartisan support—82.3% of conservatives and 91.6% of progressives—favoring the bill's passage.

If the PHIT Act is authorized, its impact could be substantial. Over half of Americans (50.8%) say they would use their accounts for fitness-related expenses, and a majority (58.0%) report they would be more likely to exercise regularly. This demonstrates the real potential of the PHIT Act to drive behavior change and promote healthier lifestyles on a national scale, offering a tangible solution to encourage more Americans to get active.

Beyond individual benefits, the public recognizes the broader health implications of the PHIT Act. Nearly 76.4% of Americans say they are more likely to support the Act knowing it could increase physical activity, reduce smoking, and lower obesity rates. Additionally, 74.6% would be more likely to support the Act knowing it could save taxpayers over \$30 billion annually through improved public health outcomes.

Taken together, these findings demonstrate strong public backing for the PHIT Act. Congress has a clear opportunity to promote healthier lifestyles and reduce healthcare costs by enabling Americans to use HSAs and FSAs for fitness-related expenses.

Methodology

J. Wallin Opinion Research, on behalf of HFA, conducted an online survey from October 31 to November 2, 2023, among a nationally representative sample of 1,000 Americans aged 18 and over. The margin of error is +/- 3.1% (95% confidence interval) and greater among subgroups.

Mr. FITZPATRICK. My first question is for Dr. Hyman. Doctor, good to see you again. According to your testimony, you state, quote, we do not practice evidence-based medicine in America. Instead, we practice reimbursement-based medicine. Dr. Hyman, in your experience, what do you think Congress should do specifically to incentivize health outcomes associated with healthier living rather than reimbursement-based medicine?

Dr. HYMAN. Thank you, Congressman Fitzpatrick. Good to see you again as well. I think this is a critical question and it is multi-dimensional and I think we have covered a lot of these potential solutions. I think covering food as medicine within Medicare is our first step, and nutrition services is critical.

I think incentivizing providers to do the right thing by paying for nutrition services is critical. Dealing with the behavior change aspect by reimbursing, for example, group programs, like the diabetes prevention program works effectively even if it is delivered by a layperson. It is effective as if it is developed by—delivered by a physician. We saw this with the Saddleback Church. You know, people heal together. Community is medicine referring to this peer support model. It works. And I think it is a very low cost model.

The patient I mentioned, Janet, she was headed for a heart transplant, which costs \$1.6 million on average for a patient. We spent a few hundred dollars to put her in a lifestyle change program with a group that was effective in reversing her heart failure, reversing her diabetes.

These are the kinds of things that need to be paid for. We had to kind of stick it together with scotch tape at the Cleveland Clinic by using shared medical appointment codes, which required physicians to be involved or required higher level providers to be involved. That is not necessary. These programs can be delivered in community settings like churches and can be reimbursed by the Federal Government through various programs.

So I think by changing our incentive structures, by changing what we pay for, we can actually start to use the science to deliver on results and improve healthcare outcomes and reduce healthcare costs.

Mr. FITZPATRICK. Thank you, Dr. Hyman.

Mr. Chairman, I also want to highlight the importance of prevention services, specifically for cancer. Currently there are more than 1.7 million people who received a cancer diagnosis every single year. Our committee's advanced legislation to increase Medicare access to multi-cancer early detection screenings, many of us are on the cancer caucus, which I co-chair.

We have also introduced numerous pieces of legislation. Dr. Peters and Senator Frist, in your experiences, what other investments, aside from early screenings, should be made to prevent further cancer diagnoses and to get our arms around this terrible killer in America?

Dr. PETERS. I think we are talking about so many things that will help. So reduction in rates of obesity will help. Increase in activity diets that aren't so unhealthy for you. I do think we need to do more earlier cancer screening that doesn't involve tests that people don't want to go do, so the blood-based tests if we can validate that they are helpful, but then people follow-up on I think are

great ideas. But I think this fundamentally comes back to everything we are all talking about.

The other thing I would add is that I don't get paid for treating prediabetes or obesity, and I need to get paid for those things and I need to be able to use tools to help my patients take away their prediabetes and go backward to have numeral glucose tolerance. So there is a lot that makes it harder for us to work in the system to do the right thing even for our patients.

Dr. FRIST. I think focusing on cancer, we talked about chronic kidney disease a little bit earlier, and I think a focus on cancer does build out the model. I think what you have heard today from all of us is—and government has historically not been good at this just because we haven't had the data in the past, but it really is to take a more holistic view in terms of where a disease starts, starting with prevention, starting with the root causes.

The root causes that we can control are lifestyle, because so much is determined by genetics, not so much by our healthcare system in terms of treatment, but it really does come back to our lifestyle that we eat, how we behave, do we smoke, how much drinking, opioids, and the thing we have concentrated on today is food because it is low hanging fruit. It is the sort of thing we can do.

You mentioned, and I really applaud it in terms of what this committee has done, in terms of the prevention, the early diagnostic test. We are going to the root causes here, the diagnostic test. I think what I would encourage the committee to do next is to look at once you get the test done, you lower access to those tests, and the communities that we have heard about, like rural communities, are a real challenge, but once you get the test, how do we act on that.

And in terms of the companies that I work with in the field, there is a huge gap between if you have a positive result or a negative result, what happens. How do you get to that facility, to that access hospital, critical access hospital, to the local hospital, to the hospital two or three hours away. And that is where an opportunity, that gap I think exists for things like we talked about it, telemedicine, patient navigation. You have to reimburse for that. You can't just talk about it. If you reimburse for that, I think it is a great opportunity that this committee and other committees can work on and will have a huge impact in connecting the overall holistic view of starting with a person and ending with a disease and an outcome.

We have settled with the outcome and the reimbursement and the value-based care. Now we need to build value-based care, not just out of the healthcare system, but all the way back to what health and well-being really is.

Mr. FITZPATRICK. Thank you all for your time. I yield back.

Mr. BUCHANAN. Mr. Horsford.

Mr. HORSFORD. Thank you, Chairman Buchanan and to Vice Chairman Mr. Davis and to the ranking member for holding this hearing today and welcoming me back to the subcommittee on health. I am eager to get to work on the issues that matter most to the people of Nevada, such as expanding healthcare affordability and accessibility, promoting health and tax justice, and creating opportunities that enable every family to thrive.

Specifically, my goal as a member of the subcommittee is to advance policy that promotes equity in our health care settings. This includes working together to pass my bills, the Mental Health Transparency Act, which would bring more transparency to the behavioral healthcare space, the School Professionals Act to fix a longstanding loophole that has prevented contracting—contracted educational support staff from accessing affordable healthcare, and the soon-to-be introduced Dependent Income Exclusion Act legislation that aims to make health insurance more affordable for families with children who have part-time jobs or are enrolled in job training programs.

On the issue of social determinants of health, earlier this year the Nevada Division of Public and Behavioral Health released the first ever statewide health improvement plan addressing longstanding challenges and inadequacies that have affected the Silver State while offering several policy recommendations to improve the health of all Nevadans.

The Silver State Health Improvement Plan focuses on four key priorities: addressing social determinants of health, improving access to healthcare, expanding mental health and substance use disorder services, and transforming the public health system.

Now, Nevada is not alone with these priorities, and it is crucial that the state does not face these challenges in isolation. As federal lawmakers, we must continue to advocate for innovative and forward-looking policies that support our advocates and those who need this support the most on the ground.

Dr. Gearhardt, the Silver State Health Improvement Plan emphasizes the importance of reducing food insecurity to address social determinants of health. Could you elaborate further on the importance of enhancing food security to the social determinants of health and suggest ways that lawmakers can address structural inequities, especially those affecting underserved communities.

Dr. GEARHARDT. Yes. Food insecurity is a huge and growing issue in America, and particularly we are seeing in communities—black communities, Hispanic communities, Native American, and rural communities it is a bigger issue.

A lot of us have spoken here today that there has been a focus on food insecurity where it is just about getting access to calories, but we have all kind of been emphasizing that it will be important for these sort of programs to also think about that people can get access to nourishing foods, really nutrient rich foods.

In my own lab we have seen that there are multiple factors about food insecurity that set people up to have unhealthy relationships with their body and with food in general. Part of that is that it is highly stressful to not have enough money to get the food you need to nourish yourself and your children, and that stress leads to inflammation and exacerbates many of these chronic health conditions that we have been talking about today.

We also see that for many of these families there is this kind of intermittent pattern where you will get access to some funds in certain parts of the month, but then you run out, and so many family members will actually starve themselves, skip meals to be able to feed their children or to feed other members of their family. And

then when the resources become available again, it can trigger this kind of binge pattern.

That is really our biology that has been set up to help us protect against famine being used against us in a modern food environment. So having consistent, reliable access to affordable nutritious foods will support not just the physical well-being but also the mental health.

And we see in our lab that experiencing food insecurity as a child, even if as you become—as you become an adult you now are food secure, that experience in those critical times of your life as a child when you didn't know if you would have enough nourishing food to eat sets you up not just in the context of diet-related chronic health disease, but also substance use disorders and increases risk for that. So we really need to focus on the nutritional security of our children across the entire United States.

Mr. HORSFORD. Thank you so much for your answer. I look forward to working with members of the committee and the staff and all of those advocates out there who support public health. Thank you.

With that, Mr. Chairman, I yield back.

Mr. BUCHANAN. Thank you. Mr. Schweikert, you are recognized.

Mr. SCHWEIKERT. Thank you, Mr. Chairman.

And Senator, you actually had a real influence on me years ago to spend more time on these subjects, and actually I listened to a podcast of the person sitting next to you. All right. And look, for a number of our friends here, thank you for tolerating me. As you know, this is one of my fixations. I also have been listening to a number of you. I don't think any of you are pushing the envelope hard enough, far enough. So let's actually walk through, and then there will be actually a question or two here.

I am the senior Republican of the joint economic committee. We actually took a leap and did something we were prepared to get the crap kicked out of us. We did the math on obesity in America. We calculate that over the next ten years obesity in America may add an additional \$9.1 trillion additional healthcare costs. And I was prepared for the incoming.

You know what happened? A bunch of the people on the left and the right came in and said I can't believe you were willing to say it, but it is true. You have a country where we are about to have the fifth year in a row where prime age males are dying younger. Look at the drug statistic. You know what is about the drug statistic? Obesity. Family formation. We actually—we haven't been able to reproduce. The number says 47 percent of all U.S. healthcare is tied to obesity.

And in many ways we also have data that in four years more than half of America will actually be up against that number. And that is a little different than what was it, census of those produced a number today, but it was a self-reporting poll, so it is crap from a statistician standpoint.

So I come to you and say what do you do? Are you willing to take on the way we finance agriculture, the way we do nutrition support? I would argue is it okay to give an EBT card to go buy onion rings?

I represent Scottsdale. I represent a very well-educated district, but I also have a tribal community that has very high per capita income, and yet it is the second highest diabetes in, I think, the world. Now, some of that is genetic. We have learned all sorts of things about the autoimmune issues and within there. Diabetes now is 33 percent of all U.S. healthcare spending, 31 percent within Medicare.

So I am going to come to you and say okay, we have been tracking the vertex experiments of type one and it looks like the data is good. We have been actually trying to look at radical ideas of a Fentanyl vaccine, because over the last six years we have lost 380,000 of our brothers and sisters to Fentanyl. We are on the cusp of amazing changes.

The fact of the matter is we already have active lobbying all up and down this campus to slow down access to glutides, the semaglutides. The fact of the matter is the prices are starting to crash. Look at the price difference in the last seven months from January until recently.

Doctor, is it Hyman? Okay. You have been willing to do podcasts in long formats and walk people through. We are dying. In 14, 15 years, the United States has more deaths than births. How do I help our brothers and sisters understand that maybe the thing is wearable? Maybe the new technology where I can put something on my wrist and it counts my calories? It is not a Dexcom. It actually counts my calories. It is not blood glucose.

How do I socialize the technology? Because we have a data set from our joint economic economist, and for our ranking member, he may find this fascinating, number one input of income and equality was not education. It is health. What would—how would you evangelize a healthier America and the fact that it is the single biggest thing you could do for U.S. debt?

Dr. HYMAN. You said something very important, we are not going far enough, and I honestly held back a little bit to tell you the truth. I think we need sweeping changes across policies. I wrote a book called Food Fix, which lays this all out from field to fork, how we subsidize agriculture in the commodity crops that are driving the chronic diseases. It is what we pay for nutrition in terms of healthcare services. It is nutrition education. It is our dietary guidelines. It is our SNAP program. It needs to be reformed. It is food marketing particular to children. It is front of package labeling with the FDA. It is nutritional research to be done by the NIH. It is so many different aspects across government.

And the GAO produced a report at—Dr. Mozafari is in the audience, and my request through Tim Ryan and Rosa DeLauro a number of years ago that looked at all government policies related to nutrition and all the agencies involved. There were over 200 policies, 21 agencies. They found that most of these were working across purposes and actually causing more harm than good and creating more problems than solving problems.

For example, you know, we subsidize commodity crops that are turned to ultraprocesed food, then we pay for \$100 billion for the SNAP program, and then we pay for the back end on Medicare and Medicaid for those patients who are chronically ill. So the tax-

payers are paying three or four times for the same problem, and we need to change that.

So there is, I think, a set of sweeping policies that need to be done across the government that can really make a huge difference. And we may not be able to get them all done at once, but we have to work towards that. I think, you know, slavery was at the center of our economy 150 years ago and we figured out, not obviously through civil war, I don't want to figure it out, but we figured out really how to end that and change our economy to something that actually created a more equitable society—

Mr. SCHWEIKERT. Mr. Chairman, thank you for your patience. I have an entire binder of articles and disruptions. With your permission, I would like to submit those for the record. And I do hope actually we can have some additional conversations, because I am optimistic we are at the time of technology changes—

Dr. HYMAN. Yeah.

Mr. SCHWEIKERT. Where the thing I have on my wrist is actually almost my primary care—

Dr. HYMAN. I do think AI driven healthcare will create AI copilot for health and create AI super docs that will transform healthcare. Nothing we talked about today, but I think it is part of what is happening outside of the traditional healthcare model and I am involved on that and part of what our company functional health is all about.

Mr. SCHWEIKERT. Mr. Chairman, thank you for allowing my rambling.



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Generative AI develops potential new drugs for antibiotic-resistant bacteria

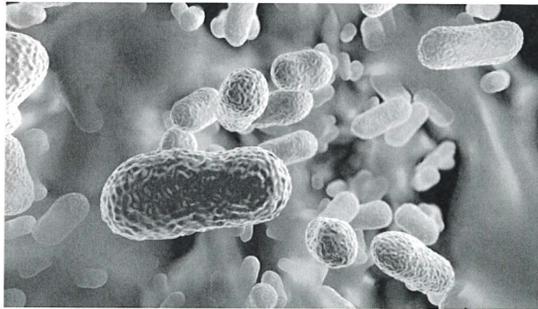
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Stanford Medicine researchers devise a new artificial intelligence model, SyntheMol, which creates recipes for chemists to synthesize the drugs in the lab.

March 28, 2024 - By Rachel Tompa

With nearly 5 million deaths linked to antibiotic resistance globally every year, new ways to combat resistant bacterial strains are urgently needed.

Researchers at Stanford Medicine and McMaster University are tackling this problem with generative artificial intelligence. A new model, dubbed SyntheMol (for synthesizing molecules), created structures and chemical recipes for six novel drugs aimed at killing resistant strains of Acinetobacter



Acinetobacter baumannii infection is a leading cause of death related to antibiotic resistance. Stanford Medicine researchers employed artificial intelligence to provide recipes for drugs that

baumannii, one of the leading pathogens responsible for antibacterial resistance-related deaths.

can treat it.
Kateryna Kon/Shutterstock.com

The researchers described their model and experimental validation of these new compounds in a study published March 22 in the journal *Nature Machine Intelligence*.

"There's a huge public health need to develop new antibiotics quickly," said James Zou, PhD, an associate professor of biomedical data science and co-senior author on the study. "Our hypothesis was that there are a lot of potential molecules out there that could be effective drugs, but we haven't made or tested them yet. That's why we wanted to use AI to design entirely new molecules that have never been seen in nature."

Before the advent of generative AI, the same type of artificial intelligence technology that underlies large language models like ChatGPT, researchers had taken different computational approaches to antibiotic development. They used algorithms to scroll through existing drug libraries, identifying those compounds most likely to act against a given pathogen. This technique, which sifted through 100 million known compounds, yielded results but just scratched the surface in finding all the chemical compounds that could have antibacterial properties.



Kyle Swanson

"Chemical space is gigantic," said Kyle Swanson, a Stanford computational science doctoral student and co-lead author on the study. "People have estimated that there are close to 10^{60} possible drug-like molecules. So, 100 million is nowhere close to covering that entire space."

Hallucinating for drug development

Generative AI's tendency to "hallucinate," or make up responses out of whole cloth, could be a boon when it comes to drug discovery, but previous attempts to generate new drugs with this kind of AI resulted in compounds that would be impossible to make in the real world, Swanson said. The researchers needed to put guardrails around SyntheMol's activity — namely, to ensure that any molecules the model dreamed up could be synthesized in a lab.

"We've approached this problem by trying to bridge that gap between computational work and wet lab validation," Swanson said.

The model was trained to construct potential drugs using a library of more than 130,000 molecular building blocks and a set of validated chemical reactions. It generated not only the final compound but also the steps it took with those building blocks, giving the researchers a set of recipes to produce the drugs.

The researchers also trained the model on existing data of different chemicals' antibacterial activity against *A. baumannii*. With these guidelines and its building block starting set, SyntheMol generated around 25,000 possible antibiotics and the recipes to make them in less than nine hours. To prevent the bacteria from quickly developing resistance to the new compounds, researchers then filtered the generated compounds to only those that were dissimilar from existing compounds.

"Now we have not just entirely new molecules but also explicit instructions for how to make those molecules," Zou said.

A new chemical space

The researchers chose the 70 compounds with the highest potential to kill the bacterium and worked with the Ukrainian chemical company Enamine to synthesize them. The company was able to efficiently generate 58 of these compounds, six of which killed a resistant strain of *A. baumannii* when researchers tested them in the lab. These new compounds also showed antibacterial activity against other kinds of infectious bacteria prone to antibiotic resistance, including *E. coli*, *Klebsiella pneumoniae* and MRSA.



James Zou

The scientists were able to further test two of the six compounds for toxicity in mice, as the other four didn't dissolve in water. The two they tested seemed safe; the next step is to test the drugs in mice infected with *A. baumannii* to see if they work in a living body, Zou said.

The six compounds are vastly different from each other and from existing antibiotics. The researchers don't know how their antibacterial properties work at the molecular level, but exploring those details could yield general principles relevant to other antibiotic development.

"This AI is really designing and teaching us about this entirely new part of the chemical space that humans just haven't explored before," Zou said.

Zou and Swanson are also refining SyntheMol and broadening its reach. They're collaborating with other research groups to use the model for drug discovery for heart disease and to create new fluorescent molecules for laboratory research.

The study was funded by the Weston Family Foundation, the David Braley Centre for Antibiotic Discovery, the Canadian Institutes of Health Research, M. and M. Heersink, the Chan-Zuckerberg Biohub, and the Knight-Hennessy scholarship.

For more news about responsible AI in health and medicine, [sign up](#) for the RAISE Health newsletter.

[Register](#) for the RAISE Health Symposium on May 14.

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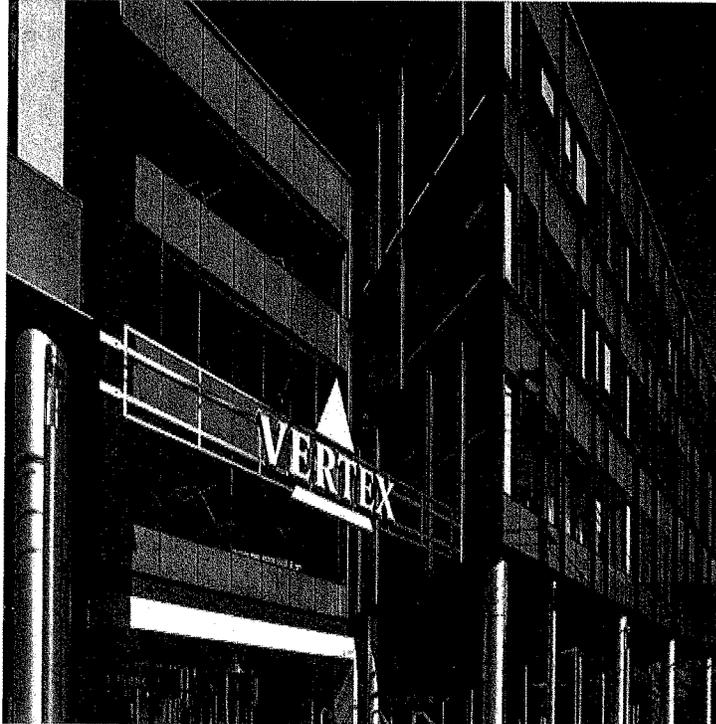
Vertex reports positive results in stem cell trial for type 1 diabetes

STAT+

Vertex reports positive results in stem cell trial for type 1 diabetes



By Elizabeth Cooney June 21, 2024



ORLANDO — Twelve people with type 1 diabetes who received a therapy derived from stem cells were able to produce enough of their own insulin to maintain healthy blood glucose levels 90 days later, Vertex Pharmaceuticals said Friday. All but one reduced or eliminated the need to inject insulin over those three months and three people followed for one year no longer needed to inject insulin at all.

Researchers say the study marks a promising approach that could one day relieve some people with type 1 diabetes of the need for daily insulin injections.

“These cells clearly work,” said Jay Skyler, an endocrinologist at the University of Miami Miller School of Medicine who was not involved in the study.

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9/17/24, 4:37 PM

Vertex reports positive results in stem cell trial for type 1 diabetes

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FENTANYL VACCINE POTENTIAL 'GAME CHANGER' FOR OPIOID EPIDEMIC

Study Suggests New Vaccine Could Prevent Deadly Opioid from Entering the Brain

By Laurie Fickman (mailto:lafickman@uh.edu) 713-743-8454

November 14, 2022



Over 150 people die every day from overdoses of synthetic opioids including fentanyl, which is 50 times stronger than heroin and 100 times stronger than morphine.

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Fentanyl Vaccine Potential 'Game Changer' for Opioid Epidemic - University of Houston



In the lab: Therese Kosten, professor of psychology and director of the Developmental, Cognitive & Behavioral Neuroscience program and Colin Haile, research associate professor of psychology and the Texas Institute for Measurement, Evaluation and Statistics (TIMES), and a founding member of the UH Drug Discovery Institute.

A research team led by the University of Houston has developed a vaccine targeting the dangerous synthetic opioid fentanyl that could block its ability to enter the brain, thus eliminating the drug's "high." **The breakthrough discovery could have major implications for the nation's opioid epidemic by becoming a relapse prevention agent for people trying to quit using opioids. While research reveals Opioid Use Disorder (OUD) is treatable, an estimated 80% of those dependent on the drug suffer a relapse.**

The findings, published in the journal *Pharmaceutics* (<https://www.mdpi.com/1999-4923/14/11/2290/htm>), could not be timelier or more in demand: Over 150 people die every day from overdoses of synthetic opioids including fentanyl, which is 50 times stronger than heroin and 100 times stronger than morphine. Consumption of about 2 milligrams of fentanyl (1/10th the weight of one grain of rice) is likely to be fatal depending on a person's size.

“We believe these findings could have a significant impact on a very serious problem plaguing society for years – opioid misuse. Our vaccine is able to generate anti-fentanyl antibodies that bind to the consumed fentanyl and prevent it from entering the brain, allowing it to be eliminated out of the body via the kidneys. Thus, the individual will not feel the euphoric effects and can ‘get back on the wagon’ to sobriety,” said the study’s lead author Colin Haile, a research associate professor of psychology at UH and the Texas Institute for Measurement, Evaluation and Statistics (TIMES), and a founding member of the UH Drug Discovery Institute.

In another positive finding, the vaccine did not cause any adverse side effects in the immunized rats involved in lab studies. The team plans to start manufacturing clinical-grade vaccine in the coming months with clinical trials in humans planned soon.

Fentanyl is an especially dangerous threat because it is often added to street drugs like cocaine, methamphetamine and other opioids, such as oxycodone and hydrocodone/acetaminophen pills, and even to counterfeit benzodiazepines like Xanax. These counterfeit drugs laced with fentanyl add to the amount of fentanyl overdoses in individuals who do not ordinarily consume opioids.

“The anti-fentanyl antibodies were specific to fentanyl and a fentanyl derivative and did not cross-react with other opioids, such as morphine. That means a vaccinated person would still be able to be treated for pain relief with other opioids,” said Haile.

The vaccine tested contains an adjuvant derived from *E. coli* named dmLT. An adjuvant molecule boosts the immune system's response to vaccines, a critical component for the effectiveness of anti-addiction vaccines. The adjuvant was developed by collaborators at the Tulane University School of Medicine and has proven vital to the efficacy of the vaccine. Also on the team are Greg Cuny, Joseph P. & Shirley Shipman Buckley Endowed Professor of Drug Discovery and his post-doctoral fellow, Anantha Duddupudi, at the UH College of Pharmacy along with researchers from Baylor College of Medicine and Michael E. DeBakey Veteran's Affairs Medical Center.

Current treatments for OUD are methadone, buprenorphine and naltrexone, and their effectiveness depends upon formulation, compliance, access to medications and the specific misused opioid.

Therese Kosten, professor of psychology and director of the Developmental, Cognitive & Behavioral Neuroscience program at UH, calls the new vaccine a potential "game changer."

"Fentanyl use and overdose is a particular treatment challenge that is not adequately addressed with current medications because of its pharmacodynamics and managing acute overdose with the short-acting naloxone is not appropriately effective as multiple doses of naloxone are often needed to reverse fentanyl's fatal effects," said Kosten, senior author of the study.

This work is supported by the Office of the Assistant Secretary of Defense for Health Affairs through the Congressionally Directed Medical Research Programs, Alcohol and Substance Use Disorders Research Program under Award No. (W81XWH-18-2-0044) as part of RTI International's Pharmacotherapies for Alcohol and Substance Use Disorders Alliance for an amount of \$763,905.

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Experimental Weight Loss Drug Beat Ozempic and Wegovy in Early Trial

People taking the experimental drug amycretin were found to lose almost twice as much weight over a 12-week period as the average weight loss seen with semaglutide.

By Ed Cara

Updated September 13, 2024 | Comments (19)

Pharmaceutical company Novo Nordisk isn't sitting on its laurels when it comes to weight loss. The Danish-based company has just revealed preliminary data suggesting that its experimental drug amycretin can help people lose even more weight than its already blockbuster drug semaglutide, the active ingredient in Ozempic and Wegovy. Even better, amycretin is taken as a pill, as opposed to the injections needed for Ozempic and Wegovy.

Researchers presented the company's data on amycretin at the annual meeting of the [European Association for the Study of Diabetes](#) this week, which comes from a Phase I trial of people living with obesity. Those taking amycretin were found on average to lose 13.1% of their body weight over a 12 week period—far above the average weight loss seen in those taking a placebo and on pace to perhaps even surpass the success seen with semaglutide.

For comparison, people taking high dose semaglutide in clinical trials have been found to lose about 6% of their body weight on average after three months and about 15% body weight after six months. That raises the tantalizing possibility that people on amycretin could expect to lose 25% or more weight during the same period, an average level of weight loss not seen with any current obesity medication and comparable with the most effective bariatric surgeries.

"It's almost like a miracle pill," Susan Spratt, an endocrinologist and the senior medical director for the Population Health Management Office at Duke Health, [told](#) NBC News.

Novo Nordisk's data has yet to be vetted by outside experts, an important part of the scientific process. And it's still only Phase I data, which is explicitly only designed to tell us whether a drug is safe to keep testing in humans, not to confirm its effectiveness. On that end, the company reported that the adverse effects seen with the drug were generally mild to moderate and comparable to those seen in semaglutide. The most common side effects with semaglutide are gastrointestinal, such as nausea and diarrhea, though these symptoms tend to wane over time.

The pharmacology behind amycretin does lend support to the idea that it could beat semaglutide. Semaglutide mimics the gut hormone GLP-1, which helps regulate our blood sugar and sense of hunger, among other things. But amycretin is designed to mimic both GLP-1 and another hormone key to our hunger and blood sugar regulation, amylin. Eli Lilly's competing drug tirzepatide, sold under the names Mounjaro and Zepbound, deploys a similar dual-action strategy (albeit using GLP and the hormone GIP), and has been found to provide greater weight loss on average than semaglutide as well.

Much more data in humans confirming amycretin's effectiveness and safety will be needed before it would be able to reach the public. But this is just one of many promising leads in the future of weight loss treatment being developed by Novo Nordisk and its competitors. One of the company's other candidates, CagriSema, blends together another amylin analog with semaglutide, for instance, and early results have suggested a similar level of weight loss as projected with amycretin.

June 25, 2024

AI tool predicts response to cancer therapy

At a Glance

- Scientists developed an AI tool that uses routine clinical data to identify cancer patients most likely to respond to immunotherapy drugs called checkpoint inhibitors.
- The approach could help guide personalized cancer treatments for patients.

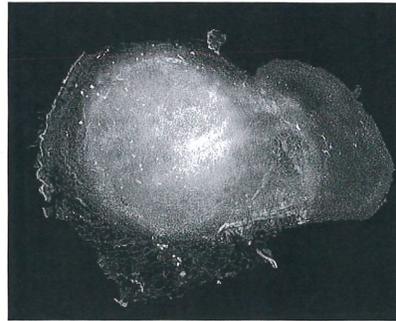
Chemotherapy, radiation, and surgical removal of tumors have long been the standard approaches for treating different types of cancer. But in recent decades, different immunotherapies have become available. These rely on the body's immune system to find and destroy cancer cells. One type of immunotherapy, called checkpoint inhibition, has greatly improved the treatment of many types of cancer. Immune checkpoint-inhibiting drugs can make cancer cells more vulnerable to immune system attack. But they don't work for everyone.

Scientists have been looking for better ways to identify patients most likely to respond to these drugs. People who probably wouldn't benefit from them could avoid unnecessary treatments and side effects and be given different treatments. To date, two biomarkers have been approved by the U.S. Food and Drug Administration to identify patients most likely to benefit from these medications. One measures tumor mutational burden, which is the number of DNA mutations in cancer cells. But results of these tests are not always accurate. Other predictive tests depend on tumor molecular data that are costly to obtain and not routinely collected.

A research team led by Dr. Eytan Ruppin of NIH's National Cancer Institute and Dr. Luc Morris of Memorial Sloan Kettering Cancer Center set out to create a more accurate predictive tool based on readily available biomarkers. To do this, they first analyzed a large data set that included information on more than 2,880 cancer patients with 18 different types of solid tumors. All had been treated with immune checkpoint inhibitors.

The team assessed over 20 different clinical, pathologic, and genomic features. They also examined patient outcomes, such as response to therapy and survival. Using machine learning, they tried to identify which combination of features could best predict a patient's response to immune checkpoint inhibitors. Results were published on June 3, 2024, in *Nature Cancer*.

After developing and testing different machine learning models, the team created a new type of AI scoring system, termed LORIS (logistic regression-based immunotherapy-response score). It is based on the tumor mutational burden along with five clinical features that are



Different immune cells, shown in yellow, red, and blue, attacking a mouse tumor after treatment with radiation and an immune checkpoint therapy. Steve Seung-Young Lee / Univ. of Chicago Comprehensive Cancer Center / National Cancer Institute

9/17/24, 4:21 PM

AI tool predicts response to cancer therapy | National Institutes of Health (NIH)

routinely collected from patients. These include the patient's age, cancer type, history of cancer therapy, blood albumin (a protein made by the liver), and blood NLR (a measure of inflammation).

Further testing showed that LORIS was better than other methods at predicting a patient's chance of responding to immune checkpoint inhibitors. This included predictive models based on many more clinical features. LORIS could also consistently predict short-term and long-term survival after immunotherapy. The scientists note that this approach could help guide treatment decisions and maximize benefits to patients. But larger studies are needed to evaluate the tool in clinical settings.

"We were able to develop a new predictive model for immunotherapy response across many different cancer types using only six simple variables," Morris says. "In contrast to prior models, some of which are very complex, this model is very accessible to clinicians."

Ruppin adds, "this study provides another example for the importance and benefit of building collaborations between clinicians and data scientists across different centers in our nation to collect and analyze large patient data cohorts to advance patient care."

The LORIS tool is publicly available at <https://loris.ccr.cancer.gov>.

Related Links

- Machine Learning Approach Detects Brain Tumor Boundaries (<https://www.nih.gov/news-events/nih-research-matters/machine-learning-approach-detects-brain-tumor-boundaries>)
- Identifying Immune Cells for Personalized Cancer Immunotherapy (<https://www.nih.gov/news-events/nih-research-matters/identifying-immune-cells-personalized-cancer-immunotherapy>)
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- Artificial Intelligence (AI) (<https://www.nibib.nih.gov/science-education/science-topics/artificial-intelligence-ai>)

References: LORIS robustly predicts patient outcomes with immune checkpoint blockade therapy using common clinical, pathologic and genomic features. Chang TG, Cao Y, Sfriddo HJ, Dhruva SR, Lee SH, Valero C, Yoo SK, Chowell D, Morris LGT, Ruppin E. *Nat Cancer*. 2024 Jun 3. doi: 10.1038/s43018-024-00772-7. Online ahead of print. PMID: 38831056.

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U.S. Department of Health and Human Services

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How the snack industry is responding to Ozempic

Matt Levin Aug 13, 2024

Heard on:



People taking appetite-suppressing treatments like Ozempic are more likely to eat small servings of high-protein foods rather than large portions of salty snacks and baked goods. Justin Sullivan/Getty Images



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Ozempic-friendly snacks are the new frontier for food companies - Marketplace

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The only semi-indulgent thing you see in Cindy's refrigerator is half of the Italian chicken sandwich she had for lunch but couldn't finish. The rest of the fridge is basically healthy, boring proteins.

"So yeah, I have my protein shakes that are always in my fridge," said Cindy, who declined to give her last name because of medical privacy concerns. "Cottage cheese, Greek yogurt."

Cindy, a 43-year-old dental hygienist, is one of [the roughly 12% of Americans that have taken a GLP-1 drug](#), the class of wildly popular obesity medications like Ozempic that help suppress appetite.

Cindy started on the [GLP-1](#) Wegovy in March of last year, when she weighed about 225 pounds. She's lost 70 pounds since then.

She's mostly kept unhealthy foods out of her house for years. But being on a GLP-1 has cut down her cravings considerably, even for coffee and alcohol.

Hosted by Kai Ryssdal

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"I don't mindlessly eat anymore," she said. "If I do want something that might be not a good food, I might have a bite of cake, and that's it. I don't need more of it. I don't need another slice."

GLP-1s make you feel full very quickly and for a long time. [Being on a GLP-1 has trimmed Cindy's food budget by about \\$200 a month.](#)

That's a problem for the food and beverage industry. [A recent Morgan Stanley analysis predicts GLP-1s will reduce the consumption of sodas, baked goods and salty snacks by up to 3% in the](#)

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next decade.

Snack makers are trying to adapt. Nestle, maker of KitKats candy and Häagen-Dazs ice cream, is planning a GLP-1-friendly frozen-food line called Vital Pursuits, with protein-infused pasta and sandwiches.

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At the Mattson food laboratory just south of San Francisco, a team of lab-coat-wearing food scientists are chopping onions and measuring spices in an industrial-size kitchen.

Mattson is a food research and development company that helps big food brands create new products. It's where White Castle's frozen jalapeno cheese sliders and Annie's pizza-flavored cheesy rice with hidden vegetables were born.

Senior food scientist Amanda Sinrod is throwing a more GLP-1-friendly snack on the grill: a chicken strip.

"So think of a packaging like a cheese stick, but instead it's chicken, which has a higher protein content and produces a little more versatility as a grab-and-go snack," she says.

Grilled chicken strips packaged like string cheese is one of the snacks Mattson developed after surveying GLP-1 users about how their tastes have changed.

"You have to understand that a consumer who might have been able to eat a 4-ounce portion of snack is now looking for a 1½-ounce portion," says Barb Stuckey, Mattson's chief innovation and marketing officer.

Stuckey says snack companies can still make money on smaller portions if they package and market them right — think of all those snack packs for nuts and cheeses you see at the grocery store.

But smaller portions are the easy part. The hard part is losing those reliable pretzel and potato chip eaters.

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"We do hear people saying, 'I'm still missing the crunchy,' says Stuckey. "But the crunchy they want to get from apples or they want to get from cucumbers or carrots. I mean, that's like a sea change."

Mattson has developed what it calls "snack concepts" tailored for GLP-1 users.

For instance, a freeze-dried chicken-and-tomato soup less than half the size of a Cup Noodles aimed at helping with nausea, a common side effect. Powdered drink mixes infused with protein and fiber, nutrients GLP-1 users often miss.

And of course, the portable grilled chicken strips packaged like string cheese. Which tasted like — you guessed it — chicken.

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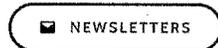
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As obesity rises, Big Food and dietitians push ‘anti-diet’ advice

General Mills warns of ‘food shaming’; dietitian influencers promote junk foods and discourage weight loss efforts

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By [Sasha Chavkin](#), [Caitlin Gilbert](#), [Anjali Tsui](#) and [Anahad O'Connor](#)

April 3, 2024 at 6:00 a.m. EDT

Jaye Rochon struggled to lose weight for years. But she felt as if a burden had lifted when she discovered YouTube influencers advocating “health at every size” — urging her to stop dieting and start listening to her “mental hunger.”

She stopped avoiding favorite foods such as cupcakes and Nutella. “They made me feel like I was safe eating whatever the hell I wanted,” said Rochon, 51, a video editor in Wausau, Wis. In two months, she regained 50 pounds. As her weight neared 300 pounds, she began to worry about her health.

The videos that Rochon encountered are part of the “anti-diet” movement, a social media juggernaut that began as an effort to combat weight stigma and an unhealthy obsession with thinness. But now global food marketers are seeking to cash in on the trend.

One company in particular, General Mills, maker of Cocoa Puffs and Lucky Charms cereals, has launched a multipronged campaign that capitalizes on the teachings of the anti-diet movement, an investigation by The Washington Post and The Examination, a nonprofit newsroom that covers global public health, has found.

General Mills has toured the country touting anti-diet research it claims proves the harms of “food shaming.” It has showered giveaways on registered dietitians who promote its cereals online with the hashtag #DerailTheShame, and sponsored influencers who promote its sugary snacks. The company has also enlisted a team of lobbyists and pushed back against federal policies that would add health information to food labels.

About this collaboration

This report is a joint investigation by The Washington Post and [The Examination](#), a new nonprofit newsroom specializing in global public health reporting.

General Mills complies with federal regulations and “works closely with a variety of scientific, health, nutrition and other credentialed experts to ensure we provide accurate, evidence-based information,” said spokesperson Andrea Williamson.

Online dietitians — many of them backed by food makers — also are building lucrative followings by co-opting anti-diet messages. Anti-diet hashtags, such as #NoBadFoods, #FoodFreedom and #DitchTheDiet, have proliferated on social media.

The Post and The Examination analyzed more than 6,000 social media posts by 68 registered dietitians with at least 10,000 followers. The analysis showed that roughly 40 percent of these influencers, with a combined reach of more than 9 million followers, repeatedly used anti-diet language.

Most of the influencers who used anti-diet language also were paid to promote products from food, beverage and supplement companies, the analysis found.

The rapid spread of anti-diet messaging — and the alliance between some of the country’s registered dietitians and the food industry — has alarmed some in the public health community.

Since the 1980s, the U.S. obesity rate has more than doubled, according to federal data. Nearly half a million Americans die early each year as a result of excess body weight, according to estimates in a 2022 Lancet study.

The anti-diet approach essentially shifts accountability for the health crisis away from the food industry for creating ultra-processed junk foods laden with food additives, sugars and artificial sweeteners.

General Mills embraces anti-diet messaging

Amy Cohn, General Mills’ senior manager for nutrition and external affairs, promoted the cereal company’s anti-diet messaging to a room of registered dietitians at a national food conference this past fall. Cohn denounced the media for “pointing the finger at processed foods” and making consumers feel ashamed of their choices.

“You can help derail the cycle of shame,” Cohn told the dietitians.

During the session, Kathryn Lawson, a registered dietitian and director of regulatory and scientific affairs at the food giant Nestlé, [tweeted](#): “People need to feel heard and seen to help break the cycle of shame when it comes to losing weight and eating.”

At least 10 registered dietitians promoted General Mills’ cereals in TikTok and Instagram posts last year, using the slogan #DerailTheShame while tagging the company in their posts. In some posts, dietitians show off personalized Cheerios boxes adorned with their names while they denounce “food shaming” of ready-to-eat cereals.

In a separate [TikTok video](#) published in November 2023, the self-described “anti-diet” dietitian Cara Harbstreet promoted the company’s “Big G” cereals, which include sugary brands such as Cinnamon Toast Crunch, Cocoa Puffs and Trix.

“I will always advocate for fearlessly nourishing meals, including cereal,” the Kansas City, Mo., dietitian told her followers in the video, which was labeled “#sponsored” and disclosed that she was working with General Mills. “Because everyone deserves to enjoy food without judgment, especially kids.”

[@streetsmart.rd](#) #sponsored Let's do a little trip down memory lane in partnership with @General Mills [🎵 original sound - Cara Harbstreet, Dietitian](#)
Harbstreet said in an email she was “no longer actively partnering” with General Mills.

Sen. Richard Blumenthal (D-Conn.), who recently co-sponsored legislation to help establish more prominent nutrition labeling on the front of food packages, said food companies’ adoption of anti-diet messaging is especially pernicious.

“I think it is really reprehensible for the food industry to prey on the vulnerabilities of people who suffer from diabetes or obesity or diseases that are caused by excessive sugar, fat and perhaps other ingredients that do them harm,” Blumenthal said. “To tell people they should be proud of eating the wrong things, that’s hardly doing them a service.”

How the food industry supports anti-diet dietitians

This past fall, following a separate [Post and Examination investigation](#), the Federal Trade Commission [cracked down](#) on industry trade groups and a dozen nutrition influencers, flagging nearly three dozen social media posts that it said failed to clearly disclose who was paying the influencers to promote artificial sweeteners or sugary foods.

Numerous food companies continue to sponsor social media ads by outspoken anti-diet dietitians.

Dietitian Colleen Christensen posted a [video](#) of herself eating rocky road ice cream on her TikTok account [@no.food.rules](#), in which she mocks low-calorie alternatives. She has made ads for pancake makers [Kodiak Cakes](#) and [Premier Protein](#) for her 300,000 followers.

[@no.food.rules](#) The healthiest= what you find most satisfying. #nofoodrules #intuitiveeating #foodfreedom #nondiet #antidietculture #antidiet [🎵 Monkeys Spinning Monkeys - Kevin MacLeod & Kevin The Monkey](#)

Lauren Smith, who calls herself a “food freedom dietitian” on TikTok, has posted ads for frozen pizza from a gluten-free brand, [Banza](#), and for a high-protein snack company, [Lorissa’s Kitchen](#), to her more than 70,000 followers.

Christensen didn’t respond to requests for comment. Smith said she only partners with brands that she uses herself and that align with her nutrition philosophy.

Harbstreet, the anti-diet dietitian who touted cereals for General Mills, also has posted ads for low-calorie sweetener Truvia, Barilla pasta and a whipped cake icing brand owned by Rich Foods.

Cargill, the parent company for Truvia, said in an email that the company does not focus on the anti-diet movement. “We engage with dietitians across diverse backgrounds and areas of expertise,” a spokesperson wrote.

“I think it is really reprehensible for the food industry to prey on the vulnerabilities of people who suffer from diabetes or obesity or diseases that are caused by excessive sugar, fat and perhaps other ingredients that do them harm.”

— Sen. Richard Blumenthal

A spokesperson for Kodiak Cakes said in an email, “We have always seen beyond of-the-moment trends and prioritize the importance of protein and whole grains in a healthy, balanced lifestyle.”

Banza, Lorissa’s Kitchen, Rich Foods, Barilla and BellRing, which owns Premier Protein, did not respond to requests for comment.

The food industry’s close relationship with dietitians was on full display this past fall in Denver at the Food and Nutrition Conference and Expo, the world’s largest gathering of registered dietitians. Dietitians noshed on vegetarian “bulgogi” samples from Beyond Meat and a pumpkin spice loaf made with the sugar substitute Splenda.

Next to Camp PepsiCo — the beverage giant’s summer-camp-themed booth — dietitians waited in line to climb a giant yellow General Mills cereal box and slide into a bowl of plushie Cheerios.

At a symposium, General Mills shared the results of a survey it funded about “food shaming” — defined as “making people feel bad about what they eat.”

The company said the research showed food shaming led to lower self-esteem and eating disorders and made people more likely to avoid the cereal aisle in grocery stores.

Cohn fielded a question from the audience about proposed Food and Drug Administration rules to label foods high in sugar, salt and fat.

“We’re doing everything we can to prevent that from happening,” she said. “Shaming is what I call it.”

The industry doubles down

General Mills has funded at least seven scientific studies since 2019 claiming that cereals are beneficial to consumers’ health. One review found that children who ate cereal, regardless of the sugar content, had healthier body weights than children who ate other breakfast food or skipped breakfast.

The company spent more than \$2 million in 2022 and 2023 lobbying the federal government, according to data from OpenSecrets, a nonprofit group.

Efforts by the FDA to regulate food labels have sparked some of the fiercest opposition from General Mills and other leading cereal producers.

Last year, General Mills and fellow cereal giants Kellogg and Post Consumer Brands threatened legal action over a proposed rule to limit what they are allowed to promote as healthy. In a joint filing, the companies argued that the proposed restrictions would violate their First Amendment rights.

“They love putting ‘healthy’ in big, red letters,” Blumenthal said. “But when it comes down to the details — how much fat, how much sugar — they resist clarity like the plague.”

How the anti-diet movement has been distorted

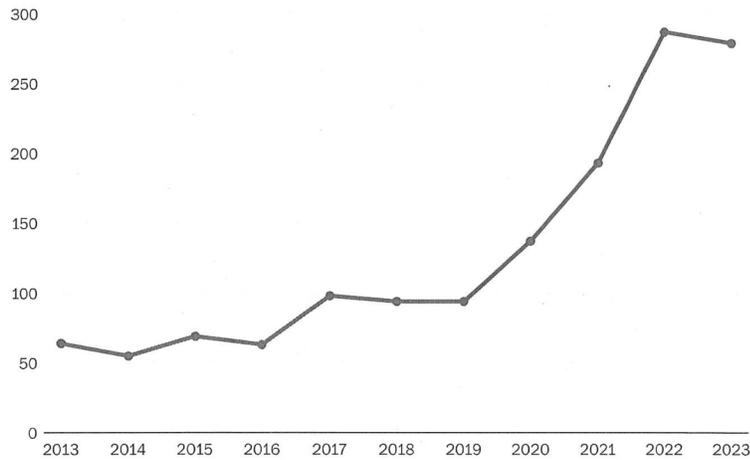
Anti-diet proponents have been fighting against weight bias and diet culture for decades. The movement now known as Health at Every Size, or HAES, began in the 1960s as a grass-roots effort in tandem with other civil rights movements to promote equal access to health care, said Ani Janzen, the operations and projects leader for the Association for Size Diversity and Health, which holds the HAES trademark.

Elyse Resch and Evelyn Tribole, both registered dietitians, popularized the term “intuitive eating” with the publication of their 1995 book “Intuitive Eating: A Revolutionary Anti-Diet Approach.” Intuitive eating urges followers to listen to their internal cues about hunger and is frequently used to help people with eating disorders.

In the past few years, academic interest in these anti-diet philosophies has surged. From 2019 to 2023, academic mentions of “anti-diet” tripled, according to a Post-Examination analysis of Google Scholar data.

Interest in anti-diet ideas spikes in recent years

Annual mentions of "anti-diet" or "antidiet" in academic publications



Source: Analysis of Google Scholar data

An analysis of 1,500 TikTok videos using the hashtags #AntiDiet or #HealthAtEverySize by The Post and The Examination found that the most commonly discussed topics included eating disorders, dieting and weight loss.

Ice cream was the top food item mentioned across the TikTok data set, with dozens of videos defending the dessert as unfairly demonized by society, the Post-Examination analysis found.

In some videos made by anti-diet dietitians, creators say no foods should be labeled as "junk" or "unhealthy" because "all foods have value," while showing snacks like Cheetos or candy brands like Reese's and Twix.

But leaders of Health at Every Size say their work has been distorted on social media. The hashtag #HealthAtEverySize is often used to promote body positivity or suggest that "you can be healthy at any size," Janzen said.

"Health at Every Size" is really about how weight bias has created a health-care system "that is harming fat people," she said.

The wide appeal of Health at Every Size online allows it to be commercialized, said Angel Austin, interim executive director for the HAES association. "You have a lot of privileged people talking about Health at Every Size, unfortunately, because it's profitable," she said.

Resch, the co-founder of intuitive eating, said that big food companies touting anti-diet slogans are “just trying to make more money, and intuitive eating has been co-opted.”

Lifting the burden of diet culture

Health experts say the most worrisome trend among anti-diet influencers is the alarming amount of misinformation they spread, including claims that excess weight isn't a health risk.

“Most chronic diseases blamed on weight can most likely be explained by other phenomena, such as weight stigma and weight cycling,” wrote Christy Harrison in her influential 2019 book, “Anti-Diet: Reclaim Your Time, Money, Well-Being, and Happiness Through Intuitive Eating.”

Harrison, a registered dietitian and podcaster, said in an email that if she were writing the book today, she would use “more nuanced language.” She maintained her opposition to “intentional weight loss” and said she still believes that “many” chronic diseases linked to weight have other causes, citing research documenting the harms of stigma and dieting.

Deaths caused by obesity, diabetes, liver disease and hypertension have climbed to record highs over the past twenty years, and conditions that once only afflicted older adults are now increasingly present in young children.

Kevin C. Klatt, a registered dietitian and research scientist and instructor at the University of California at Berkeley, says anti-diet advocates who deny the connection between excess body fat and chronic disease have “made up stuff that is a fantasy and a total fairy tale.”

Nonetheless, anti-diet influencers have found a growing audience among millennial and Gen Z viewers, many grappling with the food fears and restricted eating practiced by their parents.

Casey Purlia Johnson, a fitness coach and social media influencer, said trying intuitive eating helped her develop a healthier relationship with food, after years of being obsessed with exercise and calorie restriction.

“We have all grown up around these crazy ideas about food,” Johnson said in an interview. She said her clients encounter a lot of misinformation around restricted eating. “They ask me on the phone, ‘Are you sure I can eat fruit?’”

While advocates say the anti-diet approach has brought a needed reprieve from the burdens of diet culture, others say the pendulum has swung too far, and the new anti-diet movement is hurting people at risk of health problems related to excess weight and a poor diet.

Misled by anti-diet messages

Rochon said she initially embraced a new ideology about nutrition after years of struggling with binge eating, weight loss efforts and hunger. Some of what she heard was based in fact. **Studies show that restrictive dieting can significantly slow metabolism, a condition that can persist for years.**

Rochon grew to believe that restricting food in any fashion would put her health in danger. Listening to mental hunger meant that if she was thinking about a food, she should eat it.

“Your relationship with food would just get magically healed, if you just ate the doughnuts and ate the cookies and weren’t afraid of what you were eating,” Rochon said.

As her weight increased, it began to take a toll. The risk of humiliation while navigating crowds or fitting into seats made her afraid of going out. When she attended a concert with her brother, climbing a flight of stairs was so difficult that it “stole my joy,” she said.

“As my body got bigger and bigger and bigger, I felt like my life just shrunk,” Rochon said.

Rochon said health concerns prompted her to start watching YouTube videos that challenged what she described as the “indoctrination” of the anti-diet and fat acceptance movements.

“I’m definitely out of the movement,” she said.

A few months ago, Rochon started her own YouTube channel, which has about 125 subscribers, in which she discusses her experience and her ongoing efforts to find a sustainable approach to nutrition.

“I don’t want my parents to bury me,” she said.

Jacob Mey, a dietitian and nutrition researcher at the Pennington Biomedical Research Center in Louisiana, said Rochon’s story is not unique. He said some of his clients have gained as much as 60 pounds in six months while working with anti-diet dietitians.

“It led them to get into the largest weight of their life,” Mey said. “The downside from a health perspective is exacerbating their obesity and potentially making worse their risk for other nutrition-related diseases.”

About this story

This report is part of a joint investigation by The Washington Post and The Examination, a new nonprofit newsroom specializing in global public health reporting. [Sign up to get The Examination’s investigations](#) in your inbox. [Sign up for The Post’s Well+Being newsletter.](#)

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Americans Clicked Ads to Get Free Cash. Their Health Insurance Changed Instead.

Facebook, Snapchat ads promise people \$6,400 to switch insurers

By *Joseph Walker* [Follow](#)

Sept. 13, 2024 5:30 am ET

Hundreds of thousands of low-income Americans were unknowingly signed up for government-subsidized health insurance, often lured by social-media ads falsely promising cash for daily expenses, according to insurance agents, court documents and federal officials.

Insurance agents help people find plans and figure out whether they qualify for government subsidies for their premiums. Insurers pay agents commissions for each person they sign up to a plan.

During the pandemic, the business opportunity grew. Congress and the Biden administration made it easier and less expensive—even free—for lower-income people to get coverage under the Affordable Care Act, the 2010 law overhauling health-insurance regulations. The government started paying the entire premium for people earning up to 150% of the poverty line—\$21,870 for an individual in 2023. Previously, those individuals had to contribute up to 4% of their incomes to premiums.

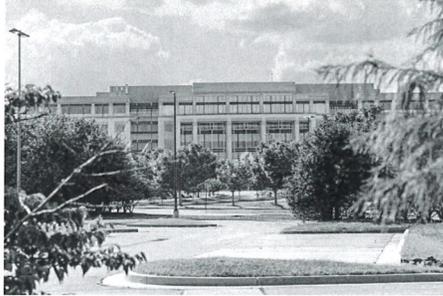
The Centers for Medicare and Medicaid Services in 2022 also allowed people in the near-poverty group to sign up for, or switch, plans any time. Enrollment is otherwise limited to a narrow window at the end of the year.

<https://www.wsj.com/health/healthcare/social-media-ads-health-insurance-scams-37d1ecfa>

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The Centers for Medicare and Medicaid Services has suspended 200 agents or brokers for suspicion of fraud. PHOTO: ROSEM MORTON FOR WSJ

Year-round enrollment created a continuous opportunity to make sales. And the boost in subsidies gave agents an enticing sales pitch: zero-premium health insurance.

To grab more commissions, some agents used misleading ads to draw business and some switched customers' plans repeatedly without their consent, according to rival agents and a civil lawsuit filed in April seeking class-action status.

"Lower-income people seem to be the target of these ads," said Lauren Phillips, an independent broker in Dallas, Ga., who said clients of hers had insurance plans switched without their consent. "They don't know the ins and outs of insurance and how it works, and they are fighting every day to keep the health insurance that they need."

The agents have targeted states that use the federally run HealthCare.gov website for consumers to buy insurance. Since 2019, the website has allowed agents to change people's health plans for them to make the process easier—but it also made it easier for bad actors to exploit.

CMS has received more than 208,000 complaints this year of unauthorized ACA insurance sign-ups. Nearly two-thirds were about people who hadn't previously been insured under the ACA. The rest were people who said their plans were switched without their consent. CMS said in July that it would stop allowing brokers to change consumers' plans unless they were already linked to the

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consumer—or conduct a three-way phone call with the customer and a CMS official. CMS said it suspended 200 agents or brokers for suspicion of fraud.



Angelina Wells found out her insurance had been canceled. PHOTO: ANGELINA WELLS

Angelina Wells last November clicked on a Facebook ad touting a government program distributing \$6,400 cash cards for groceries and other necessities. The link brought her to a website where she entered some personal details, and received a message giving a number to call to complete her application.

When she called, an agent pitched her on buying insurance. Wells asked about the cash card. The agent said it would come later. Wells, of Terrell, Texas, said she didn't consent to

changing insurance plans. The cash card never came, she said.

In March, her pharmacy said her insurance had been canceled. Under her new policy, the copay for her diabetes medicine had risen from \$2 to \$50. Wells, 53 and unemployed, stopped taking the medicine until her church took up a collection for it.

"I didn't know what was going on. I just know I went to get my medicine and my insurance was canceled," said Wells, a plaintiff in the suit filed in U.S. District Court in Fort Lauderdale, Fla.

Wells's regular insurance agent found that her insurance policy had been changed five times since November without her consent.

The suit was filed against a dozen insurance-marketing and technology companies, executives and Enhance Health, which is an arm of private-equity company Bain Capital. The defendants engaged in a racketeering conspiracy to defraud consumers using the lure of government cash handouts, the suit alleges.

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Most calls to Enhance Health call centers were from people responding to online ads expecting to receive cash cards for groceries and rent, former company agents said in affidavits filed in the suit.



Former Enhance Health CEO Matt Herman uses the social-media handle '@moneymatt305.' PHOTO: MICHELE EVE SANDBERG/SHUTTERSTOCK

One former agent said in an affidavit that Enhance Health gave agents scripts instructing them to be vague about the cash card and tell consumers benefits would arrive by mail after their policy was issued. Agents were instructed to switch plans for ACA enrollees regardless of whether they were a better fit, the agent said. The more people the agents signed up, the more commissions they would receive.

Enhance Health was started in Florida in 2021 with a \$150 million investment from Bain and insurance salesman Matt Herman. Under the social-media handle @moneymatt305, Herman posted photos of himself wearing expensive jewelry at nightclubs and boarding private jets.

Herman didn't respond to requests for comment. A Bain spokesman said that Enhance Health upholds the highest standards of compliance and that it is collaborating with state and federal agencies to enforce advertising consumer-safety guidelines.

One video ad on Facebook as recently as June promised to help viewers "put \$6,400 in your pocket right now for free," going on to say: "It's all part of a stimulus style program to help Americans get back on their feet."

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The ad, which Facebook has removed, was posted by Roberta T. Shockley, who couldn't be identified.

There were no gift cards. In truth, subsidies of as much as \$6,400 were available for some people, but only to be paid directly to the insurer to cover a plan's premium.

Meta Platforms META -0.71% ▼, Facebook's parent company, said it removed that ad—and others promoting government cash cards—for violating its policies on fraud, scams and deceptive practices. Snapchat forbids misleading ads, a spokeswoman said.



Minerva Marketing owner Brandon Bowsky
PHOTO: ARAYA DOHENY/GETTY IMAGES

The changes made it easier to sell insurance to low-income people, Brandon Bowsky, owner of Minerva Marketing—a sales-lead generation company named as a defendant in the lawsuit—said on a podcast in January. Bowsky said Minerva was generating more than \$100 million in annual revenue.

“They’re getting a discount, or they are getting it for free, or low cost, no cost, whatever the situation may be, they are more likely to sign up for something than somebody you have to sell,” Bowsky said on the podcast.

“Mr. Bowsky and his company deny the allegations of wrongdoing brought against them and will be vigorously defending the lawsuit,”

Bowsky's lawyer said.

A former agent for another brokerage named in the lawsuit, TrueCoverage, said in an affidavit that managers dismissed complaints that most callers were asking about cash cards, not insurance.

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“You must be vague and cannot give any specifics, about any rewards program under any circumstances,” a TrueCoverage manager instructed agents in a November 2023 email included in the affidavit.

TrueCoverage said that insurers sometimes offer cash cards and rewards to enrollees, but that it doesn’t enroll customers in plans without their knowledge. TrueCoverage said it hires third parties to generate sales leads, and hasn’t knowingly approved misleading content to generate leads.

CMS in August suspended two enrollment-software platforms owned by TrueCoverage’s parent company—Speridian Global Holdings—from the federal insurance marketplace.

In a September letter to Speridian, CMS said that it was suspending the platforms because of concerns U.S. patient data was being accessed at Speridian data centers in India, which would violate the CMS regulations.

The spokeswoman for TrueCoverage and Speridian said that the company is cooperating with CMS and that it isn’t aware of any security problems. TrueCoverage in August sued CMS over a suspension that it said was arbitrary and conducted without due process. CMS declined to comment on the lawsuit.

Write to Joseph Walker at joseph.walker@wsj.com

Corrections & Amplifications

Matt Herman is the former CEO of Enhance Health. A photo caption incorrectly identified Herman as Enhance Health’s CEO. (Corrected on Sept. 13)

Appeared in the September 14, 2024, print edition as ‘Promise of Cash Hid an Insurance Switch’.

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NEWS BIOLOGY

'Inverse vaccine' could help tame autoimmune diseases

Adding sugars to molecules that cause the body to attack itself shows promise in mice

15 SEP 2023 · 5:45 PM ET · BY MITCH LESLIE



Researchers used pieces of this nerve protein attached to sugars to silence autoimmune attacks in mice. J.MOL DEVELOPMENT TEAM/WIKIMEDIA COMMONS

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Vaccines rile up the immune system against pathogen invaders. But in autoimmune diseases, the immune system becomes the enemy. **Scientists have now figured out a way to tamp down this self-destructive response in mice by attaching sugars to molecules that provoke immune cells.** This "inverse vaccine," reported this month in *Nature Biomedical Engineering*, could

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The immune system responds to molecules—or pieces of them—known as antigens. Most of the time they come from dangerous invaders like viruses and bacteria. But some immune cells react to self-antigens, molecules from our own cells. And in autoimmune diseases, these misguided immune cells turn against patients' own tissues.

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For more than 50 years, researchers have been trying to stop this internal war by restoring the body's tolerance for its own antigens. They succeeded in experimental animals. In mice with an MS-like condition called experimental autoimmune encephalomyelitis (EAE), for instance, the immune system attacks the myelin insulation around nerves. Injecting myelin protein fragments into the rodents coaxes their immune systems to leave the myelin alone. But no tolerance-inducing strategy has performed well enough in people to receive approval as a therapy.

A team led by immunoengineer Jeffrey Hubbell, immunologist Andrew Treman, and biomedical engineer Rachel Wallace of the University of Chicago has been exploring a new approach: directing potential self-antigens to the liver. The organ is crucial for establishing tolerance. Immune cells there pick up self-antigens and then stifle T cells that could target these molecules. The researchers came up with a way to steer antigens to the liver by affixing them to a chain of sugars.

When researchers inject an egg white protein into mice, it normally spurs a strong immune reaction. To gauge the capability of their approach, Hubbell and colleagues first asked whether it could curb this response. The team injected the protein into mice and then gave the animals three doses of the antigen attached to the sugar chain. When the scientists later analyzed the rodents' lymph nodes and spleen, they found that the inverse vaccine weeded out and suppressed T cells that targeted the protein. These changes "all work together to reestablish immune balance," Wallace says.

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But the immune response to an egg protein isn't an autoimmune reaction. So the team next investigated whether the approach worked against EAE, which researchers can induce in mice. An inverse vaccine composed of the sugar chain carrying a fragment of a myelin protein prevented mice from developing the disease, the scientists found. And a sugar-antigen combo that targeted a different myelin protein forestalled relapses in mice with a version of EAE that resembles a form of MS whose symptoms wax and wane.

An inverse vaccine's ability to turn off a specific antigen response makes it a promising alternative to current autoimmune treatments, which more broadly suppress the immune system and leave patients vulnerable to infections and cancer, Hubbell says.

"The method they use is promising and potentially can induce better tolerance," says neurologist and neuroimmunologist A.M. Rostami of Thomas Jefferson University. But he notes that one reason previous attempts to spark tolerance failed is that researchers don't know which self-antigens are being attacked. The inverse vaccine strategy doesn't overcome that problem, he says. "Is this approach applicable to human disease in which we don't know the antigen? We don't know."

Immunologist Jane Buckner of the Benaroya Research Institute shares his mixed response to the new approach. She calls it "a good first step," but adds that the mechanisms that produce tolerance remain poorly understood.

A company Hubbell co-founded recently conducted a phase 1 trial to establish the safety of this approach in people with celiac disease, whose immune systems overreact to gluten in bread and other foods. The patients suffered no serious side effects, and the results hinted that the treatment reduced symptoms. The company has now launched a phase 2 study in celiac patients to gather further data on effectiveness, as well as a phase 1 trial of a myelin-based combination in patients with MS.

Whether the approach will finally achieve the long-sought goal of spurring tolerance in patients remains to be seen, Steinman says. "But I hope that someday somebody is going to get it right and change the world."

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BIOLOGY HEALTH

ABOUT THE AUTHOR

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Mitch Leslie writes about cell biology and immunology.

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Mr. BUCHANAN. Thanks.

Mr. Smucker.

Mr. SMUCKER. Thank you, Mr. Chairman. I don't normally serve on this subcommittee, but I have been sitting here. Very important for me to be here, because I think this is a critical important topic for several reasons. One, I admire the experience with learning more about nutrition, exercise, and saw how much impact that had on my own life in just the past few years.

Secondly, I think a lot about what I think is one of our major threats, and that is our debt and our fiscal policy. And if you look at the drivers of our increasing costs, it is—it has a lot to do with health care. And so if we can solve this problem, it will have major consequences not only on individuals lives as it did for me, but also on the health of the country going forward. And I do disagree with a few things that were said here today. I just want to mention, and then I have a question maybe for Senator Frist and Dr. Hyman.

I think there is a lot of new information here that hasn't existed a few decades ago, so I think there are a lot of people who don't understand the benefits of good food and good nutrition. And I think—so education, I think, is really, really important. Maybe I am just late to the game. I don't know. But, you know, I talk to people in my district and they have no idea how what they are eating is affecting them, cognitive ability, physically, whatever it may be, and so I think this really is going to require a lot of education, and I think that perhaps is the best investment here.

I do want to also say, so I live in Pennsylvania, Lancaster and York Counties, very strong agricultural community, a lot of nutrient dense foods. In fact, people move to my community from other states sometimes, I have talked to them, who come here just for the nutrient dense food that we have there.

We also have a great industry that has come from that, and we call ourselves the snack capital of the world. So we make—we have Hershey, we have Mars, we have Snyders, we have—we make a lot of foods that potentially would categorize as ultraprocessed food. And these are great businesspeople.

And so Ms. Gearhardt, I think it was, I probably disagree a little about with your characterization here, but I agree with a lot of the points that you make. These are individuals who if you talk to them, they are very concerned about health as well. They want to create healthy products. They are responding to the consumer.

So, for instance, I can give you a real life example of this. We implemented additional regulations some time ago that required reduced salt in chips. And when they did that, they found that people weren't buying their product anymore. Individuals who—so they are trying to respond to the consumer as well, and some of the owners of these companies are looking for ways to help address the problem that we are faced with. And so I guess, you know, Americans still like their free choice.

And Senator Frist, you talked about I strongly believe in free enterprise and capitalism and less government intervention, but that is sort of at odds with this idea that we have this opportunity where people can live much more healthily and may need to be prodded to that. What is the balance? How do you address that?

I go back to the, you know, I think education is really important, but Senator, what would you think is the right balance here? How do we move what is really an entire system that sort of feeds on itself, if you will? How do we move that to a much healthier lifestyle over time?

Dr. FRIST. You know, I think it is a great question and it is sort of the undergirding question that we have to address. Number one, the biggest and most important thing for us to remember is that healthcare is not health. And the default position of the committee structure of government the way we have set it up is that healthcare is responsible for solving the health problems.

And now with the understanding that we have all—the committee has talked about the importance of social determinants of health. Let's put genetics aside. We talked about socioeconomic status. That might be 15 percent of the health driver that we have today when it comes to obesity and chronic disease. We had the environment. I do a lot with the nature conservancy, so agriculture, you are exactly right. Regenerative agriculture we haven't talked about today, but a potential huge impact today.

But the socioeconomic aspects are important. Genetics we talked about 20 percent. Well, with technology maybe soon and some with crisper we can think about, but right now with the size of the problem, the healthcare system, me as a heart transplant surgeon, the doctor, the primary care physicians are all very important, but primarily not doing the transplant but on the education component, the trusted liaison between the patient themselves. But the 40 percent of the impact in terms of obesity and health and chronic disease does come down to the individual and the individual lifestyle and the individual behavior and the addiction that is part of—unfortunately, it was the industry itself that created not so much the addiction, but saw that the addiction worked. And if sugar is addictive, you are going to sell more potato chips, and you are going to play into that. And that is the importance of policy, you know, pursuit of happiness and our life that we are really all about.

So the balancing act is there. And so how we do that? And I think the best model that we have today, at least in the last 100 years, is smoking. Huge issue. Caused the cancer. Caused the heart disease. Caused the chronic disease. And everybody in the early 1960s says it is insurmountable, we cannot do it.

And how do we do it? We—the model was talked about earlier and we all just need to go back and study the model. It addressed the model. And today heart disease is not the issue that it was before.

The public health issue and the burden of disease and the cost of disease has been cut down to about a tenth of what it was. The cost of the way government working hand in hand with the private sector, and yes, it did involve some restrictions on advertising and freedom of speech and all the arguments it put out, but ultimately it comes back to health is more than health care, and it is the responsibility of each of us, government officials, but also individuals making choices in education—educated choices going forward.

Let me just—I am, too, very optimistic where we are today, because I think we do have artificial intelligence. We understand behavior. The scientists and the public policy people and the positions

have the tools they didn't have five years ago or ten years ago and now we have them.

Mr. SMUCKER. Mr. Chairman, I know I am out of time. I waited a long time. If we could have Dr. Hyman answer that question. I would love to get his response as well. Thank you.

Dr. HYMAN. I think we have to face the fact that, you know, we have to address the real cost to society of our food system. The Rock of Hill Foundation determined that for every dollar spend on food, that is about a trillion dollars a year in America, we spend \$3 on collateral damage in terms of public health costs from diet-related disease, antibiotic resistance that's making us more susceptible to infectious disease, environmental costs, soil degradation, loss of our water resources, the pollution of our waterways, the effective collateral damage from the farm and food workers who are not properly cared for in the labor market, and that is a legacy of the Roosevelt era and labor laws that excluded them from protections, and they are paid for by the government programs like Medicare and Medicaid and free care and hospitals. There is food insecurity, economic insecurity. All these are driving the costs that are externalized.

And so while capital is important, we are not paying the true cost of the food. The price we pay at the check-out counter for what food we are buying or for snacks is not the actual cost to society, and we have to account for those in some way and actually create incentives for businesses to do the right thing disincentives to do the wrong thing.

I think you are right, they do want to do the right thing, and I think—what I have heard from talking to the CEO of Nestle and vice chairman of Pepsi and many other large corporations, they are looking how to change, but what they hear about is this. They hear well, if I change my product, the other companies are not going to change their product. And one of the CEOs of the company said if the government could convene all the major food companies—and there is not that many. There is, like, a dozen or less food companies that control the entire food supply. And bring them together to collaborate to kind of solve this problem, I think it could make a big difference, and I think they have to be—they're working together. They can't come together because of antitrust laws, but we can do that as a government to bring them together.

Mr. BUCHANAN. Let me just close on the idea of I am hopeful personally that more people, they care about their children. I think the internet, access to information that we didn't have maybe 10, 15 years ago, to me, I want to say hopefully education will make a huge difference and people will want it. They want the best for their children. And so that is—I am hopeful on that.

So what we can do collectively is we have 20 percent of your children that are in a situation that is going to lead to issues later in life and everything else. No parent wants that. We have got to try to find a way to educate and do what we can to support that behavior.

But in closing, I would like to thank the witnesses for appearing before us today. Please be advised that members have two weeks to submit written questions to the answered later in writing. Those

questions and your answers will be made part of the formal hearing record. With that, the meeting stands adjourned.
[Whereupon, at 5:04 p.m., the subcommittee was adjourned.]

MEMBER QUESTIONS FOR THE RECORD

VERN BUCHANAN
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CO-CHAIR



COMMITTEE ON WAYS AND MEANS
TAX-WRITING COMMITTEE
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HEALTH
CHAIRMAN
TRADE

Congress of the United States
House of Representatives
Washington, DC 20515-0916

09/25/24

Dr. Frist: What impact does early detection through screening have on treatment options and outcomes for lung cancer patients?

Dr. Frist: What are the potential cost savings to the healthcare system from increased early-stage lung cancer detection?

Dr. Frist: How does lung cancer screening impact the quality of life for patients diagnosed early versus those diagnosed at late stage?

Dr. Frist: What role can this committee play in reforming Medicare's payment systems to incentivize preventive care and lower the cost of chronic disease management, particularly through value-based care models?

A handwritten signature in blue ink, appearing to read "Vern Buchanan".

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COMMITTEE ON WAYS AND MEANS
CHAIRMAN, SUBCOMMITTEE ON TAX
SUBCOMMITTEE ON HEALTH

Congress of the United States
House of Representatives
Washington, DC 20515
September 23, 2024

Senator Bill Frist,

1. How can Congress direct CMS to regularly update Medicare payments to Community Health Centers to support innovative approaches to preventing and treating chronic disease?

Sincerely,



Mike Kelly
Member of Congress

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Senator Bill Frist, MD Responses to Questions for the Record for the U.S. House Ways and Means Subcommittee on Health

Questions From Chairman Vern Buchanan (FL-16):

What impact does early detection through screening have on treatment options and outcomes for lung cancer patients?

There are several landmark studies that demonstrate the benefits of early lung cancer screening and detection. Here are some of the most significant:

1. National Lung Screening Trial (NLST) funded by the National Cancer Institute
 - Published in [New England Journal of Medicine](#) (2011)
 - 53,454 participants at high risk for lung cancer across 33 US medical centers, half randomly assigned to receive three annual screenings with low-dose computed tomography (CT), other half received three annual screenings with single-view posteroanterior chest radiography (chest X-ray)
 - Found a 20% relative reduction in lung cancer mortality with low-dose CT screening, as well as a 6.7% reduction in rate of death from any cause in low-dose CT screening group compared to the chest X-ray group.
 - From the NEJM article: “[T]he available data showed that there was a significant reduction with low-dose CT screening in the rates of both death from lung cancer and death from any cause.” The report also recommends more vigorous study of the potential adverse effects of low-dose CT screening – including high rate of false positives that require additional follow up, as well as resulting overdiagnosis and associated costs.
2. NELSON Trial (Dutch-Belgian Study)
 - Published in [New England Journal of Medicine](#) (2020)
 - 15,792 participants at high risk between the ages of 50 and 74, randomly assigned to undergo CT screening over five years vs. no screening.
 - From the NEJM article: “lung-cancer mortality was significantly lower among those who underwent volume CT screening than among those who underwent no screening.”



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3. International Early Lung Cancer Action Program (I-ELCAP)
 - Published in [New England Journal of Medicine](#) (2006)
 - 31,567 asymptomatic persons at risk for lung cancer who were repeatedly screened using low-dose CT from 1993 – 2005.
 - From the NEJM article: “CT screening according to the I-ELCAP regimen can detect clinical stage I lung cancer in a high proportion of persons when it is curable by surgery. In a population at risk for lung cancer, such screening could prevent some 80% of deaths from lung cancer. In comparison, in the United States at present, annually approximately 173,000 persons are diagnosed with lung cancer and 164,000 deaths are attributed to this disease, so that approximately 95% of those who are diagnosed with lung cancer die from it.”

What are the potential cost savings to the healthcare system from increased early-stage lung cancer detection?

While a low-dose CT scan is a more costly screening tool than a chest x-ray, it is the only tool proven to effectively determine the presence of cancer at an early enough stage to reduce lung cancer mortality, when targeted to high-risk population. Several studies have varied perspectives on the implications for cost savings.

- [Journal of Thoracic Savings](#), 2022 – “The cost-effectiveness of CT screening will likely be strongly linked to achievable smoking cessation rates. Trials and further modeling should explore the consequences of relationships between smoking behaviors and screen participation.”
- [JAMA Oncology](#), 2021: “This economic evaluation found that the 2021 US Preventive Services Task Force (USPSTF) recommendation for lung cancer screening was cost-effective; however, alternative screening strategies that maintained a minimum cumulative smoking exposure of 20 pack-years but included individuals who quit smoking within the past 25 years may be more cost-effective and warrant further evaluation.”

How does lung cancer screening impact the quality of life for patients diagnosed early versus those diagnosed at late stage?

Early detection has a substantial impact on likelihood of survival, and allows for better quality of life with generally less aggressive treatments needed in earlier stages. As a heart and lung



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surgeon, I can attest that the more minor the procedure needed, the greater the likelihood of a quick, complication-free recovery.

Outcomes:

1. Survival Rates

- 5-year survival rate for those with localized cancer at diagnosis (meaning there is no sign that the cancer has spread outside of the lung) – 65% for non-small cell lung cancer, 30% for small cell lung cancer.¹
- Compare this to the 5-year survival rate when the cancer is distant at diagnosis (meaning the cancer has spread to distant parts of the body, such as the brain, bones, liver, or the other lung) - 9% for non-small cell lung cancer, 3% for small cell lung cancer.

2. Quality of Life

- With early detection, less aggressive treatments often needed
- Fewer complications
- Better preservation of lung function

Challenges to Consider:

- False positives can lead to unnecessary procedures
- Access to screening programs varies by location and healthcare system

The [American Cancer Society recommends](#) yearly screening for lung cancer with a low-dose CT (LDCT) scan for at higher risk of lung cancer, specifically people ages 50 to 80 years who: Smoke or used to smoke AND have at least a 20 pack-year history of smoking.² ACS explains that research has shown that unlike chest x-rays, yearly LDCT scans to screen people at higher risk of lung cancer can save lives.

¹ American Cancer Society, <https://www.cancer.org/cancer/types/lung-cancer/detection-diagnosis-staging/survival-rates.html>, Accessed 11/19/24.

² A pack-year is equal to smoking 1 pack (or about 20 cigarettes) per day for a year. For example, a person could have a 20 pack-year history by smoking 1 pack a day for 20 years, or by smoking 2 packs a day for 10 years.



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What role can this committee play in reforming Medicare's payment systems to incentivize preventive care and lower the cost of chronic disease management, particularly through value-based care models?

- Federally Qualified Health Centers (FQHCs) are the community hub for low-cost, high-quality, integrated preventive primary care. Research suggests Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) with high FQHC participation generate greater savings.³ Data from the 2020-2022 HRSA Uniform Data System shows FQHCs outperforming national benchmarks on keeping diabetes and hypertension under control, despite serving more at-risk patients.
- FQHCs are reimbursed under a Medicare Prospective Payment System (PPS), which is the original value-based payment method, as it delivers a single payment per patient per visit, incentivizing cost-efficient care. In 2024, the national median FQHC PPS rate for in-person medical visits was \$195.99. For telehealth medical visits, the 2024 median FQHC PPS rate is only \$95.27. The actual amounts are less than 80% of that number when accounting for a Geographic Adjustment Factor (GAF) and beneficiary co-pay, which many health center patients cannot afford to pay.
- FQHCs report their actual costs of providing care as being closer to \$300 per Medicare patient per visit. As the 65+ age group is the fastest growing segment at health centers, the gap in reimbursement will make it increasingly difficult to sustain standard practices for treating chronic disease, let alone innovative approaches that can prevent disease progression.
- For instance, the basic cost of acquiring a routine vaccine like the one for preventing shingles outbreaks exceeds Medicare reimbursement to the FQHC, not even accounting for provider time and payment can be delayed by 12-18 months. Procedure-only visits that can prevent hospitalization and complex surgeries later such as wart removal, diabetic nail debridement, skin biopsies are not included in the Medicare FQHC PPS and billing via add-on Physician Fee Schedule (PFS) codes is not feasible due to the increased burden of provider training, hiring more billing staff. Chronic Care Management services can reduce hospital readmissions & emergency room bounce-backs, but for Medicare Advantage patients separate co-pays discourage them from using these services.
- FQHCs are still trialing innovative disease prevention approaches using limited grant or philanthropic dollars. For example, in Congressman Buchanan's district, an FQHC called MCR Health has pioneered the *Prevent2 Program* as part of its diabetes education services.

³ Medicare Accountable Care Organizations In 2022: Renewed Growth and Improved Savings Show Small Rebound from the COVID-19 Pandemic", Health Affairs Forefront, October 19, 2023. DOI: 10.1377/forefront.20231017.282343



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PreventT2 groups meet for a year — weekly for the first 6 months, then once or twice a month for the second 6 months to maintain healthy lifestyle changes. During each session, a lifestyle coach teaches a new lesson and leads a group discussion on topics such as cooking healthier food at home, adding physical activity to the daily routine, managing stressors, making good choices when eating at restaurants. The target is to help each participant reduce their risk of type 2 diabetes individually and to reinforce preventive interventions by empowering peer-to-peer support through the groups. Additionally, licensed nutritionists conduct assessments and help patients develop meal plans and exercise portion control. Initial consultations can be supplemented with telehealth registered dietitian counseling. MCR also partners with Meals on Wheels to provide healthy meals to patients who require such assistance due to their illnesses or health-related social needs. These community-based interventions can decrease recurrent hospitalization and ER visits but are not covered by the FQHC PPS or widely adopted Alternative Payment Models (APM).

○ **Solutions:**

- The Committee should consider approaches to promote universal screening for food insecurity and nutrition insecurity in Medicare, which should include treatment planning and follow-up for patients who are identified as food or nutrition insecure, ideally including bi-directional referral systems that allows health care providers to know if the patient was connected with appropriate services, such as a quality Food is Medicine interventions and/or nutrition counseling.
- The Committee should consider approaches to empower federally funded community health centers, rural health clinics, and other relevant federally funded-facilities to provide/operate Food is Medicine Programs: produce prescriptions, medically tailored groceries, and medically tailored meals.
- The Committee should consider approaches to improve coordination of care and integrating nutrition services and resources within federally-funded community health centers, rural health clinics, and other federally-funded primary care facilities, so that these facilities have the infrastructure to offer quality care for diet-related illnesses.
- The Committee should consider legislation directing CMS to conduct a periodic review of which services should be covered under the Medicare FQHC PPS and the cost of providing these services and to update the payment rate at a frequency of no less than every 3-4 years, similar to how it updates payments for Certified Community Behavioral Health Clinics (CCBHC).
- The Committee has advanced the *Preserving Telehealth, Hospital, and Ambulance Access Act* (H.R.8261), which extends essential telehealth flexibilities beyond December 31, 2024. When negotiating final language for enactment, language from



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Section 101 of the amended *Telehealth Modernization Act* (H.R. 7623) advanced by the Energy & Commerce Committee should also be included, as it fixes a critical disparity in reimbursement between in-person and telehealth medical visits at FQHCs.

- The Committee should also consider directing CMS to ensure innovative APMs are accessible to safety-net providers like FQHCs by eliminating barriers like minimum Medicare beneficiary numbers and double-sided risk.
- The Committee should request the Congressional Budget Office to fully capture the downstream savings delivered by investing in preventive health services, such as when CBO noted that investing in FQHCs could save Medicare and Medicaid more than \$700 million.⁴

Question From Representative Mike Kelly (PA-16):

How can Congress direct CMS to regularly update Medicare payments to Community Health Centers to support innovative approaches to preventing and treating chronic disease?

- Federally Qualified Health Centers (FQHCs) are the community hub for low-cost, high-quality, integrated preventive and primary medical, mental health, substance use disorder, dental, hearing and vision services. Academic research suggests Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) with high FQHC participation generate greater savings.⁵ Data from the 2020-2022 HRSA Uniform Data System also shows FQHCs outperforming national benchmarks on keeping diabetes and hypertension under control, despite serving more at-risk patients.
- FQHCs are reimbursed under a Medicare Prospective Payment System (PPS), which is the original value-based payment method, as it delivers a single payment per patient per visit, incentivizing cost-efficient care. Congress directed CMS to set a baseline FQHC PPS rate, which CMS did in 2014. This rate has been slightly updated based on the Medicare Economic Index (MEI) every year since. In 2024, the national median FQHC PPS rate for in-person medical visits was \$195.99. For telehealth medical visits, the 2024 median FQHC PPS rate is only \$95.27. The actual amounts are less than 80% of that number when

⁴ <https://www.cbo.gov/publication/60058>

⁵ Medicare Accountable Care Organizations In 2022: Renewed Growth and Improved Savings Show Small Rebound from the COVID-19 Pandemic", Health Affairs Forefront, October 19, 2023. DOI: 10.1377/forefront.20231017.282343



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- FQHCs report their actual costs of providing care as being closer to \$300 per Medicare patient per visit. As the 65+ age group is the fastest growing segment at health centers, the gap in reimbursement will make it increasingly difficult to sustain standard practices for treating chronic disease, let alone innovative approaches that can prevent disease progression.
- For instance, the basic cost of acquiring a routine vaccine like the one for preventing shingles outbreaks exceeds Medicare reimbursement to the FQHC, not even accounting for provider time and payment can be delayed by 12-18 months. Procedure-only visits that can prevent hospitalization and complex surgeries later such as wart removal, diabetic nail debridement, skin biopsies are not included in the Medicare FQHC PPS and billing via add-on Physician Fee Schedule (PFS) codes is not feasible due to the increased burden of provider training, hiring more billing staff. Chronic Care Management services can reduce hospital readmissions & emergency room bounce-backs, but for Medicare Advantage patients separate co-pays discourage them from using these services.
- FQHCs are still trialing innovative disease prevention approaches using one-off grant or philanthropic dollars. For example, in Congressman Kelly's district, an FQHC called Primary Health Network has pioneered providing "fresh food boxes" to families that screen positive for food insecurity. They have also invested in a community garden project that helps patients choose low-sodium, low-sugar, natural foods instead of highly processed items that can worsen heart disease and diabetes. These community-based interventions can decrease recurrent hospitalization and ER visits but are not covered by the FQHC PPS or widely adopted Alternative Payment Models (APM).
- **Solutions:**
 - The Committee should consider approaches to promote universal screening for food insecurity and nutrition insecurity in Medicare, which should include treatment planning and follow-up for patients who are identified as food or nutrition insecure, ideally including bi-directional referral systems that allows health care providers to know if the patient was connected with appropriate services, such as a quality Food is Medicine interventions and/or nutrition counseling.
 - The Committee should consider approaches to empower federally funded community health centers, rural health clinics, and other relevant federally funded-facilities to provide/operate Food is Medicine Programs: produce prescriptions, medically tailored groceries, and medically tailored meals.



SENATOR WILLIAM H. FRIST, M.D.
U. S. SENATE (1995 - 2007)
MAJORITY LEADER (2002 - 2007)

- The Committee should consider approaches to improve coordination of care and integrating nutrition services and resources within federally-funded community health centers, rural health clinics, and other federally-funded primary care facilities, so that these facilities have the infrastructure to offer quality care for diet-related illnesses.
- Congress should direct CMS to conduct a periodic review of which services should be covered under the Medicare FQHC PPS and the upfront cost of providing these services and update the payment rate at a frequency of no less than every 3-4 years, similar to how it updates payments for Certified Community Behavioral Health Clinics (CCBHC).
- Congress should pass the *Telehealth Modernization Act* (H.R. 7623) to extend telehealth flexibilities beyond December 31, 2024, and to fix the disparity in reimbursement between in-person and telehealth medical visits at FQHCs.
- Congress should direct CMS to ensure innovative APMs are accessible to safety-net providers like FQHCs by eliminating regulatory barriers like minimum Medicare beneficiary numbers and double-sided risk.
- Congress should pass the *Preventive Health Savings Act* (H.R. 766), which allows Committees to request the Congressional Budget Office to include 20 and 30-year budget windows in its estimates to fully capture the downstream savings delivered by investing in preventive health services. Of note, even in the limited 10-year window FQHCs have been estimated by CBO to save Medicare and Medicaid more than \$700 million.⁶

⁶ <https://www.cbo.gov/publication/60058>

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Congress of the United States
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09/25/24

Dr. Hyman: What role can this committee play in reforming Medicare's payment systems to incentivize preventive care and lower the cost of chronic disease management, particularly through value-based care models?

Dr. Hyman: What impact could removing barriers to Health Savings Accounts (HSAs) access for patients like working seniors, veterans, and individuals in a direct primary care arrangements have on patient engagement in preventive care?

Dr. Hyman: Can you please speak to the importance of the *Personal Health Investment Today (PHIT) Act*. This bill would encourage physical activity and incentivize healthier living by allowing Americans to use a portion of the money saved in their pre-tax health savings account (HSA) and flexible spending account (FSA) toward qualified sports and fitness purchases, such as gym memberships, fitness equipment, and youth sports league fees.

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09/25/24

Dr. Hyman: What role can this committee play in reforming Medicare's payment systems to incentivize preventive care and lower the cost of chronic disease management, particularly through value-based care models?

Fortunately, the House Ways and Means Committee has vast authority that can be utilized to promote value-based care, including incentives for effective preventive care that will both improve health outcomes and reduce chronic disease management costs. With respect to food and nutrition, I recommend the Committee consider and either legislate or pursue via regulatory action the following needed reforms:

- *First, we need to increase federal investment in proven strategies that prevent and treat chronic disease. Today, physicians have few if any incentives to incorporate nutrition into their medical practice, despite the central role that nutrition and diet play in the cause and cure of our epidemic of chronic disease. In Medicare, for example, the small number of programs addressing nutrition are extremely limited in scope and under-utilized. In addition, physicians and health care systems are generally being paid for performing more procedures, not for delivering greater value by achieving better health outcomes and reducing health care costs. This imbalanced approach leads to more pain, suffering, early mortality, and higher costs for everyone.*

As a result, I urge the House and Senate to pass the American Medical Innovation and Investment Act, which includes a Medically Tailored Meals Demonstration in Medicare. The demonstration would "test a payment and service delivery model under which selected hospitals provide medically tailored home-delivered meals" to qualified individuals "to improve clinical health outcomes and reduce the rate of readmissions." Under this exciting demonstration program, qualified beneficiaries would receive medically tailored home-delivered meals that meet most of their daily nutritional needs. They would also receive medical nutrition therapy from skilled clinicians including physicians, registered dietitians or other nutrition professionals, or clinical social workers. Best of all, beneficiaries would not pay cost-sharing for the services.

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In addition, I urge the Committee to explore adding other innovations to integrate nutrition into health care through innovations, such as patient assessment, produce prescriptions, and medically tailored meals as well as proven group shared medical lifestyle change programs such as Functioning for Life developed at the Cleveland Clinic Center for Functional Medicine. Approximately 240,000 seniors see a physician or nurse every weekday – and the vast majority of them will leave without a prescription for the healthy food they need to heal and thrive. This Committee can change that by prioritizing nutrition in the treatment of chronically ill Medicare beneficiaries.

Additionally, it is vital to incentivize nutrition-focused clinical care for patients with chronic diseases via such means as a Medicare nutrition add-on payment for participating physicians and hospitals. In this manner, more clinicians will assess patients' suitability for using food as medicine, offering patients the option to take control of their own health rather than automatically defaulting to conventional and costly medication and institutionalization.

- *Second, we must fully train tomorrow's clinicians about the power of nutrition and ensure they are reimbursed for its use. Patients respond very well to nutrition-centered care, but too few providers know how to deliver it. When I went to medical school, there was no focus on the impact of food on our health. Forty years later, my daughter, a 4th year medical student, has received no nutrition education, either. Although there is clinical consensus that 7 of the 10 leading killers are preventable, diet-driven chronic diseases, most medical schools don't require a single course in nutrition.*

The Committee can fix this problem by setting minimal competency requirements in nutrition as part of the federal government's \$17 billion funding of graduate medical education and require nutrition classes and functional medicine in federally funded medical schools.

- *Finally, I would like to encourage the Committee to consider additional models that are already delivering much-needed progress. For example, the National Diabetes Prevention Program (DPP) has been a valuable tool in reducing the risk of type 2 diabetes, particularly among high-risk populations. The program, which focuses on lifestyle interventions like diet and physical activity, has been shown to reduce the risk of developing diabetes by 58%. As a result, I propose a National Diabetes Reversal Program be explored in which diet and lifestyle interventions are used to bend the curve of this dreaded chronic condition.*

Dr. Hyman: What impact could removing barriers to Health Savings Accounts (HSAs) access for patients like working seniors, veterans, and individuals in a direct primary care arrangements have on patient engagement in preventive care?

Removing barriers to Health Savings Accounts (HSAs) can significantly enhance patient engagement in preventive care. Because HSAs offer individuals a tax-advantaged way to save for medical expenses, making them more accessible has the strong potential to empower working seniors, veterans, and individuals in a direct primary care arrangements to prioritize preventive care and make more informed healthcare choices.

For example, enhancing HSA access can lead to increased financial flexibility for patients. Many seniors and veterans often face financial constraints that limit their ability to seek preventive care services, such as regular check-ups, vaccinations, and screenings. By allowing these populations to use HSAs, they gain the ability to allocate funds specifically for preventive measures without the burden of immediate out-of-pocket costs. This financial incentive can motivate individuals to engage more actively with their healthcare providers, leading to earlier interventions and better health outcomes.

Just as important, expanded availability of HSAs can encourage a more proactive approach to health management. With direct primary care arrangements, patients typically have a more personalized relationship with their healthcare providers. If these individuals can utilize HSAs to cover the costs associated with preventive services, they may be more inclined and able to take charge of their health. In my practice, I often see that patients who have the means to invest in their health are more likely to engage in healthier lifestyle choices and preventive measures. This should and need not be possible solely for patients with their own economic means – instead, it should be available to all, and expanded access to HSAs can make that possible.

Finally, expanded HSA access can make a profound difference in reducing the prevalence of chronic diseases. We know, for example, that healthy food – not medication – is capable of reversing type 2 diabetes. Eating whole real food is not simply helpful in preventing disease, it is the most effective treatment, for the most costly and debilitating diseases facing Americans. Despite that, our funding reveals an obvious priority asymmetry. Indeed, we pay around \$1 billion for nutrition services a year for type 2 diabetes and an extra \$85 billion in additional medications for patients with diabetes. This asymmetry makes no sense at all and would be meaningfully addressed through broader access to HSAs for preventive care.

For these reasons, HSAs' beneficial impact on preventive care extends beyond individual patients – it can also relieve pressure on the broader healthcare system by decreasing hospital admissions and long-term healthcare costs. Indeed, the promotion of preventive care through accessible HSAs will do much to reduce the incidence of costly medical interventions and

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achieve broader use of nutrient-rich foods. As a result, using HSAs to prioritize prevention over treatment will achieve significant savings for both patients and the nation as a whole.

Dr. Hyman: Can you please speak to the importance of the *Personal Health Investment Today (PHIT) Act*. This bill would encourage physical activity and incentivize healthier living by allowing Americans to use a portion of the money saved in their pre-tax health savings account (HSA) and flexible spending account (FSA) toward qualified sports and fitness purchases, such as gym memberships, fitness equipment, and youth sports league fees.

I think the Personal Health Investment Today (PHIT) Act can be a crucial piece of the solution we need to make America healthier, more productive, and more secure. By allowing people to use a portion of their HSAs and flexible spending accounts (FSAs) for qualified sports and fitness expenses, PHIT can do much to promote physical activity and healthier living. By allowing pre-tax dollars to be used for expenses like gym memberships, fitness equipment, and youth sports league fees, PHIT will lower the financial burden of maintaining an active lifestyle.

In light of the prevalence of obesity and other chronic diseases, PHIT is needed to improve our nation's overall health. Greater levels of movement and exercise are critical for preventing chronic illnesses, including obesity, diabetes, and cardiovascular diseases. Today, nearly 75% of American adults are overweight, and 42% are obese. Even our children are suffering, with more than 40% of them overweight and more than 20% obese. These conditions were practically unheard of in children in my generation and prior, and they reduce our children's life expectancy by up to 14 years. They also impact our economic future, as they make people become lifetime patients of the medical system and reduce our global competitiveness. Just as troubling, obesity threatens our national security because most young Americans are unfit to serve in our due to conditions including overweight and obesity.

By contrast, regular exercise prevents chronic illness, enhances physical health, and greatly contributes to mental health by reducing stress, anxiety, and depression. By making financial incentives available, PHIT will enable more people to prioritize their health, engage in regular exercise, and make better lifestyle choices. Our society faces tremendous health challenges, so I urge Congress to pass the PHIT Act to pave the way for a healthier, more active future.

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09/25/24

Dr. Peters: What impact does early detection through screening have on treatment options and outcomes for lung cancer patients?

Dr. Peters: What are the potential cost savings to the healthcare system from increased early-stage lung cancer detection?

Dr. Peters: How does lung cancer screening impact the quality of life for patients diagnosed early versus those diagnosed at late stage?

A handwritten signature in blue ink that reads "Vern Buchanan".

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09/25/24

Dr. Peters: What impact does early detection through screening have on treatment options and outcomes for lung cancer patients?

- **Answer:** Lung cancer screening in at-risk individuals is very important and can substantially change treatment options for some types of lung cancers. But, it depends on the screening test and how well validated it is. Unfortunately, most blood cancer screening tests are not able to accurately pick up early disease, but the science continues to improve in this area. Spiral chest CT scans have been validated in detecting cancer early, which can substantially change the trajectory of treatment options for some patients.

Dr. Peters: What are the potential cost savings to the healthcare system from increased early-stage lung cancer detection?

- **Answer:** If a validated test is used, the relative cost savings to the healthcare system has been shown to be significant. One [study](#) estimated the national cost savings from early detection of lung cancer to be at least \$3.4 billion per year, due to the fact that lung cancer costs are 45% higher for late-stage diagnoses compared to early-stage and the majority of lung cancers are currently diagnosed at a late stage.

Dr. Peters: How does lung cancer screening impact the quality of life for patients diagnosed early versus those diagnosed at late stage?

- **Answer:** Early detection is critical for quality of life for patients and survival for patients diagnosed with lung cancer. The five-year cancer survival rate for a person diagnosed with early-stage lung cancer is about [eight times higher](#) than a person diagnosed with late-stage cancer that has spread to other areas of the body.

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A handwritten signature in blue ink that reads "Van Baker". The signature is written in a cursive style with a large, sweeping "V" and "B".

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09/25/24

Dr. Rinaldo: What role can this committee play in reforming Medicare's payment systems to incentivize preventive care and lower the cost of chronic disease management, particularly through value-based care models?

Dr. Rinaldo: In your testimony you talked about the nutrition benefits SCAN offers patients.

- *In your experience, how do these healthy meals impact patient health outcomes?*

A handwritten signature in blue ink that reads "Vern Buchanan".

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October 17, 2024

The Honorable Vern Buchanan
 Chairman
 House Committee on Ways & Means
 Subcommittee on Health
 U.S. House of Representatives
 Washington, DC 20515

Dear Mr. Chairman:

Thank you again for the opportunity to testify before the Health Subcommittee's Hearing entitled *Investing in a Healthier America: Chronic Disease Prevention and Treatment* on September 18, 2024. I appreciate the opportunity to respond to your questions for the record and have provided my responses below.

SCAN and I look forward to working with you and the Committee to develop and promote policies to help our members avoid and manage chronic disease.

Please let me know if you have any additional questions.

What role can this committee play in reforming Medicare's payment systems to incentivize preventive care and lower the cost of chronic disease management, particularly through value-based care models?

Thank you, Chairman Buchanan, for your question. This committee has an integral role to play in encouraging preventive care and high-quality, efficient, chronic disease management. One immediate action the committee can take is passing H.R. 5746, the Addressing Whole Health in Medicare Advantage Act. This bipartisan piece of legislation would expand eligibility for special supplemental benefits for the chronically ill (SSBCI) to beneficiaries who are "low-income" or fit "criteria relating to social and socioeconomic risk." SCAN believes that low-income individuals who are not eligible for Medicaid and/or the Part D low-income subsidy (LIS), often referred to as the "near poor" face many of the social and health-related risk factors as duals or LIS enrollees and should be included in these criteria. SSBCIs help lower the cost of chronic disease management by providing services like nutritional meals, non-emergency medical transportation, and other services that enhance access to care, reducing high-cost services like hospitalizations and complex treatments for late-stage disease.

In your testimony you talked about the nutrition benefits SCAN offers patients. In your experience, how do these healthy meals impact patient health outcomes?

Thank you, Chairman Buchanan, for this important and timely question. SCAN is a strong advocate of the Food as Medicine Movement. We recognize that access to high-quality, culturally tailored, nutritional meals and targeted nutritional counselling is essential for the

management of chronic diseases such as diabetes. As such, we have engaged with meal partners to offer culturally appropriate diabetic meals and nutritional counselling to our members at no additional cost to them. We also offer home-delivered meals for up to four weeks following a hospital stay, and we provide long-term services and supports meals for our qualifying dually eligible members. In 2023, we delivered a total of almost 41,000 meals per month. In 2025, we are excited to offer many of our members a benefit through Instacart, which they can use to purchase food from a curated list of nutritional products. We continuously evaluate our food and nutrition interventions to fine-tune our existing offerings and determine new opportunities to help our members.

In my professional experience, providing home-delivered meals to seniors is a vital supplemental benefit that can significantly impact clinical outcomes. Proper nutrition plays a crucial role in maintaining health and independence, managing chronic conditions, and improving overall well-being for older adults. Many seniors face significant barriers to accessing healthy food, including mobility issues and the inability to perform activities of daily living (ADLs) independently, financial constraints, or lack of support systems. Offering home-delivered meals as a supplemental benefit and ensuring regular access to nutritious meals can help seniors adhere to their plan of care for managing complex chronic conditions, like congestive heart failure or diabetes. Ultimately, this can help to reduce exacerbations of these chronic diseases, which often lead to acute care utilization such as ED visits and hospitalizations.

Sincerely,

Francesca Rinaldo

Francesca Rinaldo, M.D./Ph.D.
Chief Clinical Innovation Officer

SCAN Health Plan
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REPRESENTATIVE MIKE KELLY
SIXTEENTH DISTRICT, PENNSYLVANIA



COMMITTEE ON WAYS AND MEANS
CHAIRMAN, SUBCOMMITTEE ON TAX
SUBCOMMITTEE ON HEALTH

Congress of the United States
House of Representatives
Washington, DC 20515
September 23, 2024

Dr. Francesca Rinaldo,

1. Beneficiaries in MA had lower rates of inpatient utilization and ER visits, and higher rates of physician visits. What can we learn from MA that helps promote a health system of cost-efficiency and better health outcomes?
2. Use of preventive services is one important factor in keeping chronic health conditions from getting worse. In a recent study, Medicare Advantage outperformed fee for service Medicare in 9 out of 10 key preventive and chronic disease care measures. Are there any populations that benefit specifically from MA's focus on preventive care?

Sincerely,

Mike Kelly
Member of Congress

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October 17, 2024

The Honorable Mike Kelly
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kelly:

It was an honor to testify at the Ways & Means Health Subcommittee Hearing entitled *Investing in a Healthier America: Chronic Disease Prevention and Treatment* on September 18, 2024. I have had the opportunity review your questions for the record and am pleased to provide my responses below.

SCAN and I look forward to working with the Committee to develop and promote policies to help our members avoid and manage chronic disease. Please let me know if you have any additional questions.

Beneficiaries in MA had lower rates of inpatient utilization and ER visits, and higher rates of physician visits. What can we learn from MA that helps promote a health system of cost-efficiency and better health outcomes?

Thank you, Congressman Kelly, for this question. More than 30 million Americans – over 51% of people eligible for Medicare – choose Medicare Advantage. MA provides seniors a convenient, coordinated care option for their health coverage and provides greater value for enrollees. Most beneficiaries enjoy zero-premium plans with prescription drug coverage included. Plus, unlike for fee-for-service enrollees, MA beneficiaries have an annual out-of-pocket spending limit without needing to purchase a supplemental insurance policy.

Because MA plans are paid a capitated rate, plans are at risk for expensive inpatient stays and other often avoidable services, like a trip to the emergency room. To prevent these unpleasant and expensive services, SCAN invests in primary care and preventive services. SCAN also offers a host of supplemental benefits aimed at improving outcomes, including meal delivery, non-emergency transportation, unlimited urgent care and behavioral health support via telehealth. All of this focus is intended to diagnose and manage disease early rather than treat it in our system's most expensive settings.

Beyond these benefits, our member services team provides member-specific care management. For example, we proactively reach out to help our beneficiaries through difficult medical and non-medical moments, such as when a spouse passes away. We also conducted extremely thorough outreach during the unwinding of COVID-19 Medicaid flexibilities to ensure our dually eligible members did not have any gaps in coverage and care.

All these examples demonstrate why I believe most seniors choose MA over fee-for-service. The benefits, cost savings, and personal touch create an all-around better healthcare experience, including better outcomes.

Use of preventive services is one important factor in keeping chronic health conditions from getting worse. In a recent study, Medicare Advantage outperformed fee for service Medicare in 9 out of 10 key preventive and chronic disease care measures. Are there any populations that benefit specifically from MA's focus on preventive care?

Thank you for this question, Congressman Kelly. Medicare Advantage is a great option for all Americans, including those with health-related social needs. SCAN's mission-driven health plan implements new ways to deliver evidence-based, patient-centered care to older adults including large numbers of minority and low-income Americans.

Overall, we serve tens of thousands of members with significant health-related social needs. Around 28% of SCAN's beneficiaries live in census tracts marked by the U.S. Department of Agriculture as food deserts, while about a quarter of our members live in the most at-risk quintile of census tracts for housing insecurity, according to the Department of Housing and Urban Development. For these members, supplemental benefits like food and nutrition can make a massive difference in meeting their budget each month and improving health outcomes. In fee-for-service, this assistance is unavailable.

For some specific populations, SCAN has developed innovative new plan options, like SCAN Inspired by Women for Women and SCAN Affirm Partnered with Included LGBTQ+ Health. Our newest population-specific plan, SCAN Allied, developed to serve the large Asian population in Southern California. These seniors, who often speak English as a second or third language, can get culturally tailored care from a network of providers with the linguistic and cultural context to connect with patients and help manage chronic conditions. And, of course, any senior can join these plans, not just the target population.

In addition to our population-specific plans, we have a suite of chronic special needs plans (C-SNPs) for beneficiaries who have one or more chronic illnesses. These plans include condition-specific options for seniors with diabetes, chronic heart conditions, or end-stage renal disease. In each of these plans, we offer benefits targeted at prevention and management of disease progression, such as \$0 cost insulin in our diabetes C-SNP and low-cost cardiovascular specialty care in our C-SNP targeted at members with chronic heart conditions.

Finally, we have the only fully integrated dual-eligible special needs plan (D-SNP) in California. SCAN Connections helps low-income members get the right care for them without administrative barriers that come from having separate Medicaid and Medicare plans.

Sincerely,

Francesca Rinaldo

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U.S. House of Representatives

COMMITTEE ON WAYS AND MEANS
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September 24, 2024

**Health Subcommittee Hearing on Investing in a Healthier America: Chronic Disease
Prevention and Treatment – September 18, 2024
Questions for the Record for Dr. Gearhardt**

Dr. Gearhardt, in your testimony you draw a direct line between the marketing playbooks used by Big Tobacco and the ultra-processed food industry. In particular, you discuss the targeted marketing toward children both in-store and on social media, with children in rural communities, communities of color, and families struggling to afford nutritious food disproportionately impacted. I am deeply concerned about both the potential harms to children and the health equity implications of such targeted advertising.

How can Congress best protect children—particularly those in rural and underserved communities—from these targeted marketing tactics?

We have all seen claims in marketing materials and on food packaging that make the food inside sound healthy, such as “low-fat” or “all-natural.” It seems that these types of claims could be misleading and entice consumers to make purchases perceived as “healthier” despite being ultra-processed.

Can consumers trust health claims on food packaging or in marketing materials? How can consumers differentiate between nutrient-rich foods and nutrient-poor foods?

How are these claims currently regulated, and what more can regulators and Congress do to hold companies accountable for their marketing claims?

What are the major barriers to educating consumers about ultra-processed food, and how can Congress help address them?

What lessons can we learn from experiences of other countries implementing policies aimed at curbing the health consequences associated with ultra-processed food? What equity implications should Congress consider in any future policies?

Sincerely,

A handwritten signature in black ink, appearing to read "Lloyd Doggett". The signature is fluid and cursive, with a long horizontal stroke extending from the end.

The Honorable Lloyd Doggett

U.S. House of Representatives Committee on Ways and Means Health Subcommittee
Hearing on “Investing in a Healthier America: Chronic Disease Prevention and
Treatment”

Questions for the Record for Dr. Gearhardt

Questions for the Record from Congressman Doggett

Dr. Gearhardt, in your testimony you draw a direct line between the marketing playbooks used by Big Tobacco and the ultra-processed food industry. In particular, you discuss the targeted marketing toward children both in-store and on social media, with children in rural communities, communities of color, and families struggling to afford nutritious food disproportionately impacted. I am deeply concerned about both the potential harms to children and the health equity implications of such targeted advertising.

1. How can Congress best protect children—particularly those in rural and underserved communities—from these targeted marketing tactics?

Implementing robust policy measures to protect all children can inherently benefit those who are most targeted, including rural and underserved communities. According to recent World Health Organization (WHO) guidelines, a series of recommendations have been proposed to safeguard children from the detrimental effects of food marketing. The key points include:

1. **Mandatory Regulations**: The WHO recommends enforcing mandatory regulations to restrict the marketing of foods and non-alcoholic beverages high in saturated fats, trans fats, added sugars, and/or salt (HFSS). Growing evidence also suggests potential health risks associated with artificial sweeteners, and the absence of long-term studies on their impact on youth further justifies the need for the consideration of marketing restrictions in this area. Consideration should also be given to brand marketing strategies that implicitly promote unhealthy products without explicitly showcasing them. Attention should be paid to restricting both the exposure channels of marketing (i.e., places where children are likely to see junk food ads, including television, digital, physical advertisements such as billboards, schools) as well as the creative content (i.e., restricting the use of appeals that target children, like cartoons). Often times the places where children are exposed are not necessarily “children’s channels;” for example, more children view the Superbowl than view children’s TV programs. To address this gap, policies should target all places where children are exposed, not only places that have a high proportion of child viewers.

2. **Age Range**: Protections should encompass all individuals under the age of 18. Adolescents are often neglected in regulatory efforts, yet this demographic experiences a significant increase in the consumption of ultra-processed foods. During this developmental stage, they exhibit greater independence, reduced parental supervision, heightened reward sensitivity, and increased susceptibility to peer pressure. Consequently, the aggressive marketing tactics targeting teens for unhealthy products interact with key developmental vulnerabilities, akin to igniting gasoline with a match. This is particularly concerning given the increasing use of

social media, like TikTok, to market unhealthy foods and beverages to adolescents. On social media, innovative strategies are employed to market unhealthy products in a targeted way. These include paying social media influencers to promote the products and creating branded hashtag challenges to boost consumption.

3. **Comprehensive Approach**: Policies must be comprehensive to prevent marketing efforts from shifting to alternate media channels or targeting different age groups. The guidelines employ a broad definition of marketing that includes all forms of commercial communication.

4. **Rights-Based Approach**: Although challenging in the United States due to First Amendment protections on speech, these recommendations are grounded in children's rights to health, nutritious food, privacy, and freedom from exploitation. There are already restrictions on certain products for children, such as alcohol, tobacco, and gambling. Increasing evidence suggests that unhealthy ultra-processed foods and beverages resemble these restricted products in terms of design and health impact, much more so than they resemble naturally nutritious foods. Therefore, implementing analogous marketing bans may be justified.

By adopting these comprehensive and rights-based policy measures, there is potential to effectively reduce the negative impact of food marketing on children's health across various demographics with the biggest impact on the children who are most strongly targeted by advertisers (e.g., rural children, under-resourced children, Black and Hispanic children).

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Fischer, N. M., Duffy, E. Y., & Michos, E. D. (2021). Protecting our youth: Support policy to combat health disparities fueled by targeted food advertising. *Journal of the American Heart Association*, 10(1), e018900.

We have all seen claims in marketing materials and on food packaging that make the food inside sound healthy, such as “low-fat” or “all-natural.” It seems that these types of claims could be misleading and entice consumers to make purchases perceived as “healthier” despite being ultra-processed.

**2. Can consumers trust health claims on food packaging or in marketing materials?
How can consumers differentiate between nutrient-rich foods and nutrient-poor
foods?**

There is limited oversight of claims and promotions placed on ultra-processed foods and beverages. A significant proportion of these nutrient-poor, heavily processed foods and beverages targeted at children feature some form of health claim. A typical example involves ultra-processed products adorned with images of fruit and claims about Vitamin C content, while in fine print it is disclosed that the product contains 0% fruit. Nearly 100% of fruit drinks- the top sugary drink among children- carry nutrition-related claims, and research shows that these claims mislead parents into thinking products are healthier than they are. In stark contrast, minimally processed, nutrient-rich foods (e.g., fruits, vegetables, legumes, intact whole grains) often lack the packaging and marketing budgets necessary to compete with such flashy health claims.

Many individuals, particularly caregivers and those with limited resources, lack the time for extensive food preparation and shopping. Navigating the food environment should not require expertise in nutrition science; consumers should not be expected to evaluate the scientific validity of each health claim on product packaging. It is imperative to implement improved labeling systems that are free from industry influence to clearly indicate beneficial products for both individual and family health. One approach being considered by the FDA is the implementation of “high in nutrient” labels on unhealthy products for specific nutrients. However, this could potentially allow companies to reformulate their ultra-processed products just enough to be less overtly harmful, while still retaining their addictive qualities and unfounded health claims. This phenomenon was previously observed when the food industry increased levels of refined carbohydrates and sugars in response to efforts to reduce fat intake among Americans. A similar trend is evident with the rise of artificial sweeteners in reaction to added sugar labels, despite the lack of long-term randomized controlled trials confirming the safety of these sweeteners, especially when regularly consumed from early childhood. Moreover, it is very critical that these labels are clear, bold, and easy for consumers to see and understand. There are many global examples with strong science to show that warning labels work to improve consumer knowledge and help people make healthier choices.

Adopting labeling systems that consider whether a food is ultra-processed (as practiced in some countries) rather than focusing solely on specific nutrients could be beneficial. Recent unpublished data indicate that warning labels that identify ultra-processed products effectively help consumers recognize them as ultra-processed. Substantial scientific evidence and common sense support the conclusion that diets consisting of whole foods, such as fruits, vegetables, and intact whole grains, are optimal. Any system that detracts from this understanding is problematic. The FDA could enhance its efforts both in preventing misleading health claims and in ensuring that government labels intended to identify healthy foods are not co-opted by the food industry to mislead consumers, thereby complicating their ability to make health-protective dietary choices.

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World Health Organization. (2023). WHO guideline on non-sugar sweeteners. World Health Organization.

3. How are these claims currently regulated, and what more can regulators and Congress do to hold companies accountable for their marketing claims?

In the United States, the regulation of health claims on food labels falls under the jurisdiction of the FDA, as stipulated by the Federal Food, Drug, and Cosmetic Act (FD&C Act) and the Nutrition Labeling and Education Act (NLEA) of 1990. Although the FDA holds the authority to regulate these claims, it has not been sufficiently rigorous in its oversight, partly due to inadequate resources. Health claims are categorized into three types: authorized health claims, which are based on significant scientific consensus; qualified health claims, which are supported by some evidence but require qualifying language; and structure/function claims, highlighting the role of nutrients in normal body functions. The FDA is responsible for reviewing scientific evidence before approving authorized claims and evaluating petitions for qualified claims, ensuring that all health claims are truthful, scientifically substantiated, and compliant with specific nutritional criteria.

While the FDA monitors food labels and has the power to take action against deceptive claims, designating non-compliant products as "misbranded," its efforts are hampered by limited resources. The need for balance between public health protection and free speech rights, protected under the First Amendment, complicates the FDA's regulatory actions, often requiring the application of the Central Hudson test. Although the FDA updates its guidance on food labeling as scientific evidence evolves and legal challenges emerge, the agency needs more funding and a more proactive stance.

The current regulatory framework is skewed, placing a heavier evidentiary burden on public health advocates, who are expected to provide extensive, costly, and time-consuming long-term randomized controlled trials. Meanwhile, companies often need only minimal evidence to support their health claims. This imbalance disadvantages consumers, who ultimately bear the cost of inadequate regulation. Therefore, it is crucial to support the FDA with enhanced

resources and push for more stringent oversight to ensure that health claims on food labels are genuinely beneficial and not misleading.

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4. What are the major barriers to educating consumers about ultra-processed food, and how can Congress help address them?

The primary source of consumer education currently comes from companies' marketing and promotional claims, which prioritize profits over public health. No public health or government agency possesses a budget comparable to that of ultra-processed food and beverage companies; for instance, Coca-Cola's marketing expenses were approximately \$4 billion in 2021. It is imperative to hold these companies to higher standards before allowing them to make nutritional claims or engage in marketing practices for products that do not meet essential nutrition requirements. Smaller, less prominent public health campaigns risk being overshadowed by these vast marketing efforts.

Moreover, focusing on the overall nutrient profile of a product rather than individual macronutrients allows for the dissemination of well-established nutritional science principles (such as eating whole foods and abundant plant-based options) and prevents companies from making minor modifications to unhealthy products to justify health claims. This approach would help ensure that government-endorsed healthy food labels are not co-opted by the industry to the detriment of consumer health.

For example, the FDA is considering the implementation of a "healthy" label to provide clearer guidance to consumers on nutritious products. However, there is a legitimate concern that if the label focuses solely on specific nutrients, the industry could design products, such as Greek yogurt with chocolate cookie crumbles, to qualify for the label despite not being genuinely healthy. The objective is to maintain the integrity of such labels in promoting public health rather than enabling industry profit at the expense of consumer well-being.

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Pomeranz, J. L., & Harris, J. L. (2020). Children’s fruit “juice” drinks and FDA regulations: opportunities to increase transparency and support public health. *American journal of public health*, 110(6), 871-880.

5. What lessons can we learn from experiences of other countries implementing policies aimed at curbing the health consequences associated with ultra-processed food? What equity implications should Congress consider in any future policies?

Several countries have embarked on ambitious measures to improve their food environments, notably Chile, which has implemented a comprehensive framework aimed primarily at children's health. Chile's policies mandate the use of prominent black octagon "stop sign" warning labels on the packaging of foods high in sugar, sodium, saturated fats, or calories, thereby providing clear nutritional content indicators. Additionally, marketing directed at children under 14 years old for products bearing these labels is heavily restricted, encompassing bans on television advertisements, the use of cartoon characters, and other child-centric marketing techniques. Within educational settings, the sale, promotion, and marketing of labeled foods and beverages are prohibited, and school meal programs are required to adhere to specific nutritional standards. To further discourage the consumption of unhealthy products, a tax on sugar-sweetened beverages has been enacted. These initiatives were phased in through the Law of Food Labeling and Advertising, with implementation stages in 2016, 2018, and 2019, introducing progressively stringent nutrient thresholds.

Chile employs a consistent nutrient profiling model across its regulatory framework, and products with warning labels are prohibited from carrying health or nutrient claims regarding the excessive nutrient. The National Nutrition and Food Policy, introduced in 2017, adopts a rights-based approach to nutrition and considers the social determinants of health. Continuous evaluations are conducted to measure the effects of these policies on purchasing behaviors, consumption patterns, and health outcomes. Collectively, these measures represent one of the world's most extensive regulatory efforts to combat obesity and non-communicable diseases.

Equity considerations are crucial in addressing the disproportionate impact of unhealthy food marketing on rural, Black, Hispanic, and Native American populations. In reducing the prevalence of these products, there is a need to establish economic incentives that promote the availability of convenient, affordable, and accessible options predominantly composed of minimally processed foods that support both physical and mental well-being. This necessitates a fundamental rethinking of the food supply chain, as the current paradigm incurs substantial costs and widespread suffering.

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- Dr. Lindsey Smith Taillie (taillie@unc.edu) Taillie is an associate professor of nutrition at the University of North Carolina at Chapel Hill (UNC-Chapel Hill). She is a national expert on global and domestic nutrition policy.

PUBLIC SUBMISSIONS FOR THE RECORD

NACCHO

National Association of County & City Health Officials

The National Connection for Local Public Health
October 1, 2024

Chair Vern Buchanan
Ways & Means Health Subcommittee
House of Representatives
Washington, DC 20515

Vice Chair Lloyd Doggett
Ways & Means Health Subcommittee
House of Representatives
Washington, DC 20515

Chair Buchanan & Vice Chair Doggett,

Thank you for holding the recent hearing entitled, “Investing in a Healthier America: Chronic Disease Prevention and Treatment.” On behalf of the National Association of County and City Health Officials (NACCHO) and the over 3,300 local health departments across the country, I write to highlight the importance of local public health in chronic disease prevention and treatment. It is critical that federal policy continues to support the work of local public health and their community-level partners. According to NACCHO’s Profile, a census study, over half of local health departments provide population-based chronic disease primary prevention services and nearly 3 out of 4 local health departments provide population-based nutrition services.¹

Local health departments play a critical role in identifying local-level strategies to advance local policy, systems, and environmental changes to reduce the risk factors for chronic disease, as well as reduce health disparities through community and health system interventions. For example, Ross County, Ohio is working to address several health disparities, including heart disease, as a significant portion of their population is in poverty. In fact, the Appalachian Regional Commission noted that the region’s heart disease mortality rate of 204 per 100,000 is 17% higher than the national rate of 175 per 100,000. In response, Ross County Health District partnered with the Chillicothe Farmers Market, Hopewell Health Centers, and Ross County’s Ohio State University Extension Office’s SNAP-Ed Program to implement a heart healthy pilot initiative that incorporated the evidence-based strategies of team-based care, utilizing community health workers, nutrition education, and self-measured BP monitoring. This program is one of the many examples of ways that local health departments use data to identify the specific challenges facing their residents, convene key partners, and develop solutions to address chronic disease challenges in their communities.²

While much conversation around chronic disease focuses on treatment of a patient who is already sick, funding prevention efforts not only saves lives and reduces pain, but it also saves money. Tobacco use has long been the leading preventable cause of death in the United States. Tobacco is responsible for more than 480,000 deaths and approximately \$241 billion in health care costs in the United States each year. Tobacco use causes nearly one in three heart disease deaths, nearly one in three cancer deaths, and nearly eight in 10 chronic obstructive pulmonary disease deaths. Tobacco use almost always begins during adolescence, and most adult smokers want to quit, but overcoming an addiction to nicotine is difficult and often requires multiple quit attempts. To address

¹ [NACCHO_2022_Profile_Report.pdf](#)

² [Ross-County-Health-District-Chillicothe-OH-Compendium.pdf \(naccho.org\)](#)



this, 70% of local health departments across the country provide tobacco prevention services, in both urban and rural areas. Efforts like this save lives and money — at the federal level, the Public Health and Prevention Fund's Tips from Former Smokers Campaign alone saved an estimated \$7.3 billion in smoking-related healthcare costs from 2012 to 2018 and helped more than one million Americans quit smoking for good.³

Congress can support this work by investing in federal public health programs that address chronic disease, their causes, and their contributors and ensuring that sufficient funds reach the local health department level. Strong annual appropriations for chronic disease programs through the Centers for Disease Control and Prevention (CDC) are particularly important as they address these issues at the population level. Another important way to support federal chronic disease efforts is to protect the Prevention and Public Health Fund, a mandatory funding stream meant to support prevention and public health activities. When originally crafted, it was an acknowledgement that clinical care is necessary but is not sufficient for the larger goal of getting and keeping Americans healthy. Most chronic diseases are preventable if we prioritize prevention and public health. The Prevention Fund provides financial support critical to addressing pressing health challenges with programs and services most appropriate for community needs. Over the years, the fund has been reduced to pay for other, unrelated programs. NACCHO strongly supports protecting the fund and restoring cuts made previously.

Beyond important disease-specific funds, annual appropriations for public health infrastructure and data modernization are other key investments, as these funds aim to strengthen the overall capabilities, data availability, and workforce of health departments. Together, strong investments in disease-specific and infrastructure funds can ensure public health departments have the core capabilities they need to best support and maintain chronic disease-related activities in their communities.

Finally, it is important that any federal authorizing legislation designed to prevent or address chronic disease include local health departments as both eligible clinical providers as well as supporting their work on upstream population health interventions, in order to expand access to these services in communities across the country. NACCHO stands ready to help support you in these efforts.

NACCHO appreciates the opportunity to submit comments for the hearing record and looks forward to working with Congress to strengthen public health prevention efforts. If you have any questions about these comments, please contact Adriane Casalotti, Chief of Government and Public Affairs, at acasalotti@naccho.org.

Sincerely,



Lori Tremmel Freeman, MBA
Chief Executive Officer

³ [Tips Impact and Results](#) | [About the Campaign](#) | [Tips From Former Smokers](#) | CDC





October 2, 2024

Delivered via Email

Ways & Means Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515-6065
WMSubmission@mail.house.gov

Re: Hearing on Investing in a Healthier America: Chronic Disease Prevention and Treatment

Dear Health Subcommittee Chairman Buchanan, and other Members of the Committee;

On behalf of the American Association of Naturopathic Physicians (AANP), we thank you and the Subcommittee on Health for its interest in investing in prevention to address our nation's chronic disease epidemics.

According to the CDC, 90% of our nation's \$4.1 trillion in annual health care expenditures are for people with chronic and mental health conditions. More than 99% of Medicare beneficiaries and 72% of Veterans Administration patients are treated for chronic disease, creating a crushing financial challenge for our system to provide the best care.

The federal barriers to investing in a Healthier America are myriad: Because of an outdated definition of "physician" in §1861 (42 U.S.C. 1395(r)(1)) of the Social Security Act (SSA), CMS is not allowed to include a workforce of naturopathic physicians whose very philosophy is that of prevention, behavior, and lifestyle modification. Likewise, the majority of federally-funded state Medicaid programs are glaringly excluding educated, trained and licensed healthcare professionals who specialize in whole-health, prevention-based healthcare. Medicare Quality Measures that are process vs. outcome based currently incentivize medication adherence in chronic disease rather than disease remission or reversal through lifestyle and behavior changes. Additionally, the Veterans Administration (VA) and Department of Defense (DOD) cannot currently take advantage of licensed naturopathic physicians who can contribute to the care of their respective populations with evidence-based whole-person and prevention-focused approaches to chronic disease because a Qualification Standard, and Employment Code for NDs has yet to be developed.

The AANP represents licensed naturopathic doctors (NDs), a healthcare workforce trained as prevention-focused primary care providers licensed in 26 US jurisdictions **whose services are currently recognized by private insurance, Medicaid in only 6 states, and Medicare Advantage programs, but have yet to be recognized in any federal health care program.**

Naturopathic medicine is recognized by the World Health Organization (WHO) and has been a system of health care in the US for over a century, with an educational model consistent to that of conventional medicine grounded in biomedical physiology and diagnostics, but with a reprioritization of the order of therapeutics. Specifically, naturopathic medical training's core therapeutic focus is on lifestyle-oriented self-care, preventive behaviors, physical activity, stress-management, clinical nutrition, herbal medicine, and hands-on manual therapies —only resorting to more-costly prescription drug therapies or surgical interventions when appropriate.

Examples of evidence-based, cost-effective preventive health measures or interventions that can improve health outcomes, while reducing long term health costs

A body of literature, too vast to enumerate here, supports the cost-effectiveness of lifestyle-oriented self-care, nutrition, preventive behaviors and other modalities that are grounded in the approach used by naturopathic doctors to manage, improve, or reverse these conditions. The preventive focus of naturopathic care addresses many modifiable risk factors – lifestyle behaviors, physical activity, sedentariness, obesity, alcohol consumption, dietary choices, and environmental exposures – associated with the increased cost of chronic diseases.

A recently released Health Technology Assessment (HTA)¹ provides an evidence-based summary of naturopathic practice and the safety, economics and effectiveness of naturopathic care in improving health outcomes related to chronic disease. The scope of the HTA was informed by research conducted by the international naturopathic community over the last thirty years encompassing over 2000 peer-reviewed scientific articles, of which more than 300 clinical studies involving over 100 different health populations are included. Key findings have included:

- Naturopathic researchers have conducted original clinical research involving over 80 different illness populations.
- 81.1% of the studies on the effectiveness of naturopathic clinical practice identified a positive response to at least one primary or secondary outcome measure.¹
- Naturopathic physician care has been shown to reduce employee sick days and cost, while improving productivity.^{2,3}

¹ Lloyd, I., Steele, A., and Wardle, J., *Naturopathy, practice, effectiveness economics & safety*. World Naturopathic Federation. Section 3, Chapter 8. 2022.

² Herman, P.M., Szczerko, O., Cooley, K., and Mills, E.J., *Cost-effectiveness of naturopathic care for chronic low back pain*. *Alternative Therapies in Health & Medicine*, 2008.

³ Noe, B. *Vermont Car Dealers Help to Quantify the Benefits of Naturopathic Care*, in 21st Annual Conference of the American Association of Naturopathic Physicians. 2006. Portland.

- Numerous studies have demonstrated that using non-invasive, non-toxic approaches lowers health care costs.^{4,5} Patients with the greatest disease burden show the most significant reduction in total medical expenditures when utilizing integrative medicine.⁶
- A systematic review of randomized clinical trials found that use of natural health products such as those recommended by naturopathic doctors has the potential to reduce costs compared to conventional treatment by up to 73%.⁷

Policymakers should ensure the ability of licensed healthcare professionals, like naturopathic doctors, who prioritize these kinds of cost-effective modalities that lead to better outcomes to perform to the top of their scope of practice, and to be recognized and covered as eligible providers in all federal programs.

Regulatory, statutory, or implementation barriers to investing in health

Two highly relevant and recent studies from the National Academies of Sciences, Engineering, and Medicine (NASEM) succinctly highlight key areas of failure in our healthcare system, and outline the benefits of taking a whole health approach to patient care such as that offered by naturopathic doctors:

- *Improving Diagnosis in Health Care*,⁸ and
- *Achieving Whole Health: A New Approach for Veterans and the Nation*⁹

Fully embracing the recommendations in these NASEM reports on Whole Health would change the trajectory of patient care, improve patient outcomes, and decrease spiraling costs.

However, policymakers should also ensure that ***all licensed healthcare professionals who prioritize this kind of wellness approach are recognized, enumerated in statute, and eligible for insurance coverage - especially government-sponsored medical coverage - to support patient access to true preventive, whole-person, root-cause approaches to health restoration and wellness.***

Congress and regulatory agencies can readily address the federal barriers that prevent patient access to licensed naturopathic doctors, and to naturopathic medicine that prioritizes the type of preventive healthcare known to save money, improve outcomes, and most importantly prevent the chronic diseases that are

⁴ Herman PM, Szczurko O, Cooley K, Seely D. A naturopathic approach to the prevention of cardiovascular disease: cost-effectiveness analysis of a pragmatic multi-worksite randomized clinical trial. *J Occup Environ Med.* 2014 Feb;56(2):171-6. doi: 10.1097/JOM.000000000000066. PMID: 24451612; PMCID: PMC3921268.

⁵ Tais S, Oberg E. [The economic evaluation of complementary and alternative medicine.](#) *Natural Med J.* 2013;5(2).

⁶ Sarnat RL, Winterstein J, Cambron JA. Clinical utilization and cost outcomes from an integrative medicine independent physician association: an additional 3- year update. *J Manipulative Physiol Therapeutics* 2007; 30(4): 263-269.

⁷ Kennedy DA, Hart J, Seely D. Cost effectiveness of natural health products: a systematic review of randomized clinical trials. *eCAM* 2009; 6(3) 297-304.

⁸ National Academies of Sciences, Engineering, and Medicine. *Improving Diagnosis in Health Care.* The National Academies Press; 2015. doi:[10.17226/21794](#)

⁹ National Academies of Sciences, Engineering, and Medicine. *Achieving Whole Health: A New Approach for Veterans and the Nation.* The National Academies Press; 2023. doi:[10.17226/26854](#)

bankrupting our system. The following policy changes would dramatically improve patient access to preventive medicine for millions of people:

Policy Solutions:

- 1. Modernize the definition of “physician” in §1861 (42 U.S.C. 1395(r)(1)) of the Social Security Act (SSA) to include licensed naturopathic doctors.**

This outdated definition does not accurately reflect the landscape of qualified and licensed providers today, and it excludes an entire workforce whose entire philosophy is lifestyle-based preventive medicine that evidence now shows is a leading driver of decreasing costs and improving outcomes. Modernizing this outdated definition would correct a cascade of barriers that currently prevents Medicare-eligible Americans from being able to access naturopathic doctors and receive whole-health prevention-based medicine, in arenas including private practice, hospitals, rural clinics, unfilled residency positions, and Federally Qualified Health Centers FQHC’s that are tied to Medicare funding.

- 2. Direct the Department of Health and Human Services (HHS) to authorize the Centers for Medicare & Medicaid Services (CMS) to require that states receiving federal Medicaid funding credential Naturopathic Doctors (NDs) and cover services provided by them for Medicaid patients, in jurisdictions where NDs are licensed.**

Medicaid - and Medicare for that matter - are glaringly not utilizing educated, trained and licensed healthcare professionals who specialize in whole-health prevention-based medicine, which further exacerbates the growing crisis and spiraling costs in healthcare.

Only 6 states cover naturopathic doctors in Medicaid: VT, WA, CT, OR, AZ¹⁰, and NM. These states provide examples of successful integration of NDs in Medicaid. As with Medicare, covering NDs in Medicaid helps address the workforce shortages in county health departments, community clinics, FQHCs, hospital out-patient and private clinics, with doctors who focus on prevention that reduces healthcare costs and improves health outcomes.

Clinics with NDs covered by Medicaid in Washington and Oregon alone care for hundreds of thousands of patients/year. In Washington alone, there were over 450 NDs credentialed as Medicaid providers, serving over 21 rural and urban counties in the state in August 2023.¹¹ That number increased to 655 as of April 2024 as more Medicaid patients seek out Naturopathic Doctors.

Policymakers should ensure that all licensed healthcare professionals who prioritize a wellness approach are recognized, enumerated in statute, and eligible for insurance coverage - *especially*

¹⁰ Arizona is still in the process of integrating NDs into the Medicaid program, and only for pediatrics.

¹¹ Washington Association of Naturopathic Physicians [Proposal to Increase Scope of Practice](#), August 2023

government-sponsored medical coverage in all states - to support patient access to true preventive, whole-person, root-cause approaches to health restoration and wellness.

3. Encourage prioritizing the creation of Qualification Standard and Employment Code for Naturopathic Doctors in the Veterans Health Administration (VA) and Department of Defense (DoD) so that these agencies can hire NDs who specialize in Whole Health, cost-effective, prevention-centered medicine.

The VA and DoD do not recognize licensed NDs as an eligible provider type. The lack of recognition prevents them from hiring licensed NDs, even when they would like to do so.

In rare cases VA administrators have been able to conduct a "work around" to this barrier by hiring licensed NDs with multiple credentials. Despite hiring them for their training in naturopathic medicine and whole-person healthcare, the licensed ND is technically employed under some secondary credential. This is not a solution for the short- or long-term, as it does not allow veterans access to the majority of naturopathic doctors available to help in this workforce.

As experts in non-pharmacologic options in the treatment of disease and pain, licensed NDs would enhance the VA and DoD's delivery of "personalized, proactive, and patient driven care," as these are the underpinnings of naturopathic medicine's principles of practice, core competencies in clinical training, and evidence-informed practice.

4. Support changes to Medicare Quality Measures that unintentionally incentivize maintenance of disease rather than successfully treating or reversing disease through lifestyle or behavior interventions. While naturopathic doctors are not currently eligible for participation in Medicare because of the need to modernize the definition of "physician" in §1861 (42 U.S.C. 1395(r)(1)) of the Social Security Act (SSA), the current Medicare Quality Measures reward process vs. outcome-based health care. We recommend the standards be updated to ensure providers are incentivized for helping patients reverse disease rather than simply ensuring medication adherence in patients with diabetes, or hyperlipidemia, as examples.

5. Support policies that promote the use of food as medicine, including coverage of food and nutrition "prescriptions" by physicians.

Naturopathic Doctors and our naturopathic medical institutions were among the original founders of institutions, community centers, and programs promoting "food as medicine" such as the National University of Natural Medicine's [Food as Medicine Institute](#). As Congress and the White House hold forums and discussions about "food as medicine," policymakers should ensure that the original experts in this field have a seat at the table.

Efforts to promote and incorporate innovation into programs like Medicare to improve patient outcomes and reduce health care spending

The ability to innovate requires having a diversity of experience, practice, philosophies, and expertise at the table. In 2016, Congressional members asked HHS to direct Medicare to do a pilot study on treatment outcomes for cardiovascular disease using naturopathic care, following a trio of studies conducted between 2010-2014 and published in journals as diverse as the *Journal of Occupational and Environmental Medicine*, the *Canadian Medical Association Journal*, and the *Journal of Alternative and Complementary Medicine*, which suggested that naturopathic care is effective for preventing the onset of cardiovascular disease and cost-effective in producing positive health outcomes.¹²

The response from HHS was to welcome ideas about healthcare improvement, however “Please note, CMS can only test physician focused models that involve a “doctor of medicine or osteopathy” as outlined in section 1861(r)(1) of the Social Security Act.”¹³

This reliance on the outdated definition of doctors in section 1861(r)(1) of the Social Security Act will forever preclude Medicare from pursuing innovative and evidence-based programs delivered by licensed naturopathic physicians who are experts in this kind of preventive medicine.

Policy Solutions:

1. Update the outdated definition of “physician” in §1861 (42 U.S.C. 1395(r)(1)) of the Social Security Act to include licensed naturopathic doctors (NDs).
2. Appoint Naturopathic Doctors to relevant task forces, committees and advisory panels charged with incorporating innovation into Medicare.

Comments on CBO’s modeling capabilities on health care policies

Historically, CBO and other analysts for third-party payers researching investment in prevention have been limited by the expectation of a five-year return on investment (ROI), which simply is not possible for prevention strategies targeting chronic disease. CBO modeling should evaluate preventive measures and lifestyle changes with a framework that recognizes that maximum ROI is likely 20 or 30 years away from the point(s) of intervention.

In summary, we suggest the following substantial methods to support the Committee’s efforts to help address our nation’s health care spending crisis, while looking for solutions to improve health outcomes.

¹² Seely D, Szczerko O, Cooley K et al. [Naturopathic medicine for the prevention of cardiovascular disease](#): a randomized clinical trial. *Can Med Assoc J* 2013; 185(9):E400-416.; Herman PM, Szczerko O, Cooley K, Seely D. [A naturopathic approach to the prevention of cardiovascular disease](#): cost-effectiveness of a pragmatic multi-worksites randomized clinical trial. *J Occup Environ Med*. 2014; 56(2):171-76; Link BK, Lafferty WE, Tyree PT, Diehr PK. [Comparison of health care expenditures among insured users and nonusers of complementary and alternative medicine in Washington State](#): a cost minimization analysis. *J Altern Complement Med* 2010; 16(4):411-17.

¹³ Letter from Department of Health and Human Services to Representative Mark Pocan, dated October 19, 2016.

1. **Improve access to a currently underutilized health care work force of licensed Naturopathic Doctors by:**
 - a. **Modernizing the definition of “physician” in §1861 (42 U.S.C. 1395(r)(1)) of the Social Security Act to include licensed Naturopathic Doctors.**
 - b. **Encouraging the prioritization of the creation of a Qualification Standard and Employment Code for Naturopathic Doctors in the Veterans Health Administration and Department of Defense.**
 - c. **Directing HHS to authorize CMS to require that states receiving federal Medicaid funding credential NDs and cover services provided by them for Medicaid patients, in jurisdictions where NDs are licensed.**
2. **Appoint Naturopathic Doctors to relevant task forces, committees and advisory panels charged with incorporating innovation into Medicare, and improving nutrition or “food as medicine” programs.**
3. **Support changes to Medicare Quality Measures that incentivize successfully treating or reversing disease through lifestyle and behavior interventions.**
4. **Encourage CBO modeling methods to evaluate preventive measures and lifestyle changes with a framework that recognizes that maximum ROI is likely 20 or 30 years away from the point(s) of intervention.**

Please let us know if you have questions about the provided information, and recommendations. As experts in preventive medicine who use evidence-based approaches proven to reduce costs and improve outcomes, we stand ready to work with the Ways & Means Subcommittee on Health to develop additional policy recommendations to invest in a healthier America.

Sincerely,



Laura Farr
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About the AANP

The [AANP](#) is the national professional association representing 8,000 Naturopathic Doctors (NDs) who are licensed, licenseable or regulated in 26 states and territories. The AANP's physician members are graduates of naturopathic medical schools accredited by the Council on Naturopathic Medical Education. CNME is recognized by the US Department of Education as the national accrediting agency for programs leading to the Doctorate of Naturopathic Medicine (ND or NMD) or Doctor of Naturopathy (ND) degree.



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October 2, 2024

The Honorable Vern Buchanan
Chair, Subcommittee on Health
House Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

The Honorable Lloyd Doggett
Ranking Member, Subcommittee on Health
House Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

Re: Investing in a Healthier America: Chronic Disease Prevention and Treatment

To Whom it May Concern,

On behalf of our 159,000 members, we would like to submit this statement for the record of the Subcommittee's September 18, 2024, hearing, titled Investing in a Healthier America: Chronic Disease Prevention and Treatment.

Dental caries (or tooth decay) is one of the most common chronic diseases of childhood. About 1 in 4 preschool children experience dental caries in their primary teeth, and at least 1 in 6 children aged 6 to 11 years-old experience dental caries in their permanent (adult) teeth.¹

Eating patterns and food choices play an important role in maintaining good oral health. For example, no amount of sugar can be consumed without increasing the risk for tooth decay. Sugar increases the build-up of plaque (a sticky, colorless, bacterial film), which weakens enamel and can potentially form a cavity. Yet most Americans continue to exceed the U.S. Dietary Guidelines' recommendation to limit added sugar intake to less than 10 percent of calories per day.¹

We recognize that it is neither practical nor possible to remove all sugary foods from the human diet, or to classify some nutrient rich foods as being unhealthy based on sugar content alone. Even milk has a measurable amount of sugar. But it is both practical and possible to encourage good eating habits, which would necessarily include limiting sugar consumption. We therefore urge the Subcommittee to take the following action.

- Support increased funding for the nutrition education components of the Supplemental Nutrition Assistance Program; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); and Team Nutrition.
- Bolster efforts to make healthy foods more attractive, available, and affordable than sugar-laden food products, especially for those in poverty.
- Fund longitudinal studies examining the extent to which dental caries rates correlate with fluctuations in added sugar prices and individual product sales.

We also hope the Congress will soon reauthorize the Child Nutrition Act. This law, along with the farm bill, provides the statutory authority for most federal nutrition and food assistance programs to operate, including the National School Lunch Program, the School

The Honorable Vern Buchanan
The Honorable Lloyd Doggett
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Page 2

Breakfast Program, and WIC. All these programs can be leveraged to promote healthy diets.

Thank you for providing us the opportunity to comment. We look forward to working with the Congress to foster healthy diets that promote optimal oral health. If you have any questions, please contact Mr. Chris Tampio at 202-789-5178 or tampioc@ada.org.

Sincerely,



Linda J. Edgar, D.D.S., M.Ed.
President



Raymond A. Cohlma, D.D.S.
Executive Director

LJE:RAC

¹ National Institutes of Health. Oral Health in America: Advances and Challenges. Bethesda, MD: US Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2021.



October 2, 2024

To: House Committee on Ways and Means Chairman Jason Smith and Health Subcommittee Chairman Vern Buchanan

Re: Response to the hearing *"Investing in a Healthier America: The critical role preventive medicine and healthy living play in combatting chronic disease and the growing obesity epidemic"*

On behalf of the over 13,000 members of the American College of Lifestyle Medicine (ACLM), we welcome the opportunity to offer a written statement related to the hearing on *"Investing in a Healthier America."*

We would like to briefly introduce ourselves so that you better understand the unique perspective that we bring to this discussion. Founded in 2004, the American College of Lifestyle Medicine is the nation's only interdisciplinary and multispecialty medical professional association dedicated to educating, equipping and empowering physicians and health professionals to address root causes of chronic disease through evidence-based therapeutic lifestyle interventions—including nutrition, physical activity, sleep, stress management, positive social connections and avoidance of risky substances—to **prevent, treat and even reverse** chronic diseases.

The power of lifestyle medicine (LM) transcends all healthcare specialties and payment models as we see examples of implementation in nearly every area of healthcare across the entire care continuum. The composition of ACLM's current and immediate-past Boards of Directors reflects the breadth of impact that LM has: two cardiologists, an endocrinologist, an oncologist, an OBGyn, a pediatrician, a physiatrist, a psychiatrist, internal medicine primary care physicians, family medicine docs, a physician associate, a nurse practitioner, a PhD in behavioral health, and an RD with a PhD in nutrition. Moreover, ACLM's members are representative of the interdisciplinary clinical practice team that enables scalability, supporting the lifestyle behavior change that's at the heart of chronic disease treatment. The recent induction of ACLM into the American Medical Association (AMA) House of Delegates and LM certification status of the AMA's President Elect, Board of Trustees Chair, and AMPAC Board of Director's Chair demonstrates the massive interest in LM's formal and permanent integration within mainstream healthcare.

Clinician members of ACLM have been promoting a transformed healthcare system with a focus on root-cause lifestyle medicine as a first-treatment approach for the past 20 years. ACLM's vision is a world wherein lifestyle medicine is the foundation of health and all health

care and our mission is to advance evidence-based lifestyle medicine to treat, reverse, and prevent non-communicable, chronic disease.

While prevention of lifestyle-related chronic diseases is ideal; 60% of U.S. adults have already been diagnosed with one or more chronic diseases.¹ If the adult incidence rate of chronic disease was not alarming enough, [according](#) to the U.S. Centers for Disease Control and Prevention, as of 2021 more than 40% of school-aged children and adolescents had at least one chronic health condition.²

Unhealthy lifestyle behaviors are continuing to escalate the unsustainable upward trajectory of U.S. healthcare spending, driving as much as 90% of the healthcare dollars and putting our nation at severe economic risk.^{3,4} Most chronic diseases are caused by a short list of risk factors: **smoking, poor nutrition, physical inactivity, and excessive alcohol use.**⁵ Lifestyle-related chronic conditions are not properly addressed within the currently dominant fee-for-service healthcare system, which emphasizes and incentivizes disease and symptom management through increasing quantities of pills and procedures instead of acknowledging and rewarding achievement of health restoration, disease remission, medication de-escalation and chronic disease prevention.

When you look at chronic disease clinical practice guidelines (CPGs) for hypertension^{6,7}, type 2 diabetes^{8,9}, cardiovascular disease¹⁰, obesity¹¹ and cognitive decline¹², you'll see lifestyle interventions listed as the first treatment approach. Most pharmaceutical drugs, including the new GLP-1 medications, also list diet and exercise as crucial elements to successful outcomes, and research shows that many surgical interventions also benefit from a perioperative lifestyle intervention for best and most sustainable long-term health outcomes.¹³ Health restoration and disease remission for a variety of chronic diseases is possible. Studies demonstrate that the same modifiable unhealthy lifestyle factors that increase risk for some of the most common chronic diseases¹⁴ are also the same factors that, when dosed appropriately, can be used to treat and reverse¹⁵ existing chronic diseases and prevent future disease.¹⁶⁻²⁴

Improved health outcomes achieved through lifestyle interventions have been demonstrated within and outside of the field of lifestyle medicine; notable examples include results from the Ornish, Pritikin and Benson Henry's Intensive Cardiac Rehabilitation programs, the Diabetes Prevention Program, The Diabetes Remission Clinical Trial (DiRECT), Adventist Health Studies and The Nurses' Health Study.

Conventional healthcare has largely underemphasized that diseases can be reversed or put into remission, asserting the false narrative that once a diagnosis of a chronic disease is made, there is nothing that can be done other than to manage the disease through medications or procedures, which do not treat the root cause and often have negative side effects. With evidence to show that lifestyle interventions can result in disease remission and reversal, outcome goals, payment models, quality measures and incentive systems need to adjust accordingly.

Meaningfully addressing modifiable risk factors in healthcare settings takes time, proper payment, quality measure alignments and interventions across the care continuum. To date, interventions targeted at the evidence-based, modifiable lifestyle behaviors that contribute most to chronic conditions are underutilized, underpaid and not tied to performance metrics in healthcare. In some cases, especially when quality measures are tied to medication adherence, and process rather than outcomes, using lifestyle interventions to treat common chronic conditions can lead to lower payment for providers despite improved health outcomes.²⁴

Perhaps the most important modifiable health behavior and social driver of health is access to and consumption of healthy food. **Poor overall diet quality is the single leading cause of premature death in the United States today**, causing an estimated 500,000 deaths each year.²⁵ An astounding 75%²⁶ of all healthcare spending is related to the management of diet-related chronic disease. As healthcare innovation and policy change continue to provide new and more effective tools to prevent, treat, and reverse diet-related chronic conditions, payment must support these new pathways of successful care.

Excellent outcomes from lifestyle intervention programs have been demonstrated in rural and underserved populations due to their ability to address not only lifestyle behaviors but also social determinants/drivers of health such as nutrition insecurity. Programs that address access to healthy food through medically tailored meals and produce prescriptions combined with nutrition and culinary education and skill building have been highly effective at achieving better health outcomes and lower downstream healthcare costs.²⁷⁻²⁹

Despite the recent increase in interest and attention to the integration of Food is/as Medicine interventions into healthcare payment and delivery systems, there remains a lack of adequate codes to document and bill for these Food is Medicine interventions that have the ability to modulate health behavior and social drivers of health outcomes. For this reason, ACLM believes that coding and payment should be available to address not only nutrition security but also nutrition education, counseling, and culinary medicine in clinical care settings and with the support of community-based organizations. Federally supported payment should cover accredited medically tailored meal programs, produce prescription programs, nutrition and behavior change counseling, and culinary medicine education to address all diet-related chronic conditions. Patient copays should be waived to encourage engagement in these programs from patients who may already be food insecure or experiencing financial hardship preventing them from applying healthy lifestyle interventions.

Lifestyle medicine education in medical and health professional schools is also necessary to begin addressing root-cause treatment approaches earlier in health professions careers. Unfortunately, physicians receive little to no training in nutrition or exercise science in most of our medical schools and residency programs, with data showing that an overwhelming majority feel ill-equipped to provide the kind of expert guidance their patients need in these areas.³⁰

We believe taking steps to expand the practice of lifestyle medicine is an absolutely necessary part of any strategy that hopes to create a healthcare work force capable of helping to stem this epidemic tide of chronic disease. Lifestyle medicine trained interdisciplinary care teams are

well equipped to address both health-related social needs (HRSN) and lifestyle behaviors. Lifestyle intervention training for the prevention, treatment and remission of chronic conditions is available for health professional students, medical students, residents, practicing physicians and other members of the healthcare team through the American College of Lifestyle Medicine.

While early detection, enhanced technology and novel treatments for chronic diseases can certainly help with the chronic disease epidemic in the United States, focusing on the root-cause, modifiable lifestyle behaviors that lead to most chronic diseases and related spending is a solution that is already being applied by lifestyle medicine trained clinicians across the country with incredible results. With proper clinician education and alignment of incentives in healthcare, all clinicians could practice root-cause medicine. In doing so we could see a restoration of American health and the shift toward prevention of future chronic disease.

While we recognize that healthcare transformation through a lifestyle medicine, root-cause treatment approach cannot solve for all factors that contribute to health and health outcomes in the U.S., **it is one of the solutions that is already being leveraged by clinicians across the country with great success** despite the barriers cited above. Working synergistically with policies aimed at addressing the environmental and social factors, including our ultra-processed food system, will be necessary to move the needle on chronic disease.

A transformed healthcare system in America should have a goal of **reducing the need for medication, high-cost surgical interventions, medical devices and detection services. Outcomes should focus on achieving health restoration for many patients and preventing future lifestyle-related chronic conditions from proliferating.**

It is only when lifestyle factors that contribute to the leading chronic conditions are addressed will we truly be able to achieve a healthier America. Clinician members of the American College of Lifestyle Medicine have been promoting a transformed healthcare system and focus on root-cause lifestyle medicine for the past 20 years. Our dedicated clinician members would be happy to be featured in any future briefings, meetings, discussions or hearings related to the topic of "Investing in a Healthier America."

For questions related to feedback and recommendations from the American College of Lifestyle Medicine, please contact Kaitlyn Pauly, Deputy Director of Practice Advancement and Administration at kpauly@lifestylemedicine.org

Sincerely,



Beth Frates, MD, FACLM, DipABLM
President



Susan Benigas
Executive Director

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**Statement of the
American College of Physicians
to the U.S. House Ways and Means Health Subcommittee Hearing
on
Investing in a Healthier America: Chronic Disease Prevention and Treatment
September 18, 2024**

The American College of Physicians (ACP) is pleased to provide comments in response to the House Ways and Means Health Subcommittee's hearing on "Investing in a Healthier America: Chronic Disease Prevention and Treatment." We thank Ways and Means Chairman Smith and Health Subcommittee Chairman Buchanan and Ranking Member Doggett for holding this hearing to examine the prevalence of chronic disease in America and the value of investing in prevention and innovative treatment options. We hope these comments will lead to bipartisan action to strengthen chronic care solutions as well as ensure that the Medicare Physician Fee Schedule (MPFS) provides the resources necessary for our physicians to deliver high quality care to our nation's seniors. We urge the Ways and Means Committee to act on the following recommendations outlined in this letter to achieve these goals.

ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness.

Although passage of the Creating High-Quality Results and Outcomes to Improve Chronic (CHRONIC) Care Act made important changes in improving care for seniors with chronic conditions, additional steps are needed to ensure that our patients have access to high quality chronic care. Six in ten American [adults](#) have at least one chronic disease and four in ten have two or more, and at \$3.3 trillion in annual health costs, chronic disease is responsible for 75 percent of aggregate national health care spending and is the largest cause of [disability and death](#). General internal medicine physicians assume principal responsibility for coordinating and managing patients' overall care, particularly for those with multiple [complex chronic conditions](#). As the Subcommittee examines policies to bolster chronic care, we urge you to adopt the following measures to ensure lower costs and improve the quality of chronic care in this country:

- Strengthen and Stabilize the MPFS
- Revise Requirements for Budget Neutral Payment Cuts in the MPFS
- Extend Alternative Payment Models (APMs) Incentive Payments

- Ensure Accurate Estimates of Utilization of New Codes in the MPFS
- Remove Beneficiary Cost Sharing for Chronic Care Management Services
- Support Increased Access to Telehealth Services
- Expand the Primary Care Physician Workforce

Strengthen the Medicare Physician Fee Schedule

It is unrealistic to assume that the current MPFS provides the adequate stability and resources necessary for our physicians to deliver high quality chronic care for our patients. Unlike nearly every other segment of the Medicare payment system, the MPFS does not include annual inflationary adjustments. As a result, when accounting for inflation, Medicare physician payments have declined 29 percent from 2001 to 2024. The Medicare Access and CHIP Reauthorization Act (MACRA) must be viewed within the broader context of the physician payment system. While physician services represent a very modest portion of the overall growth in health care costs, they are primary targets for cuts when policymakers seek to tackle spending. For years physicians have struggled with a broken Medicare payment system that does not allow them to keep up with practice expenses and rising inflation. That has made it much harder for physician practices to manage sharp increases in practice expenses or navigate staffing and supply shortages.

The modest statutory updates previously included in MACRA have ended and physicians are in a six-year period with no updates. The result is real reductions to payments when accounting for inflation and budget neutrality requirements. ACP [urges](#) Congress to pass H.R. 2474, the Strengthening Medicare for Patients and Providers Act, to provide an annual Medicare physician payment update tied to inflation, as measured by the Medicare Economic Index (MEI). An MEI update for the MPFS would allow physicians to make needed investments in their practices to help ensure that they are able to deliver high quality care to their patients.

Revise Requirements for Implementing Budget Neutral (BN) Payment Cuts in the MPFS

In addition to a lack of inflationary updates, each year physician practices face arbitrary payment cuts due to budget neutrality requirements in the annual fee schedule that, unless addressed in a comprehensive way, will continue to plague physicians in the years to come. Although we appreciate that Congress has provided some financial relief to physicians to mitigate the effect of these payment cuts, these measures do not provide the consistency and stability for physicians to meet their expenses and provide high quality care to seniors.

We urge Congress to act this year to pass the Provider Reimbursement Stability Act, H.R. 6371, which would give the Centers for Medicare and Medicaid Services (CMS) more flexibility in setting payment rates, updating average costs doctors incur in calculating reimbursement and making payments more predictable. The bill would require CMS to conduct a look-back period, to reconcile overestimates and

underestimates in utilizations. We support this approach as it would allow for a more accurate calculation of the Medicare conversion factor based on actual utilization data and claims. Further, it would raise the BN utilization estimate threshold from \$20 million to \$53 million and would use cumulative increases in the MEI to update the threshold every five years afterwards. The \$20 million threshold was established in 1992 and has not been updated since. Raising the BN threshold would allow for greater flexibility in determining pricing adjustments for services without triggering across-the-board cuts in Medicare physician pay. We believe that this is a practical approach, which would help account for inflation.

An alternative bill ACP also supports is H.R. 6475, the Physician Update and Improvements Act. This bill would also raise the threshold for implementing budget neutral payment cuts from \$20 million to \$53 million and would provide an increased update to the threshold every five years afterwards based on the MEI. ACP also supports the provisions in the bill that would require CMS to update the direct costs associated with practice expenses (clinical labor, the prices of equipment, and the prices of medical supplies) simultaneously at least once every five years.

Another provision in this bill we support would allocate three percent to the 2024 Medicare conversion factor, as well as extend incentive payments for participation in eligible advanced alternative payment models (APMs) through 2026 and would tier bonuses according to how long a physician has participated in an APM, to account for increased upfront costs. Further, the bill includes a provision that would provide the Secretary of Health and Human Services (HHS) with flexibility for tiering bonuses. ACP supports extending incentive payments for APMs to support physicians' transition from a volume-based fee-for-service health care system to one that is based on the value of health care delivered to the patient. Instead of having a tiered approach for bonuses, we recommend that Congress considers freezing the revenue threshold increase for five years to encourage more physicians to transition from fee-for service into AP

Pass the Value in Health Care Act to Extend APM Incentive Payments

ACP [supports](#) extending incentive payments for participation in eligible alternative payment models through 2026. Congress should pass the Value in Health Care Act of 2023, H.R. 5013, to extend the five percent bonus for physician participation in advanced APMs. This bipartisan legislation makes several important reforms to ensure that APMs continue to produce high quality care for the Medicare program and its beneficiaries. The [Value in Health Care Act](#) makes a number of important reforms to strengthen Medicare's value-based care models and Accountable Care Organizations (ACOs) to ensure that these models continue to produce high quality care for the Medicare program and its beneficiaries as well as to generate savings for taxpayers. The bill extends MACRA's five percent advanced APM incentives that are scheduled to expire at the end of the year. It also gives CMS authority to adjust APM qualifying thresholds so that the current one-size-fits-all approach does not serve as a disincentive to including rural, underserved, primary care or specialty practices in APMs. This approach

would help to maintain incentives that support physicians' transition from a volume-based fee-for-service health care system to one that is based on the value and quality outcomes of health care delivered to the patient. Another bill we support, H.R. 6369, also extends incentive payments for participation in eligible alternative payment models.

Ensure Accurate Calculation of Utilization of New Medicare Payment Codes

ACP is requesting that Congress directs the Government Accountability Office (GAO) to conduct a study and report on the utilization estimates and actual payments incurred from the implementation of new Medicare codes by CMS. This language is needed to more accurately determine how much money in Medicare Part B was unnecessarily held back versus the actual amount needed to pay for those services within the first year of implementation. The concern is that money is often withheld from the fee schedule due to budget neutrality and if the estimates are above the actual code utilization, that money doesn't get put back into the fee schedule to fund other service costs. If there is an overestimation in utilization of new codes, it can lead to unnecessary physician payment cuts, which ultimately can hinder patients' access to timely care.

Remove Beneficiary Cost Sharing for Chronic Care Management Services

We remain concerned that despite the implementation of new chronic care management codes in the MPFS, which allow physicians to bill services provided outside of face-to-face patient visits, many seniors fail to access chronic care services from their primary care physician. The latest [data](#) reveals that only four percent of Medicare beneficiaries potentially eligible for chronic care management received these services. That amounts to 882,000 out of a potential pool of 22.5 million eligible beneficiaries.

ACP urges Congress to pass H.R. 2829, the Chronic Care Management Improvement Act of 2023. This legislation would remove the cost sharing requirement for patients to access chronic care management services. We believe that access to chronic care services remains low due to patient cost sharing associated with this code.

Current law mandates that Medicare beneficiaries are subject to a 20 percent coinsurance requirement to receive CCM services. This cost-sharing requirement creates a barrier to care, as beneficiaries are not accustomed to cost-sharing for care management services and may forego the services altogether as a result. ACP also supports allowing the physician that performs chronic care management services to waive the requirement that the patient pay the 20 percent coinsurance fee associated with this service.

Physicians who use CCM services are also required to document the amount of time spent with each patient resulting in excessive administrative burdens associated with these codes. We believe that the additional imposed administrative burdens associated with these codes are contributing to the reluctance of physicians to provide and bill for CCM services. We urge Congress to work with CMS to remove the burdensome time documentation requirements associated with billing CCM services. A

solution to this burden would be to simply require the physician to attest to the amount of time spent providing the service.

Protect and Preserve Medicare Beneficiaries' Access to Telehealth Services

ACP supports the use of telemedicine as a method of health care delivery that will improve the health of patients with chronic conditions by enabling and enhancing patient physician collaborations, increasing access to care and members of a patient's health care team, and reducing medical and resource costs when used as a component of a patient's longitudinal care. Telehealth flexibilities from the pandemic-era public health emergency (PHE) have been instrumental in improving access to care for patients across the U.S. We were pleased that the Consolidated Appropriations Act of 2023 extended many of those flexibilities through the end of 2024. ACP believes that the following coverage policies should be continued – and not allowed to expire – to support making telehealth an ongoing and continued part of medical care now and in the future.

- Expand originating sites and lift geographic requirements for telehealth services
- Allow federally qualified health centers (FQHCs) and rural health clinics (RHCs) to continue to provide telehealth services
- Allow the furnishing of audio-only telehealth services for evaluation and management services

We urge Congress to make these existing flexibilities permanent or to provide long-term extensions for them. ACP Supports S. 2016/H.R. 4189, the Connect for Health Act of 2023. This legislation would permanently facilitate access to essential telehealth services by expanding originating sites and lifting geographic requirements for telehealth services and allowing FQHCs and RHCs to continue to provide telehealth services.

We also support S. 1636/H.R. 3440, the Protecting Rural Telehealth Access Act, a bill that would ensure that seniors can continue to access audio-only telehealth consults with their physician after this option expires at the end of this year. ACP strongly supports the use of audio-only telehealth as an effective modality to address gaps in health equity. These services are instrumental for patients who do not have the requisite broadband/cellular phone networks or have privacy concerns and do not feel comfortable using video visit technology or do not possess the digital literacy to use video technology.

Expand the Primary Care Workforce

It is estimated that there will be a [shortage](#) of up to 86,000 physicians by 2036. This includes a shortage of projected supply and demand for primary care physicians of between 20,200 and 40,400 physicians by 2036. As our population ages with higher incidences of chronic diseases, it is especially important that patients have access to physicians trained in comprehensive primary and team-based care for adults—a hallmark of internal medicine GME training. It is worth noting that the federal government is the largest explicit provider of GME funding (over \$15 billion annually), with most of the support coming from Medicare.

ACP appreciates Congress' continued GME expansion with the Consolidated Appropriations Act, (CAA), 2023, which added 200 new GME slots, 100 for psychiatry and psychiatric subspecialties and 100 for other physician specialties. We urge Congress to ensure that this progress does not stall by passing the Resident Physician Shortage Reduction Act of 2023, H.R. 2389/S. 1302, which would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years.

Conclusion

We commend you for working in a bipartisan fashion to identify ways to improve the delivery and value of health care provided to those with chronic conditions. If you have any further questions or if you need additional information from ACP, please contact George Lyons at (202) 261-4531 or glyons@acponline.org.



October 2, 2024

Representative Jason Smith (R-MO)
Chairman
House Ways & Means Committee

Representative Richard Neal (D-MA)
Ranking Member
House Ways & Means Committee

Representative Vern Buchanan (R-FL)
Chairman
Ways & Means Health Subcommittee

Representative Lloyd Doggett (D-TX)
Ranking Member
Ways & Means Health Subcommittee

Re: *Chronic Disease Prevention and Treatment*

Dear Chairmen Smith and Buchanan and Ranking Members Neal and Doggett,

The Association of Diabetes Care & Education Specialists (ADCES) thanks you for holding the Ways & Means Health Subcommittee Hearing “Chronic Disease Prevention and Treatment” on September 18, 2024. We also appreciate the opportunity to provide written comments for the hearing record on these issues.

ADCES is an interdisciplinary professional membership organization dedicated to improving prediabetes, diabetes, and cardiometabolic care through innovative education, management, and support. With more than 12,000 professional members including nurses, dietitians, pharmacists, and others, ADCES has a vast and diverse network of practitioners working to optimize care and reduce complications. ADCES supports an integrated care model that lowers the cost of care, improves experiences, and helps its members lead so better outcomes follow.

The subcommittee and its panel of witnesses highlighted many salient challenges faced by this country in addressing chronic disease including diabetes and obesity. Mentioned during the hearing were diabetes self-management training, medical nutrition therapy, and the Diabetes Prevention Program, which are evidence-based services that can prevent or treat diabetes. All are currently covered by Medicare, but in ways that significantly limit beneficiaries access to them despite their low cost and high efficacy. Below are recommendations to the committee on how to support access to chronic disease prevention and treatment in Medicare through investment in these upstream programs.

Diabetes Self-Management Training

In her testimony, Dr. Rinaldo noted that her health plan’s C-SNP offers free diabetes self-management training as one strategy for increasing access to preventive services. Diabetes self-management training is a service that “[gives] people with diabetes the knowledge, skills, and confidence to accept responsibility for their self-management. This includes collaborating with

their health care team, making informed decisions, solving problems, developing personal goals and action plans, and coping with emotions and life stresses”.¹ A part of the ADA standards of care for diabetes,² DSMT (also referred to as diabetes self-management education and support), has decades of evidence supporting its effectiveness.³ The 2022 National Standards for Diabetes Self-Management Education and Support⁴ found that:

“Numerous studies have proven the benefits of DSMES, which include improved clinical outcomes and quality of life, while reducing hospitalizations and healthcare costs.^{5, 6, 7, 8, 9, 10} Engagement in DSMES services lowers hemoglobin A1C (A1C) by at least 0.6%, as much as many diabetes medications—however with no side effects.⁵ Greater A1C reductions have been associated with more than 10 h of DSMES services.^{5”}

Of note is that traditional Medicare is required to charge beneficiaries a 20% copay for this service because it is considered “treatment” and not “prevention” despite its role in preventing many downstream complications from diabetes. This is one contributing factor to fewer than 5% of Medicare beneficiaries with diabetes utilizing DSMT in the first year after diagnosis.¹¹

The **Expanding Access to Diabetes Self-Management Training Act** (DSMT Act, [H.R. 3842](#)) from Reps. Schrier, Bilirakis, and DeGette, would address this and other challenges with the benefit to improve beneficiary access. The DSMT Act was amended and passed in fall 2023 by the [Energy & Commerce Health Subcommittee](#) (unanimous voice vote) and [Full Committee](#) (44-0). The amended version of the bill would expand who can refer for the service and make it easier for beneficiaries to use the hours available, but the provision to eliminate cost-sharing was unfortunately not advanced. In acknowledgement of the cost-saving potential of DSMT, the amended version of the bill was scored by the Congressional Budget Office as costing +/- \$500,000 over 10 years.

ADCES encourages the committee to support the DSMT Act’s inclusion in any end-of-year health care package.

Medical Nutrition Therapy

The importance of Medical Nutrition Therapy (MNT) access was also discussed at the hearing. MNT is the benefit that allows access to nutrition counseling from registered dietitians to help beneficiaries manage their health through medically tailored nutrition recommendations. Currently, Medicare only covers MNT for beneficiaries with diagnosed diabetes or kidney disease. This means that beneficiaries with prediabetes, obesity, heart disease, high blood pressure, and other chronic diseases have little to no access to a registered dietitian unless they can afford to see one and pay completely out of pocket. This is a serious health equity concern given the higher rates of these metabolic diseases among racial and ethnic minorities and lower income populations in the US, which was noted by many members of the subcommittee and witnesses.

The **Medical Nutrition Therapy Act** ([H.R. 6407](#)) would help Medicare beneficiaries improve their food choices and nutrition status by creating coverage for MNT for an array of chronic diseases and conditions and giving the Secretary the authority to add additional diseases and conditions in the

future based on clinical guidelines. Despite numerous hearings discussing the importance of nutrition in improving the health of American's, this legislation has yet to directly be the subject of a hearing or markup. ADCES encourages the subcommittee to include the MNT Act in their next legislative hearing or markup so that the members can learn more about this effective, low-cost preventive service.

Medicare Diabetes Prevention Program

Multiple witnesses also expressed support for the Diabetes Prevention Program (DPP). The DPP is one of the most well-studied prevention interventions in the country, with nearly 30 years of evidence on its effectiveness and helping people with prediabetes stop or delay their progression to type 2 diabetes through lifestyle change.¹² Since 2018, Medicare has covered the DPP through a nationwide expanded model under the Centers for Medicare and Medicaid Innovation. Despite the successes of the National DPP, the Medicare DPP has struggled due to overly complex payment and supplier enrollment requirements. The program also continues to operate under temporary status, reducing the incentive for National DPPs to invest in becoming Medicare suppliers.

The **PREVENT DIABETES Act (H.R. 7856)** from Reps. DeGette and Bilirakis seeks to increase the number of suppliers in the Medicare DPP and increase beneficiary participation by making the program permanent, removing the one-in-a-lifetime restriction on participation, and instructing Medicare to cover all modalities of DPP from programs that have received CDC Recognition. The PREVENT DIABETES Act was amended and passed by [the Energy & Commerce Health Subcommittee](#) in May and was scheduled to be marked up by the full Committee in June before the markup was cancelled. ADCES encourages the committee to support the PREVENT DIABETES Act's inclusion in any end-of-year health care package.

Permanent Telehealth in Medicare

Lastly, the importance of telehealth was brought up by both members and witnesses including Dr. Peters who shared that telehealth has significantly improved diabetes management. Our members can attest to the widespread popularity of telehealth in rural, suburban, and urban areas alike. While the shift to telehealth was not easy in the early days of the COVID-19 pandemic, clinics and health systems have made significant investments in digital platforms and workflow practices to make care available to beneficiaries well beyond the clinic walls and the continued success of many diabetes self-management training programs depends on the continuation of telehealth access for Medicare beneficiaries.

We thank the committee for reporting out a two-year extension to the Medicare telehealth flexibilities and we encourage its passage as soon as possible. We have heard from our members that waiting until late December to enact the extension will cause significant challenges as practices are hesitant to schedule telehealth visits for January until this legislation is signed into law guaranteeing payment for such services.

* * * * *

Thank you again for holding this hearing and providing the opportunity for organizations to submit written comments. Please contact ADCES director of advocacy Hannah Martin should you have any questions regarding ADCES' comments.

Sincerely,



Matthew Hornberger, MBA, Chief Executive Officer



Hannah Martin, MPH, RDN, Director of Advocacy

References

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June 26, 2024

The Honorable Jason Smith
Chair
House Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
House Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

RE: Support for Medicare Coverage for the Treatment of Obesity

Dear Chair Smith and Ranking Member Neal,

As clinician members of the Alliance for Patient Access we are writing in support of the Committee's proposed "Amendment in the Nature of a Substitute to H.R. 4818," which will be heard in the upcoming Ways and Means Committee markup. The legislation would expand Medicare coverage for FDA-approved obesity treatments.

Founded in 2006, AfPA is a national network of policy-minded health care providers who advocate for patient-centered care. AfPA supports health policies that reinforce clinical decision making, promote personalized care and protect the clinician-patient relationship. Motivated by these principles, AfPA members participate in clinician working groups, advocacy initiatives, stakeholder coalitions and the creation of educational materials. AfPA manages an Obesity Initiative which convenes providers dedicated to ensuring a patient-centered approach to obesity treatment.

Obesity is a chronic disease as defined by the American Medical Association in 2013¹ with significant health and economic impacts, much like diabetes and hypertension. We believe treating obesity as a disease is critical to the discussion on improving chronic care. The obesity epidemic in the United States is no secret. The New England Journal of Medicine predicts that 1 in 2 adults will have obesity by 2030, while 1 in 4 adults will have severe obesity. Obesity currently affects 42.4% of Americans.² In addition, communities of color are disproportionately impacted, with Black Americans having an obesity rate of 50% and Latino Americans experiencing a rate of 46%.³

Furthermore, obesity is expensive. The aggregate annual medical costs due to obesity among adults in the United States is over \$260 billion. Total obesity-related government expenditures, including Medicaid and Medicare spending and federal outlays, are estimated to be \$91.6 billion per year, approximately 30% of Medicare spending.⁴ As you consider the overall health and well-being of Americans, these numbers are impossible to ignore.

Obesity is not an insular disease; it is related to a host of other diseases including certain cancers, heart disease, stroke, and type 2 diabetes.⁵ These diseases are among the leading causes of both preventable and premature death.⁶ In addition, obesity can lead to greater rates of inflammation and further exacerbate existing conditions.⁷ Ensuring proper access to treatment for obesity can have downstream impacts that alleviate related conditions, as well.

¹ [H-440,842 Recognition of Obesity as a Disease | AMA \(ama-assn.org\)](#)

² [Adult Obesity Facts | Overweight & Obesity | CDC](#)

³ <https://obesitymap.norc.org/>

⁴ <https://www.jmcp.org/doi/10.18553/jmcp.2021.20410>

⁵ [Adult Obesity Facts | Overweight & Obesity | CDC](#)

⁶ Ibid.



As you are aware, patients with obesity now have very effective FDA-approved pharmacologic options to treat obesity disease. However, ensuring patients can access appropriate obesity care, including pharmacologic therapies in addition to intensive behavioral interventions, is paramount to address the obesity epidemic. This approach should be no different than current approaches to treating other chronic diseases.

Importantly, the FDA has approved several therapies for the treatment of obesity, meant to be used in conjunction with lifestyle changes. These treatment options have been revolutionary in ensuring patients and providers have additional tools to handle this complicated disease. Proper and effective treatment of obesity would benefit patients through improved health outcomes, as well as the health care system in the form of long-term savings.

Despite the value of these therapies to providers and patients, we are very concerned that the outdated ban on Medicare coverage severely limits access to appropriate, FDA-approved therapies. The lack of Medicare Part D coverage creates challenges for patients and their clinicians that result in fewer treatment options for those with obesity. Placing barriers between patients and the therapies that their healthcare provider prescribes interferes with patient care and undermines the primacy of the clinician-patient relationship, a relationship that serves as the backbone of our health care system. For patients with obesity at higher risk of developing other deadly and preventable diseases, access to all appropriate medications is particularly important.

Given the impact of obesity, this legislation is an important step toward addressing this treatable disease. The proposed would remove outdated guidelines and provide an avenue for coverage for anti-obesity medications under Medicare Part D. Allowing patients and providers to access the full regimen of treatment options, including behavioral therapy, bariatric surgery, and anti-obesity medications, will have a significant impact on seniors across the country.

It is for these reasons that we urge your support for legislation ensuring comprehensive obesity coverage during the upcoming markup. If we can provide further details or answer any questions, please reach out to cmcperson@allianceforpatientaccess.org or (202) 951-7097.

Sincerely,

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⁷ [Health Risks | Obesity Prevention Source | Harvard T.H. Chan School of Public Health](#)



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Prepared by Kevin Volpp, MD, PhD, FAHA

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Submitted to the House Ways and Means Committee
Subcommittee on Health

Hearing on Investing in a Healthier America: Chronic Disease Prevention and Treatment

September 18, 2024

Dear Chairman Jason Smith and Ranking Member Richard Neal, Health Subcommittee Chairman Vern Buchanan and Ranking Member Lloyd Doggett, and members of the House Ways and Means Subcommittee on Health, thank you for holding this hearing, "Investing in a Healthier America: Chronic Disease Prevention and Treatment." My name is Dr. Kevin Volpp, and I currently serve as the scientific lead for the American Heart Association's food is medicine (FIM) initiative, Health Care by Food (HCXF). I am also the founding Director of the Penn Center for Health Incentives and Behavioral Economics (CHIBE) and the Mark V. Pauly President's Distinguished Professor at the University of Pennsylvania's Perelman School of Medicine and the Wharton School.

For 20 years, I served as a part-time primary care doctor and hospitalist taking care of patients at the Philadelphia Veterans Affairs Medical Center. Many of my patients struggled with chronic diseases such as diabetes and congestive heart failure, which were exacerbated by their challenges finding affordable healthy food. As a behavioral economist, my work has largely focused on testing innovative ways of applying insights from behavioral economics in improving patient health behavior and clinician performance. Through my work with a variety of health plans, health systems, consumer companies, and individual patients, I have developed a deep understanding about what physicians, individuals, and families need to promote health, prevent disease, cure illness, and manage chronic health conditions. As a member of the American Heart Association's advocacy committee, I have worked to advance the organization's mission to be a relentless force for a world of longer, healthier lives for all.

As laid out in the AHA's presidential advisory on FIM,¹ AHA developed a call to action for the organization, as well as for the rest of the FIM research field, as we look toward strengthening the overall body of the work. Our call to action is the following:

- Define and determine the scope of FIM and its role in health care and strengthen the FIM evidence base across diverse populations to inform our collective understanding of the limitations to the existing evidence and the opportunities for incremental impact.
- In partnership with others, lead efforts to increase the rigor of FIM studies so that the field moves away from predominantly conducting pre-post studies in which causal inferences are difficult to draw to one that leads the field of nutrition research by using experimental and quasi-experimental designs that support more robust and reliable conclusions.
- Bring behavioral science and human-centered design into FIM trials more systematically to increase engagement and ultimately both efficacy among those who choose to participate and population health effectiveness of interventions.
- Make concerted efforts to obtain funding for more rigorous, adequately powered longer-term studies to affect measured clinical outcomes. Conduct comparative effectiveness and cost-effectiveness studies, capturing tradeoffs between intervention costs and effectiveness to inform decisions on which FIM approaches to choose for different populations, outcomes, and settings.

¹ Volpp KG, et al. Food Is Medicine: A Presidential Advisory From the American Heart Association. *Circulation*. 2023;148:1417-1439.

- Use rapid-cycle innovation principles to improve program enrollment and engagement and to study design innovations such as adaptive study designs to accelerate learning from research studies.
- Embed FIM principles of research, including equity, transparency, rigor, quantitative/qualitative balance, dignity, and incorporating lived experience of patients and practitioners, to ensure that effective FIM interventions have reach, adoption, acceptability, and sustainability within the populations served.
- Create common data platforms and standardize data elements and metrics in FIM studies to facilitate comparisons across studies that could support the translation of research into policy.
- Catalyze partnerships across communities, food systems, health systems, commercial entities, and funding agencies to empower a patient-driven, health-for-all approach to mitigate food insecurity and to improve diet quality and health outcomes among the most disenfranchised.
- Leverage implementation science to examine questions on enrollment, dose, engagement, and adherence inclusive of health system or health plan integration. Identify and develop strategies to examine predictors of implementation success of individuals and incorporate these into program design.
- Expand complementarities of advocacy and policy work through cross-sector, community-engaged, inclusive coalitions at the regional and national levels, as well as governmental partnerships to create dialogue and build trust, collaboration, and collective action.
- Standardize professional education nationally to include nutritional science and FIM research to facilitate adoption of FIM best practices in clinical practice by the next generation of health professionals.

Why take a FIM approach to health care?

The connection between chronic disease and nutrition is undeniable. Our diets not only play a role in our risk of developing chronic diseases, but also can prevent, manage, and treat these diseases. Cardiovascular disease is the leading cause of death in the United States, and chronic diseases affected by nutrition including cardiovascular disease, stroke, and diabetes account for most of the nation's \$4.3 trillion in annual health care costs.² Cardiovascular disease alone accounts for 12 percent of total U.S. health expenditures, considerably more than any other disease.³ Heart disease and stroke cost the U.S. health care system \$216 billion annually and cause \$147 billion in lost job productivity.⁴ Nutrition insecurity and unhealthy diets—characterized by a high intake of calories, sodium, added sugars, and saturated fat, and low intake of vegetables, fruits, and whole grains—significantly contributes to the development of cardiometabolic disease and chronic diseases more broadly. There are significant equity disparities as well, with higher rates of chronic disease mortality among those with low income, less education, and across different racial/ethnic populations. Black, Latino, and Native populations and low-income households, have higher rates of poor diet quality compared with the overall population.⁵ The COVID-19 pandemic has only exacerbated these disparities. Stable availability, access, affordability, and use of nutritious foods across the lifecycle can help reduce the risk of chronic diseases and help treat and manage chronic diseases. Unfortunately, many individuals in the United States are nutrition and food insecure⁶ and do not have access to affordable, nutritious food. There is a growing body of evidence that the health care system can be used to help patients access and consume healthy foods. To help address unhealthy diets and nutrition insecurity, evidence-based, cost-effective nutrition and food programs can be integrated into the health care system.

What is FIM?

FIM refers to a medical treatment or preventive intervention for patients with a diet-related health risk or condition and/or nutrition and food insecurity, to which they are referred by a health care provider, health care organization, or health insurance plan.⁷ Often these FIM interventions are coupled with medical nutrition therapy (MNT) and efforts to increase enrollment or participation in other federal and state safety net programs, and programs that

² Martin AB, et al. National Health Expenditure Accounts Team. National health care spending in 2021: decline in federal spending outweighs greater use of health care: study examines national health care expenditures in 2021. *Health Aff (Millwood)*. 2023; 42:6–17.

³ Tsao CW, et al. Heart Disease and Stroke Statistics—2022 Update: A Report From the American Heart Association. *Circulation*. 2022;145:e153–e639.

⁴ Centers for Disease Control and Prevention. Health and Economic Costs of Chronic Diseases. Accessed online April 15, 2024. <https://www.cdc.gov/chronicdisease/about/costs/index.htm>.

⁵ Tsao CW, *ibid*.

⁶ Coleman-Jensen A, et al. Household Food Security in the United States in 2020. Economic Research Report No (ERR-298) pp. 2021.

⁷ Harvard University Center for Health Law and Policy Innovation. Accessed online April 15, 2024. <https://chplpi.org/project/food-is-medicine/>.

address other social determinants of health (housing, education, transportation, social services, etc). There are distinct approaches that are described broadly as FIM, including but not limited to:

- **Medically Tailored Meals (MTMs).** MTMs are used to address diet-related diseases and food access among higher-risk individuals. MTMs provide home delivery of fully prepared meals designed by a registered dietician to meet the specific dietary needs of an individual living with one or more chronic diseases. This intervention is ideal for patients living with chronic diseases who are unable to shop for or prepare meals for themselves, such as patients following a hospitalization for congestive heart failure who are frail and have difficulty ambulating.
- **Medically Tailored Groceries (MTGs).** MTGs include a selection of groceries, such as vegetables, fruits, grains, beans, lean proteins and/or dairy prescribed by a registered dietitian nutritionist for a broader range of patients—those with diet-related acute and chronic conditions who can shop or pick up and prepare food at home. MTGs are part of a treatment plan for an individual with a defined medical diagnosis, confirmed by a health care provider or health plan. Food sourcing varies across programs and often incorporates community partners.
- **Healthy Food Prescription Programs.** Food prescription programs (also called produce prescription programs) incorporate food access directly into the patient-provider relationship which better enables patients to follow their providers' dietary advice. In these programs, providers "prescribe" fruits and vegetables, or other healthy foods, to at-risk patients in the form of coupons or vouchers for local farmers' markets, grocery stores, or mobile markets. These programs are also typically accompanied by nutrition education and/or counseling and can be paired with services provided by registered dietitians or community health workers. Food prescription programs are typically offered to people living with chronic diseases that are exacerbated by unhealthy food and who have nutrition and food insecurity. Some food prescription programs have been funded through the farm bill reauthorization process. The 2018 farm bill provided \$250 million of mandatory funding for GusNIP, some of which is allocated for produce prescription pilots.

It is important to note that FIM complements other critical efforts to address food and nutrition security needs, such as supporting Supplemental Nutrition Assistance Program (SNAP), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the charitable food system (food banks and pantries), among others. However, it is distinct from these programs in that it is specifically targeted for people living with or at high risk of chronic disease, due in large part to diet, through health care settings.

The interest in FIM programs and their increasing use within health care has been in part ahead of the research, driven in large part by organizations and advocates who have worked to develop service delivery programs to meet the nutritional needs of people living with chronic diseases. Within the past several years, health care integration of FIM interventions has become increasingly common. FIM programs are growing, which allows for more researchers to assess the effectiveness of the implementation of different FIM approaches.

Already there has been tremendous momentum at the state and federal level. State Medicaid agencies may currently apply for waivers (i.e., Section 1115 demonstration waiver and 1915(b) waiver) to test new FIM approaches, including MTMs and produce prescription programs, and nearly a dozen states have begun to take advantage of these opportunities for innovation. The administration has called for testing MTMs in Medicare, expanding and enhancing Medicare coverage of nutrition and obesity counseling (MNT), and increasing funding for nutrition research, and have held multiple convenings on FIM as part of the National Strategy on Hunger, Nutrition, and Health. The Centers for Medicare and Medicaid Services (CMS) now requires hospitals to screen patients for needs related to food insecurity, housing, transportation, and other social determinants of health. Medicare Advantage plans already voluntarily offer supplemental benefits that include food assistance and FIM-like benefits (MTMs, MTGs, produce prescription), but this is an emerging area with limited information about its utilization. The Department of Health and Human Services (HHS) is currently developing common measures and a framework for evaluating FIM set to be released by the fall. Finally, produce prescription programs and pilots continue to grow in numbers, including at the Indian Health Service and Department of Veterans Affairs.

Strengths and Room for Improvement in FIM Research

FIM programs have commonly been evaluated as part of small-scale studies and pilot projects conducted using local resources that are generally not scalable. The HCXF initiative is funding smaller studies with a goal of addressing implementation challenges that would limit the potential for scalability and then will fund larger studies. HCXF has also identified populations to prioritize in research, including the acutely ill, patients with recent hospital discharges, high-risk pregnant women, and alternative paths or wrap-arounds for glucagon-like peptide 1 drugs (GLP-1), drugs. We are also prioritizing having geographically and ethnically and racially diverse populations as participants in the initiative.

Of the studies on FIM programs, the literature on MTMs is the most well-developed, with a number of rigorous study designs and results that examine clinical outcomes and health care utilization and spending. MTMs are associated with improved health outcomes for people living with chronic diseases such as diabetes, heart failure, HIV, and chronic liver disease. Patients on medically tailored meals have reported higher quality of life scores, lower rates of food insecurity, and improved diet quality.^{8,9} MTM are also associated with reduced hospital admissions and overall health care costs.^{10,11} The research suggests that produce prescription programs are effective at increasing fruit and vegetable consumption^{12,13} and reducing household food insecurity.¹⁴ The studies conducted on food prescription programs have found that some of these programs are associated with improved health outcomes and reduced health care burden including decreased hemoglobin A1C levels¹⁵ and lower body mass index.¹⁶ While modeling studies have suggested that food prescription programs may prevent cardiovascular disease and diabetes, these have typically had to make assumptions about the longer term effects of short-term interventions that may or may not end up being confirmed.¹⁷

In general, many of the FIM studies that have been conducted using pre-post examination of a group that received an intervention without comparison groups; the measured impact of such interventions may be overstated since they do not account for the general tendency of measured outcomes to regress to the mean.¹⁸ Furthermore, only a small number of randomized controlled trials have been done and those that have been done with few exceptions are small and typically not tested using a scalable infrastructure. More broadly, there are important questions to answer regarding the intensity of FIM interventions, the duration, delivery, the role of patient preferences and choice, the incorporation of educational or behavioral strategies or coaching in addition to food permission, the testing of comparative effectiveness of ways to change behaviors and habits, and of cost effectiveness. More testing using infrastructure that can be replicated and scaled will be particularly important in determining ways to create solutions that could be deployed widely across the United States.

While there have been studies showing no significant results, this further illustrates the importance of carefully considering study design, and various implementations that take into account the lived experience of the populations most likely to benefit. The recent negative study by Doyle et al tested a very specific intervention, in

⁸ Ishaq O, et al. Food as medicine: A randomized controlled trial (RCT) of home delivered, medically tailored meals (HDMTM) on quality of life (QoL) in metastatic lung and non-colorectal GI cancer patients. *Journal of Clinical Oncology*. 2016;34.

⁹ Berkowitz SA, et al. Medically Tailored Meal Delivery for Diabetes Patients with Food Insecurity: a Randomized Cross-over Trial. *J Gen Intern Med*. 2019;34:396-404.

¹⁰ Berkowitz SA, et al. Association Between Receipt of a Medically Tailored Meal Program and Health Care Use. *JAMA Intern Med*. 2019;179:786-793.

¹¹ Berkowitz SA, et al. Meal Delivery Programs Reduce The Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries. *Health Aff (Millwood)*. 2018;37:535-542.

¹² Bhat S, et al. Healthy Food Prescription Programs and their Impact on Dietary Behavior and Cardiometabolic Risk Factors: A Systematic Review and Meta-Analysis. *Advances in Nutrition*. 2021.

¹³ Marcinkavage J, Auvinen A and Nambuthiri S. Washington State's Fruit and Vegetable Prescription Program: Improving Affordability of Healthy Foods for Low-Income Patients. *Prev Chronic Dis*. 2019;16:e91.

¹⁴ Ridberg RA, et al. A Pediatric Fruit and Vegetable Prescription Program Increases Food Security in Low-Income Households. *J Nutr Educ Behav*. 2019;51:224-230.e1.

¹⁵ Bryce R, et al. Participation in a farmers' market fruit and vegetable prescription program at a federally qualified health center improves hemoglobin A1C in low-income uncontrolled diabetics. *Prev Med Rep*. 2017;7.

¹⁶ Cavanagh M, et al. Veggie Rx: an outcome evaluation of a healthy food incentive programme. *Public Health Nutr*. 2017;20:2636-2641.

¹⁷ Lee Y, et al. Cost effectiveness of financial incentives for improving diet and health through Medicare and Medicaid: A microsimulation study. *PLoS Med*. 2019;16:e1002761.

¹⁸ Doyle J, et al. Effect of an Intensive Food-as-Medicine Program on Health and Health Care Use: A Randomized Clinical Trial. *JAMA Intern Med*. 2024;184:154-163.

which participants had to drive to an on-site food farmacy to pick up their food on a bi-weekly basis and did not have a great many options with regards to their meal choices.¹⁹ Lack of effectiveness in one specific intervention does not negate that other differently designed interventions may be effective, and both negative and positive studies provide important learnings that inform future research studies.

A common challenge and barrier to system transformation has been that among the wide variety of programmatic interventions at the intersection of food and health, most exist on a small and siloed scale. Different hospitals, payors, and health care providers have approached these programs in various ways, without any clear or standardized set of implementation approaches likely to be capable of scaling nationally. To create more generalizable approaches, there would ideally be coordination between HHS and the United States Department of Agriculture (USDA) with support for research from the National Institutes of Health (NIH) and involvement of public-private partnerships both to facilitate the testing of scalable ideas and to provide financial support. Current FIM interventions do not consistently include the perspectives and voice of potential participants, which can reduce engagement by those who are offered the programs and thereby diminish their impact. In FIM studies that are focused on improving health outcomes or reducing health care utilization, careful assessment of cost effectiveness should be conducted as this will be important in informing decisions about public or private health insurance coverage. Finally, research can also help us understand how to increase uptake and engagement, and thereby full utilization of FIM programs, to maximize their potential impact on health and health care costs.

Strengths of Medical Nutrition Therapy Research

As noted previously, MNT is often part of a FIM intervention. MNT research has shown it to be a cost-effective, evidence-based intervention to manage chronic conditions, especially obesity, diabetes, and cardiovascular disease.^{20,21,22} CMS defines MNT as “nutritional diagnostic, therapy, and counseling services for the purpose of disease management, which is usually conducted by a registered dietitian (RD) or nutrition professional.” MNT services involve in-depth individualized nutrition assessment and use the Nutrition Care Process (NCP) to manage disease. This intervention is also designed to improve a patient’s nutritional knowledge of their health condition and diet behavior. Coverage for MNT varies depending on the insurance provider. For Medicare and Medicaid, MNT services are reimbursable for certain populations. Medicare Part B only covers MNT and other related services for patients diagnosed with diabetes, non-dialysis kidney disease or patients within 36 months post kidney transplant, who are referred by a physician and when services are provided by a registered dietitian (RD) who is enrolled as a Medicare provider. Medicare covers three hours of MNT the first year of treatment and up to two hours of MNT for each subsequent year. While the costs for these services are reimbursable for patients with diabetes or chronic kidney disease, MNT services are not reimbursed through Medicare for patients with pre-diabetes or other chronic conditions (e.g., hypertension, obesity, CVD, etc.). Medicaid coverage for MNT for adults and children varies from state to state and some states do not recognize RDs as approved Medicaid providers. States are required by federal law to provide “mandatory” benefits including services like inpatient and outpatient hospital services, physician services, laboratory and x-ray services, and other “optional” benefits like prescription drugs, case management, physical therapy, and occupational therapy, which can also be covered by Medicaid. However, coverage for nutritional services is not outlined specifically by Medicaid on the list of mandatory or optional benefits.

MNT is used in a variety of programs that may include FIM interventions or could be augmented with FIM interventions in various programs that counsel on diet for people with or at risk of developing diabetes or heart disease. Efforts are being made at the federal level to increase access of MNT to vulnerable populations. For the past few Congresses, legislation has been introduced to expand MNT access. The first of which was introduced in 2017. As noted previously, the administration has called for expanding coverage of MNT in Medicare.

¹⁹ Doyle J, *ibid*.

²⁰ Anderson JM. Achievable Cost Saving and Cost-Effective Thresholds for Diabetes Prevention Lifestyle Interventions in People Aged 65 Years and Older: A Single-Payer Perspective. *Journal of the Academy of Nutrition and Dietetics*. 2012;112:1747-1754.

²¹ Sikand G, et al. Clinical and cost benefits of medical nutrition therapy by registered dietitian nutritionists for management of dyslipidemia: A systematic review and meta-analysis. *Journal of Clinical Lipidology*. 2018;12:1113-1122.

²² Troyer JL, McAuley WJ and McCutcheon ME. Cost-effectiveness of medical nutrition therapy and therapeutically designed meals for older adults with cardiovascular disease. *Journal of American Dietetic Association*. 2010;110:1840-1851.

Conclusion

Chronic conditions and unhealthy diets are inextricably linked, and health disparities remain all too pervasive. FIM interventions within the health care system is a promising approach in helping patients access and consume healthy foods that could improve health outcomes for people living with chronic diseases. Important research gaps, however, continue to exist in our knowledge base on what FIM interventions would be the most effective.

The AHA's HCXF initiative is committed to helping generate the evidence and tools needed in the health sector to design and scale cost-effective FIM programs. Working with patients and partners in government, academia, health care, industry, and community-based organizations, the HCXF initiative will accelerate the rate of innovation to unlock solutions to these most complex challenges.

The AHA supports efforts to increase prioritization of nutrition and equitable access to healthy, affordable food in the health care delivery system and to connect patients with community resources that improve access to and consumption of healthy food.²³ By increasing coverage for nutrition services through health insurers like Medicare and Medicaid and expanding existing food and nutrition programs, patients can be connected with the resources they need to prevent, treat and manage chronic diseases that drive health care costs across the United States. The AHA further supports efforts to expand investments in nutrition and FIM research, and in existing programs that address food and nutrition insecurity.

About Health Care by Food™ (HCXF)

In conjunction with the White House Conference on Hunger, Nutrition, and Health in 2022, the American Heart Association and The Rockefeller Foundation launched the Health Care by Food initiative to strengthen the evidence base for FIM. Our vision is to accelerate a future in which millions of patients receive the benefit of a more holistic approach to diet and health, health care professionals and practitioners know how FIM programs can help prevent and manage disease, and payors have sufficient, objective cost-effectiveness evidence for reimbursing FIM programs. The initiative will provide the large-scale clinical evidence required to help identify, support and implement the most viable FIM strategies as a covered benefit through public and private health insurance.

Launched in Spring 2023, the HCXF initiative is made up of over 257 leading researchers across the country in diverse academic fields, including the support of dozens of experts who comprise nine volunteer task forces that are examining issues ranging from health equity and common measures for FIM, community engagement and implementation science, behavioral science, cost effectiveness, human-centered design, and evaluation of the Medicaid waivers, among other issues. Already the HCXF initiative has funded over \$8 million in 23 research grants that are testing the clinical effectiveness of different FIM interventions in diverse patient populations with diabetes, hypertension, cardiovascular disease, and high-risk pregnancy. The initiative is also funding an implementation analysis of the high and low redemption rates in the Gus Schumacher Nutrition Incentives Program (GusNIP) program through the Gretchen Swanson Center for Nutrition. Together, these grants involve researchers from more than 20 academic institutions, 27 community-based organizations, and a number of national corporations with participation throughout much of the United States. These promising short-term and smaller studies will inform larger, scalable research studies.

²³ American Heart Association. Strategies to Address Socioeconomic and Racial and Ethnic Disparities in Chronic Diseases by Incorporating Food and Nutrition Programs into the Primary Healthcare Setting. June 2022. Accessed online April 15, 2024. <https://www.heart.org/-/media/Files/About-Us/Policy-Research/Policy-Positions/Access-to-Healthy-Food/Medical-Nutrition-Therapy-Policy-Statement-2022.pdf>.

Statement for the Record
From Russ Paulsen, Chief Operating Officer, UsAgainstAlzheimer's
House Committee on Ways and Means
"Investing in a Healthier America: Chronic Disease Prevention and Treatment"

UsAgainstAlzheimer's (UsA2) thanks the House Committee on Ways and Means for holding this hearing on the vitally important topic "Investing in a Healthier America: Chronic Disease Prevention and Treatment" and appreciates the opportunity to submit this Statement for the Record.

UsA2 was founded in 2010 to disrupt and diversify the movement to end Alzheimer's, a chronic, ultimately fatal, disease. Through urgent and inclusive mobilization, UsA2 has worked to dramatically increase funding for Alzheimer's and dementia research. Our work to stop Alzheimer's now centers on prevention, early detection and diagnosis, and access to treatments for all regardless of gender, race, or ethnicity.

Alzheimer's is a Chronic Disease

Alzheimer's disease and related dementia (ADRD) is a chronic condition whose death toll is outpacing other chronic conditions such as heart disease, stroke, and cancer. ADRD is included on the Centers for Medicare & Medicaid Services' (CMS) list of chronic conditions identified in its advisory on chronic care management codes ([MLN909188 – Chronic Care Management](#), page 6):

Alzheimer's disease and related dementia • Arthritis (osteoarthritis and rheumatoid) • Asthma • Atrial fibrillation • Autism spectrum disorders • Cancer • Cardiovascular disease • Chronic Obstructive Pulmonary Disease (COPD) • Depression • Diabetes • Hypertension • Infectious diseases like HIV and AIDS.

The Risk and Prevalence of ADRD Can Be Reduced

ADRD not only requires significant management, but it is also interconnected to other chronic conditions and shares similar risk factors that if addressed could significantly reduce its prevalence by 40% or more.

Over the last decade, a growing and now undeniable body of evidence suggests that a significant percentage of dementia cases are, in fact, preventable or delayable, with the same strategies that can reduce the risk of other chronic diseases including cardiovascular disease, obesity, type 2 diabetes, chronic kidney disease, depression, and certain forms of cancer. These strategies include physical activity, proper nutrition, and sleep, and addressing other specific conditions that increase the risk of cognitive impairment including hypertension, hearing loss, and traumatic brain injury.

Because the science is now clear, the Department of Health and Human Services (HHS) in 2022 updated the National Alzheimer's Plan to Address Alzheimer's Disease to add a sixth goal: "Accelerate Action to Promote Healthy Aging and Reduce Risk Factors for Alzheimer's Disease and Related Dementias."

Achieving this goal means adopting strategies designed to combat chronic disease and promote a healthy aging agenda including interventions to encourage greater physical activity, a healthy diet, cognitive stimulation, hearing loss treatment, social engagement, and sleep hygiene. The evidence shows that the earlier

people begin these activities the better opportunity they have to reduce their risk of ADRD. It is critical that Medicare reimbursement provides adequate payment for the services and supports provided by physicians to prevent and manage chronic conditions.

Even a five-year delay in the onset of Alzheimer's disease would reduce the population with the disease by 41% in 2050, which could [reduce annual costs by \\$640 billion](#). The Risk Reduction Subcommittee of the National Alzheimer Project Act Advisory Council set a goal of [reducing dementia risk factors](#) by 15% by 2030. A 15% proportional reduction in risk factor prevalence would be associated with [approximately 427,000 fewer prevalent dementia cases](#) in the U.S. population.

Early and Accurate Detection Is Essential

Recently the Ways and Means Committee advanced an important policy in the area of prevention and risk reduction -promoting the early and accurate detection of Mild Cognitive Impairment (MCI), so patients and their medical team have as much time as possible to implement strategies to slow the progression of the disease.

We thank the Committee for passing the bicameral, bipartisan Concentrating on High-Value Alzheimer's Needs to Get to an End (CHANGE) Act (S. 2379/H.R. 4752) that strengthens dementia detection. The act directs CMS to require professionals providing the Medicare Annual Wellness Visit (AWV; 42 USC § 1395x [hhh]) and the Initial Preventive Physical Examination (also known as Welcome to Medicare Benefit, WMV; 42 USC § 1395x[ww][1]) to use cognitive impairment detection tools identified by the National Institute on Aging (NIA). The Committee included the measure in the recently marked up H.R. 8816, the American Medical Innovation and Investment Act.

CMS currently encourages, but does not require, providers to use a brief identified structured cognitive assessment tool. Consequently, many providers use "direct observation," rather than an identified tool, to assess patients' cognitive health. Direct observation is the least useful and least appropriate tool, all too often contributing to under-diagnosis, delayed diagnosis, misdiagnosis, and non-disclosure of diagnosis. Recent studies showed that among patients aged 70 years or older, seen in primary care settings, cognitive impairment goes unrecognized [in more than 50% of cases](#). Underutilization of identified assessment tools delays detection and diagnosis, resulting in decreased opportunities for people to implement important lifestyle modifications, access timely treatment options, and participate in clinical research. Use of these tools will allow clinicians to better detect MCI and other early symptoms of Alzheimer's disease and related forms of dementia.

When people receive a timely and accurate diagnosis, they have improved opportunities to make informed and productive lifestyle, medical, financial, legal, and spiritual choices to strengthen both their own quality of life and that of their family caregivers. The CHANGE Act would help providers detect Alzheimer's sooner, which is increasingly important in light of new Food and Drug Administration (FDA)-approved and Medicare-covered therapies for use in early-stage Alzheimer's disease. It is also critically timed, as Medicare prepares to launch its nationwide comprehensive dementia care model.

We urge the House to pass the CHANGE Act into law and include the bill as Congress considers larger health care packages this year.

In conclusion, as the Committee considers policies around chronic care prevention and treatment, ADRD should be included in relevant policy proposals, alongside cardiovascular disease, type 2 diabetes, hypertension, and other conditions that have more traditionally been seen as chronic conditions. For too long,

Alzheimer's and Related Dementia has gone unaddressed, and we know now there is much we can do to reduce the risk, detect it early, manage the disease, and soon (we hope) effectively cure it.



Comment

On the House Committee on Ways and Means Health Subcommittee Hearing on Investing in a Healthier America: Chronic Disease Prevention and Treatment





The American Nutrition Association hereby submits comments in response to the House Committee on Ways and Means Health Subcommittee Hearing on Investing in a Healthier America: Chronic Disease Prevention and Treatment, which took place on September 18, 2024.

A central theme emerged on how nutrition should play a prominent role in preventative medicine to address America's chronic disease epidemic and its associated cost to individuals, families, and taxpayers. There is great value in utilizing evidence-based, personalized nutrition interventions to prevent and treat chronic disease. Wrongly, current practice consists primarily of managing conditions once people have already fallen ill.

As the nation's leading nonprofit organization focused on advancing the science and practice of personalized nutrition to prevent and reverse the chronic disease epidemic, we appreciate the Committee's attention to this pressing issue. Addressing the root cause of the chronic disease epidemic is of vital importance to the health and well-being of Americans across the country.

The American Nutrition Association (ANA) is tackling the chronic disease epidemic and improving the quality of healthcare by providing high quality, evidence-based and clinically relevant nutrition education, training programs, and certifications to clinicians across the spectrum of healthcare. ANA fills the wide gaps in current medical curriculum and ongoing post-graduate training by enhancing knowledge of nutrition and promoting its application in clinical practice for the prevention and treatment of chronic disease.

American Nutrition Association

The American Nutrition Association (ANA) is the professional association for the science and practice of personalized nutrition, bringing to life our vision of a society of Healthy People, Powered by Nutrition. Building on 64 years of history, ANA advances science and data, professional education and training, and clinical guidance and therapeutics to elevate the impact of nutrition on human health and move nutrition to the core of healthcare.

The ANA champions the practice of personalized nutrition (PN). PN is rooted in the concept that one size does not fit all. According to *Toward the Definition of Personalized Nutrition: A Proposal* by the American Nutrition Association, published in the *Journal of the American Nutrition Association* in 2020, "differences in biochemistry, metabolism, genetics, and microbiota contribute to the dramatic inter-individual differences observed in response to nutrition, nutrient status, dietary patterns, timing of eating, and environmental exposures."¹

To bring our vision of Healthy People, Powered by Nutrition to life, the ANA educates and certifies health professionals in nutrition science and practice. Notably, the ANA administers the gold-



standard certifications for nutrition practitioners: the Certified Nutrition Specialist (CNS) and the Certified Personalized Nutrition Practitioner (CPNP). The ANA also educates the public in science-based, unbiased nutrition, both directly and through the professionals we train. Additionally, the ANA advocates for state and federal policy that expands public access to nutrition practitioners and insurance reimbursement.

Chronic Disease is Crippling the Health of the Nation

The United States has a massive health crisis, and it's getting worse. Poor nutrition is the leading cause of chronic disease, responsible for more deaths in the U.S. than tobacco, inactivity, or any other risk factor.ⁱⁱ It is estimated that about 60% of American adults suffer from at least one chronic health condition and 42% of Americans have multiple chronic conditions.ⁱⁱⁱ A systematic analysis for the Global Burden of Disease in 2017 found that approximately 11 million global deaths could be attributed to dietary risk factors.^{iv}

It is well established that poor nutrition is the root of the problem, while good nutrition is the root of the solution. Diets rich in plant-foods including vegetables, fruits, whole grains, legumes, and nuts are associated with lower risk of cardiometabolic diseases within adult sub-populations.^{v vi} Certain therapeutic foods, including higher consumption of green tea and coffee, have been associated with reduced all-cause mortality, with a combined effect appearing to be additive in patients with type 2 diabetes.^{vii} In fact, early intervention with nutrition and lifestyle prevents diabetes more effectively than the leading prescription drug.^{viii} Moreover, programs combining personalized data with behavior and lifestyle coaching produce sustained improvements in clinical markers related to cardiometabolic risk such as inflammatory markers, triglycerides, and hemoglobin A1C.^{ix}

While the U.S. Dietary Guidelines were introduced in 1980 to advise the public, such guidelines have failed to address rising chronic disease rates. Good nutrition is critical to good health, demonstrated by the expanding body of scientific evidence that nutritional status correlates to quality of life, especially in aging and chronic disease populations.^{x xi xii} Nutrition is indeed a powerful way to prevent, treat, and manage chronic diseases and is an extremely cost-effective intervention.^{xiii}

Despite this awareness, nutrition remains at the periphery of the healthcare system, primarily due to the woeful lack of nutrition education in our medical schools and the resulting failure to prepare medical students to use the tool of nutrition in practice.^{xiv xv} While 94% of resident physicians believe it is a doctor's obligation to discuss nutrition and patients, only 14% feel that doctors are equipped to do so.^{xvi} Medical students and residents report a profound lack of



confidence incorporating nutrition into their treatments, despite understanding its importance in health.^{xvii}

Public surveys indicate that doctors are considered trustworthy sources of nutrition and are expected to provide nutritional care during medical visits.^{xviii} In fact, patients are up to three times more likely to attempt nutrition behavior change if advised to do so by their doctor.^{xix} A 2019 microsimulation study estimated that if physicians prescribed healthy foods to their patients, \$3.28 billion worth of medical conditions could be prevented and \$100 billion in medical expenses could be averted.^{xx} This is especially encouraging, considering that nearly half of all deaths due to cardiometabolic diseases in the U.S. can be attributed to poor diet and insurance reimbursement for nutrition intervention is trivial compared to its effectiveness for chronic disease.^{xxi}

Chronic Disease is Crippling America’s Fiscal Health – Good Nutrition Saves Costs to U.S. Healthcare

Beyond the human cost of personal suffering, family burden, and reduced quality of living for those with chronic diseases, treating chronic disease accounts for 90% of the \$4.1 trillion annual U.S. healthcare costs.^{xxii} Across the United States, diabetes is estimated to cost \$327 billion annually. By 2050, combined treatment and care for Alzheimer’s disease alone is estimated to reach \$1.1 trillion,^{xxiv} a stark figure considering how obesity and blood sugar dysregulation are risk factors for development of the brain disease.^{xxv}

A 2010 National Alliance for Nutrition and Activity report aiming to quantify the benefit of healthy nutrition suggested that eating healthfully could save at least \$87 billion per year in medical costs, lost productivity, and lost lives.^{xxvi} Thus, there is a great need for a policy framework to support nutritional approaches to healthcare.

Poor nutrition reduces workforce productivity by up to 20% (either due to malnutrition or obesity), and costs U.S. employers around \$3.9 billion annually.^{xxvii} Employees who reported difficulty consuming fruits, vegetables, and low-fat foods during the workday were 93% more likely to lose productivity.^{xxviii} Iron deficiency alone was shown to reduce physical work capacity by 30%.^{xxix} Heart disease and stroke kill one third of Americans annually and these two conditions account for \$147 billion of lost on-the-job productivity.^{xxx}

In addition to reducing the economic cost of chronic disease care (mitigated through dietary interventions), numerous health-promoting foods are less expensive than unhealthy options per portion. Although good food costs about \$1.50 more per day, long-term healthcare costs are dramatically reduced when Americans eat well.^{xxxi} For example, hospital admissions for dangerously low blood sugar for food insecure individuals lead to millions of dollars in extra



healthcare costs.^{xxiii} Nutrition needs to be accessible, affordable, adoptable, and advantageous to positively impact individual and societal health.

The ANA Educates Physicians and All Healthcare Practitioners to Use Nutrition as a Foundational Tool

The ANA is tackling the chronic disease epidemic and improving the quality of healthcare by providing high quality, evidence-based and clinically relevant nutrition education, training programs, and certifications to clinicians across the spectrum of healthcare. ANA's education and trainings fill in the gaps in current medical curriculum and ongoing post-graduate training. ANA trainings are designed to enhance knowledge of nutrition and promote the application of such knowledge in clinical practice for the prevention and management of chronic disease.

The Certified Nutrition Specialist Credential – the Gold Standard for Personalized Nutritionists

The Board for Certification of Nutrition Specialists (BCNS) is the credentialing arm of the American Nutrition Association (ANA). BCNS administers the Certified Nutrition Specialist (CNS) credential. Holders of the CNS credential are highly trained, advanced nutrition care professionals who provide patient-centered medical nutrition therapy and nutrition education using evidence-based decision-making, with a special emphasis on providing personalized nutrition care from assessment through monitoring, feedback and modification as needed. CNSs incorporate patient health history, laboratory assessments, health goals, diet and available resources, and consider behavior, readiness for change, environmental influences, and nutrition diagnosis to design appropriate personalized, therapeutic nutrition.

Certified Personalized Nutrition Practitioners – The Gold Standard for Personalized Healthcare Practitioners

Congruent with our mission to bring nutrition from the periphery to the center of healthcare, the Board for Certification of Nutrition Specialists (BCNS) administers the Certified Personalized Nutrition Practitioner (CPNP) credential.

This certification prepares healthcare professionals – doctors, nurse practitioners, physician's associates and other licensed professionals – with the skills and knowledge to apply personalized nutrition strategies to their practice, educate their patients on the latest nutrition science, and optimize patient outcomes.

Integrating Evidence-Based Nutrition Strategies Into Healthcare Systems



Thank you for the opportunity to comment in response to the House Committee on Ways and Means Health Subcommittee Hearing on Investing in a Healthier America: Chronic Disease Prevention and Treatment. We appreciate the Committee's commitment to addressing America's chronic disease epidemic and emphasize the importance of integrating evidence-based nutrition strategies into healthcare systems as a part of a comprehensive preventative approach to improve outcomes for individuals and communities nationwide.

Sincerely,

A handwritten signature in black ink, appearing to read "Corinne Bush".

Corinne Bush MS, CNS
Chief Executive Officer

ⁱ Bush CL, Blumberg JB, El-Soheily A, et al. Toward the Definition of Personalized Nutrition: A Proposal by The American Nutrition Association. *J Am Coll Nutr.* 2020;39(1):5-15. doi:10.1080/07315724.2019.1685332

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Statement for the Record

House Ways and Means Committee Health Subcommittee Hearing on Investing in a Healthier America:
Chronic Disease Prevention and Treatment

September 18, 2024

On behalf of the American Osteopathic Association (AOA), and the more than 197,000 osteopathic physicians (DOs) and medical students we represent, we write to express our appreciation for the Committee's interest in improving patient access to care and making meaningful strides toward addressing the substantial impact chronic diseases have on Americans, particularly those in rural and underserved communities. This is a particularly important opportunity to provide insight on matters impacting osteopathic physicians and our patients.

Among the core principles of osteopathic medicine are providing patient-centered, coordinated care across the health care spectrum. We recognize that health care stakeholders across the United States share the responsibility of promoting reforms and policies that ensure individuals with chronic diseases have access to high-quality, continuing and comprehensive care when and where they need it. As such, the AOA unequivocally believes that the current Medicare physician payment model cannot sufficiently provide the stability physicians need to be able to deliver coordinated, longitudinal care – particularly for patients with chronic diseases.

Medicare Payment and Patient Access

Nearly 95 percent of adults aged 60 and older have at least one chronic illness or condition, and nearly 80 percent of the same cohort have two or more chronic conditions.¹ Over the next decade, the projected number of patients with at least one chronic condition is expected to double and encompass more than 142 million Americans by 2050, placing increasing strain on the U.S. healthcare system and workforce.² At the same time, the United States could see a shortage of as much as 86,000 physicians by 2036 if the current trends are not reversed.³ The current structure and unsustainable rates for physician payment is a key driver in practice closures and physician shortages, particularly in rural areas.

Physicians across the country face ongoing uncertainty regarding the payment they will receive for services rendered year after year. On January 1, 2025, a 2.8% cut to Medicare payment under the Physician Fee Schedule will go into effect; the fifth consecutive year of statutory cuts to physician payment. This cut coincides with ongoing increases in costs to practice medicine – which CMS acknowledges, as the projected increase in the Medicare Economic Index (MEI) for 2024 will be 4.6%. **Unlike nearly all other Medicare providers and suppliers, physicians do not**

¹ National Council on Aging. Chronic Inequities: Measuring Disease Cost Burden Among Older Adults in the U.S. A Health and Retirement Study Analysis. Page 5, Figure 2. April 2022. Accessed online at: <https://ncoa.org/article/the-inequities-in-the-cost-of-chronic-disease-why-it-matters-for-older-adults>.

² Anshah JP, Chiu CT. Projecting the chronic disease burden among the adult population in the United States using a multi-state population model. *Front Public Health*. 2023 Jan 13;10:1082183. doi: 10.3389/fpubh.2022.1082183. PMID: 36711415; PMCID: PMC9881650.

³ Association of American Medical Colleges: Report Reinforces Mounting Physician Shortage. March 21, 2024. Accessed online at: <https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage>



receive an annual inflationary payment update. Changing this would provide stability to independent physician practices facing unique economic challenges in rural communities. This type of reform has previously been proposed through the bipartisan *Strengthening Medicare for Patients and Providers Act* (H.R.2474), and **the AOA strongly urges the Ways and Means Committee to consider this legislation further.**

The AOA also recommends further supplementing support for rural physicians by utilizing economic levers that would make practicing in rural and underserved communities more accessible and appealing to a broader base of physicians. These levers include increasing Physician Health Professional Shortage Area incentives and/or creating new means of improving payment specifically for rural physicians. For example, in its March 2024 report, MedPAC recommended creating an add-on payment for physicians caring for low-income patients to better support physicians working with rural and underserved populations.⁴ Without predictable inflationary payment updates and additional incentives for rural and underserved areas, access to health care in these communities is likely to decline.

Furthermore, Medicare's current budget neutrality obligations within the physician payment schedule exacerbate the lack of inflationary updates. A provision within the Omnibus Budget Reconciliation Act of 1989 mandated that any adjustments to the MPFS due to upward payments or new procedures in one category that increase costs by \$20 million or more must be offset by cuts in other areas of the fee schedule. This issue is reflected in the implementation of a new and controversial care complexity add-on code (G2211). Improved payment for longitudinal, coordinated primary care is necessary for physicians, but those payment improvements should not come at the expense of payment reductions in other specialties that would limit the benefits the new code provides.

In comparing the United States with nine other high-income nations, the United States has significantly lower rates of patients reporting a longstanding relationship with a primary care physician.⁵ At the same time, evidence shows that longitudinal relationships, which are integral to both the philosophy of osteopathic medicine and delivering high-quality care, lead to better management of chronic conditions and improved patient outcomes.⁶ Investment in the physician workforce, especially in primary care, is needed to build capacity across the country. **To help alleviate building pressure on the physician workforce and subsequent access impacts upon patients, the AOA strongly urges the Committee to consider the *Resident Physician Shortage Reduction Act* (H.R.2389).** The bill would increase the number of residency positions funded by Medicare, with particular emphasis on hospitals in rural areas and Health Professional Shortage Areas (HPSAs).

Additionally, the Committee should evaluate proposals such as the bipartisan *Rural Physician Workforce Production Act* (H.R.834), which would allow certain hospitals to receive additional payments from Medicare for employing resident physicians in rural areas. This would increase the number of physicians practicing in rural communities and would provide financial support to make these residencies more accessible.

⁴ MedPAC. "March 2024 Report to Congress." April 18 2024. Accessed online at: https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch4_MedPAC_Report_To_Congress_SEC.pdf

⁵ Gumas ED et al. "Finger on the Pulse: The State of Primary Care in the U.S. and Nine Other Countries," March 28, 2024. The Commonwealth Fund. Accessed online at: <https://www.commonwealthfund.org/publications/issue-briefs/2024/mar/finger-on-pulse-primary-care-us-nine-countries>.

⁶ Jennifer Arnold, "Fostering Long-Term Doctor-Patient Relationships to Improve Outcomes," Duke Health, January 17, 2017.



Continued patient access to high quality care, particularly for chronic conditions, is contingent upon the confluence of all three factors: sustainable and predictable updates to physician payment under the Medicare Physician Fee Schedule, adjustments to the budget neutrality threshold, and investment in the physician workforce, particularly in rural and underserved communities.

Aligning Sites of Service and Medicare Payment

Differences in payment predicated upon the site of service create fundamental inequities in the care delivery landscape, and the year-over-year MIPFS cuts that will worsen on January 1, 2025, exacerbating existing site of service differences for services that are demonstrably similar. AOA supports policies that would require payments to physicians that reflect the resources required to provide patient care in each setting. These changes would also ensure that physicians delivering longitudinal care to patients with chronic conditions are not disadvantaged compared to Hospital Outpatient Departments (HOPDs) delivering urgent care for emerging issues related to chronic conditions. Not only would more equitable payment lower costs, but it would support better outcomes for patients.

The inequities, in the current payment model, allow for HOPDs to net higher payments for certain services, driving up costs to both Medicare and patients, while driving consolidation and reducing competition in the care delivery ecosystem. As the Committee considers policies that will align payments for various sites of service, it should prioritize payment models that account for costs incurred to the provider while also taking into account the nature of the patient population being served. Payment policies should also include factors such as the provision of care coordination, after-hours care, emergency care, quality-based payments, and other costs.

MedPAC recommended Congress implement site-neutral payment policies in its July 2023 [report](#), and the AOA strongly echoes that recommendation.⁷

Value and Innovation

The AOA has long advocated for payment predicated upon delivering high quality, value-based care rather than the volume-based nature of the current fee-for-service payment model. Despite that, transitions to value-based payments must account for the unique needs of different specialties, practices current capacities, and the ways physicians deliver care. It also must not create additional barriers to entry, result in reduced or inequitable payment, or increase administrative burden. To better promote high-value care and reduce burdens, the Committee should look at Advanced Alternative Payment Models (APMs) rather than the Merit-Based Incentive Payment System (MIPS) when building new policies.

Advanced APM pathways include Accountable Care Organizations (ACOs), including those under the Medicare Shared Savings Program (MSSP), and Centers for Medicare and Medicaid Innovation (CMMI) models. Many APMs are well suited for physicians helping patients manage chronic conditions, as they include added incentives for providers who take on additional risk when treating patients as they deliver high quality, coordinated, and efficient

⁷ MedPAC. "Health Care Spending and the Medicare Program: July 2023 Data Book." 2023.



care. Ultimately, in considering any shifts towards expanding existing APMs or seeking to accelerate physician participation in such models, efforts must:

- Support practices in making the necessary infrastructure investments to succeed under such models;
- Ensure sufficient flexibility in the range of models available to account for differences across specialties and the ways different physicians deliver care;
- Minimize administrative burden to enable physicians who commit to value-based models to focus on patient care; and
- Ensure adequate payment for the range of services the particular physician provides, and in the case of primary care, support the comprehensive services that advanced primary care seeks to deliver.

Ensuring that financial support is available to incentivize this transition is essential, and the AOA applauds Congress' extension of AAPM bonuses for PY2024, despite our disappointment at the reduced bonus rate. **We urge the Committee to reinstate the increased AAPM bonuses in 2025.**

When Congress passed the *Medicare Access and CHIP Reauthorization Act* (MACRA) it clearly intended to deliver an accelerated pathway for physicians to participate in APMs. The transition to value-based payment has not materialized as Congress had hoped because practices have not been paid enough to be able to reinvest to have the capacity to succeed in APMs. It is important to note that most APMs are built upon the foundation of our FFS system, and continuously declining payment rates in FFS create a vicious cycle that only makes it more challenging to transition as revenue, and funds available to make investments, declines.

Moreover, the current structure of MIPS does not effectively measure performance on meaningful outcomes or accurately predict care quality, and it is not an effective means of delivering value and penalizes small and rural practices.

Further, the Committee should consider additional funding for the Quality Payment Program's Small Practice, Underserved, and Rural Support (QPP-SURS) program. This program ensures small and rural physicians can participate in quality payment models that will improve patient outcomes and access while lowering costs. Most small and rural providers do not have access to the technical or administrative staff necessary to ensure proper participation in the MIPS, which currently disadvantages small and independent physician practices. Physicians in small and rural practices consistently receive below-average MIPS scores, demonstrating that practice size and resources are better indicators of MIPS performance than patient outcomes. Research shows that association with large hospital systems and provider networks receive better MIPS performance ratings, despite large health systems not delivering demonstrably better quality of care.⁸ Physician-owned practices deliver high-quality and cost-effective care regardless of health system affiliation, and this research demonstrates the technical and administrative disadvantage small and independent physician practices are currently facing. Ensuring physicians at small or rural practices can participate in APMs that incentivize high-quality, cost-effective care is integral to improving patient access to care for chronic conditions.

⁸ Johnston K, Wiemken T, Hockenberry J, et al. Association of Clinician Health System Affiliation with Outpatient Performance Ratings in the Medicare Merit-based Incentive Payment System. *JAMA Netw Open.* 2020;3(10):e200992



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Value-based payment is an important tool that can be used to enhance access to primary care, particularly for patients with chronic conditions. The AOA applauds the Committee's interest in taking steps to ensure physician payment reform drives patients access to high quality, affordable, coordinated care, and we look forward to working with the committee further.

Conclusion

Again, thank you for the opportunity to submit comments for the record. The Committee's work on these important issues will support the stability of both the physician workforce and patient access to affordable, high-quality care. The AOA and our members stand ready to assist the Committee at large as you consider new policies and legislation to improve patient access to care and minimize red tape for doctors. If you have any questions or if the AOA can be a resource, please contact AOA Vice President of Federal Affairs and Public Policy, John-Michael Villarama, MA, at jvillarama@osteopathic.org, or (202) 349-8748.

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October 2, 2024

The Honorable Vern Buchanan
Chair
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20010

The Honorable Lloyd Doggett
Ranking Member
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20010

Dear Chair Buchanan and Ranking Member Doggett,

Thank you for the opportunity to submit for the record this statement on the importance of addressing chronic disease. ASTHO is the national nonprofit organization representing the public health agencies of the 50 states, five U.S. territories, three freely associated states, and Washington, D.C. ASTHO members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy and to ensuring excellence in public health practice. ASTHO's members remain concerned about the impact of chronic disease on quality of life, the disproportionate share of disease burden on marginalized communities, and costs borne by individuals, families, and health systems.

Chronic diseases, including heart disease, cancer, and diabetes are leading causes of death and disability in the United States.¹ More than two in five (42% of) Americans have at least two chronic conditions, and over 90% of our nation's \$4.1 trillion healthcare expenditures go toward managing or treating chronic disease and mental health conditions.² Further, of 17-24 year olds who comprise 90% of military applicants, one in three is ineligible to serve due to their weight.³ Chronic disease has disproportionate impacts across demographics because, for example, people who live in rural areas are more likely to die from chronic disease than those in urban areas.⁴ Among patients with chronic conditions, those whose social determinants of health (SDOH) include insecure access to food, housing, and other resources experience poorer health outcomes.⁵

Public health programs addressing chronic diseases are crucial components of the U.S. healthcare system. By emphasizing prevention, early detection, and disease management, CDC's evidence-based public health programs can significantly reduce healthcare costs and keep our nation safe and secure from global and domestic public health threats. As the burden of chronic diseases continues to escalate, investing in public health initiatives is increasingly critical for Americans' physical and mental health, and the financial sustainability of the nation's healthcare system. We urge the committee to support

¹ CDC National Center for Health Statistics: Leading Causes of Death

² Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area

³ CDC Physical Activity - Unfit to Serve

⁴ Preventing Chronic Diseases and Promoting Health in Rural Communities

⁵ The Relationship Between Social Determinants of Health and Functional Capacity in Adult Primary Care Patients With Multiple Chronic Conditions

programs that mitigate risk factors of known drivers of chronic disease, including tobacco use, lack of access to healthcare, nutritious foods, and other critical determinants of health.

In partnership with state health departments, CDC is instrumental in reducing chronic disease rates in communities nationwide. They focus on community-specific efforts to prevent, treat, and reduce chronic disease and address SDOH. Among CDC's efforts are the [National Tobacco Control Program](#), [Healthy Tribes](#), and [SDOH Accelerator Plans](#). CDC also awards the [Preventive Health and Health Services Block Grant](#) across all 50 states, Washington, D.C., two American Indian tribes, five territories, and three freely associated states. This grant allows health departments to use funding where it is needed most in their communities, including programs that reduce chronic disease risks such as smoking, poor nutrition, and lack of physical activity.

Preventing, treating, and more broadly reducing disease burden remain priorities for ASTHO's members. ASTHO's priorities and recommendations for chronic disease prevention are outlined in our [policy statements](#), including our [Commercial Tobacco and Nicotine Use Prevention Policy Statement](#) and [Preventing and Reducing Obesity in the United States and U.S. Territories Policy Statement](#). Our members oversee programs that help mitigate chronic health conditions. For example, the Florida Department of Health collaborates with the Department of Elder Affairs to implement the [Senior Connection Center](#) program, which provides resources on chronic disease prevention and mental health services for older adults. The Texas Department of State Health Services has several programs such as the [Heart Disease and Stroke Prevention](#) program that focus on reducing risk factors for heart disease and stroke such as high blood pressure, cholesterol, diabetes and tobacco use by promoting clinical interventions and community-based efforts to increase physical activity and improve dietary habits.

We appreciate the committee's dedication to this important issue and urge you to support legislation that helps prevent, treat, and reverse chronic conditions. We look forward to working with the committee to develop solutions that lift the burden of chronic disease and better the long-term health of all Americans. If you have any questions or require additional information, please contact Catherine Murphy, ASTHO's Government Affairs Analyst (cmurphy@astho.org).

Sincerely,



Joseph M. Kanter, MD, MPH

Chief Executive Officer, Association of State and Territorial Health Officials

Chronic Disease Prevention 2024 Update: Essential to our Health and Future

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Mini Review

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Abstract

To the great frustration of public health practitioners and healthcare providers alike, preventable chronic conditions and risk factors continue to be present and, in some cases, grow in influencing our collective health and wellbeing. Despite some reduction in demand on health systems with a lessening of the Covid-19 pandemic, we continue to read of long waits for appointments for primary and specialty care, and our definitions of "Urgent" and "Emergency" bear scrutiny. Workforce shortages remain an issue across jurisdictions and other functional challenges remain including ambulance diversion and delays on entry to emergency rooms, closing floors while demand for beds increases, shortages of supplies and medications, and continued presence of risk factors (i.e. tobacco and related products, unhealthy foods, community challenges to regular physical activity). These are important, but an incomplete picture without addressing the proven opportunities for prevention of chronic conditions and risk factors that lead to these troubling phenomena. When we consider what could be gained by preventing many cases of overweight and obesity, reducing stress on our bodies through better diet and more activity, better outcomes through earlier screening for common cancers and other public health strategies, we see clearly that investing in these efforts on a national basis must be part of the solution. Further, these challenges must be addressed in a way the levels the playing field so people now subject to disparate conditions have equitable access comparable to all.

Keywords: Chronic Disease; Covid-19; Obesity; Heart Disease; Cancer

Abbreviations: CDC: National Center for Chronic Disease Prevention and Health Promotion; WHO: World Health Organization; USDA: United States Department of Agriculture; NTCP: National Tobacco Control Program; DPP: Diabetes Prevention Program; IARC: International Agency for Research on Cancer.

Introduction

We live in a time when our knowledge and our actions don't always match up. In this case, the knowledge of the value of preventing disease and disability far surpasses our investment in public education, provider incentives,

and public health infrastructure that could support putting that knowledge into practice. Today's disturbing news about our healthcare system includes waits of months for an initial appointment with a specialist for newly diagnosed heart disease, diabetes, potential cancers, dementias, mental health issues and other chronic conditions. They also terrifyingly include waits in hospital parking lots for emergency ambulance patients, sometimes for hours [1]. These are system issues that must be addressed, but we would be sorely misled if that was all we corrected. The analogy that comes to mind is wiping up around an overflowing sink while the faucet runs full force. This is absolutely the time to revisit the issue of improving our health generally through better lifestyle choices and enhancing efforts for prevention of chronic conditions that all too often turn critical. If we make these changes, we won't eliminate the issues we mentioned, but we can reduce the impact they have on our lives and health in both the short and long term. Having access to clear, accurate information consistently is part of the answer that we've addressed previously in these pages [2]. We will revisit and review some of these critical areas and how they impact our decision making and health systems.

We hear much discussion about healthcare coverage and costs associated with workforce shortages, insurance, pharmaceuticals, surgical interventions, and related issues [1]. All of these are important but leave out perhaps the most important topic - prevention. There is a growing desperate need to understand this comparison and public health chronic disease prevention programs are in place and ripe for expansion to be sure these messages are understood [3].

Facts Matter

The urgency of addressing chronic disease can't be stressed enough - these conditions account for over 86% of our healthcare costs, and much of this is preventable [4]. If we invest at levels that make a difference, we could spend \$240 now on prevention instead of \$1,000 in the future on reactive healthcare costs for chronic diseases. Healthcare costs are only the tip of the iceberg. Absenteeism (time taken off work due to illness or other reasons) and presenteeism (attending work despite an illness that prevents full functioning) in school and at work take a significant toll on family life, the ability to plan for the future, and our global economic competitiveness [5].

Almost every American family is adversely affected by chronic diseases in one way or another through the premature death of a loved one or due to family members with lifelong illness, disability, or compromised quality of life. These burdens affect society on both the personal and community level, not just in the physical disease, but also in the financial burden that comes with the cost of chronic disease [5].

At a time when our investments in housing, education, and medical care have outstripped inflation, our investment in prevention has lagged far behind. Today in the U.S., we fund prevention efforts at approximately the same amount we did in 2001, effectively a funding cut of 42% when inflation is considered. To summarize and focus:

- As of 2014, 1 in 4 has obesity and 60% of American adults had at least one chronic condition, and 42% had more than one chronic condition [6].
- Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. Seven in 10 leading causes of death in 2017 were due to chronic diseases, totaling about 1.75 million American deaths [7,8].

Chronic Disease Prevention

- More than 86% of the nation's healthcare costs relate to chronic diseases, and most of those costs are preventable [9,10].
- The projected prevalence of any cardiovascular disease in the United States will increase to over 45% by the year 2035 [11].
- Risk factors such as poor diet, lack of activity, alcohol and drug abuse, and ignoring medical advice all contribute disproportionately to this crisis [12].
- 27% of young adults are too overweight to serve in the military. Many others lack necessary fitness to meet requirements [13].
- According to the CDC, 90% of the nation's \$3.8 trillion per year healthcare costs can be attributed to people with chronic diseases and mental health conditions [1].
- A recent Partnership to Fight Chronic Disease publication determined that treatment of the seven most common chronic diseases, coupled with productivity losses, will cost the U.S. economy \$2 trillion dollars annually - \$8,600 per person - by 2030. The same analysis estimates that reductions in unhealthy behaviors could save 1,100,000 lives per year.
- In terms of public insurance, treatment of chronic disease constitutes a significant proportion of spending and improving prevention would result in significant cost savings. Preventing child obesity is a critical step for the nation and there are cost-effective interventions in child care, schools and community. For example, improving physical activity in child care costs only \$4.60 per child per year and would avert over 74,000 cases of childhood obesity including among children on Medicaid and CHIP. In addition, increasing the colorectal cancer screening rate to 70% could reduce Medicare spending by \$14 billion in 2050 [3].

It is long past time for us to face reality - if we don't invest in prevention now many of us will die sooner, after

living lives with serious chronic conditions that dramatically alter lifestyle choices. We have created a culture where the healthy choice often is the hardest choice at every stage of our lives. We know we need to eat better, be more active, and avoid tobacco - but we're cutting back on recess and physical education, cutting back on the ability to be active in our everyday lives, and tobacco is still widely available, especially to children [14-32].

The CDC estimates that modifying three risk factors - poor diet, lack of physical activity, and smoking - can prevent 80% of heart disease and stroke, 80% of type-2 diabetes, and 40% of cancer. Good, healthy food options are more available today - but not everywhere - and not for everyone. If we are serious about improving the lives of Americans, having an impact on healthcare costs, reforming our system, and reducing disparities, we need to invest in a meaningful way in prevention [19-23].

Investing in Chronic Disease Prevention Today

In the current environment only a fraction of 1% of federal healthcare investment goes to prevention - this amounts to policy malpractice, we know better. Even with this limited funding, states are implementing diverse, cost-effective strategies that work for: early detection of some cancers, prevention and control of diabetes, reduction of heart disease and stroke, reduction of the disability associated with all these conditions, and arthritis as well (chronicdisease.org), and in recent years the Healthy Brain Initiative to reduce dementia risk and health risks of caregivers. To continue and expand this work, there needs to be a substantial investment in CDC's National Center for Chronic Disease Prevention and Health Promotion and through this vehicle state health agencies and then on to local organizations. State Chronic Disease Directors and the State Health Agencies where they work have a unique role in coordinating activity and steering resources to communities most in need and in creating linkages across systems with healthcare providers, insurers, educators, community organizations, and others.

Good, healthy food options are more available today - but not everywhere - and not for everyone. If we are serious about improving the lives of Americans, having an impact on healthcare costs, reforming our system, and reducing disparities, we need to invest in a meaningful way in prevention.

Safe places to get physical activity in our daily lives are more available, but not everywhere, and not for everyone. Knowledge of the dangers of tobacco and unhealthy food and beverages is more readily available - but not equally. This is a trend we can reverse!

Social Determinants of Health, Health Equity and Justice

The World Health Organization's (WHO) Commission on Social Determinants of Health cites a growing body of evidence that the conditions, circumstances, and situations in which people live have a greater influence on health than health care or lifestyle choices. The social determinants of health are key factors in understanding and addressing disparities in chronic disease outcomes. These determinants encompass a wide range of conditions and circumstances in which people are born, grow, live, work, and age, and they significantly impact health risks and outcomes. Examples include access to quality education, stable housing, employment opportunities, healthcare access, and exposure to environmental hazards. By recognizing and addressing these social determinants, we can work towards creating a more equitable society where all individuals can lead healthy lives and have access to health promoting resources. Initiatives that focus on improving these social determinants, such as affordable housing programs, educational reform, and employment opportunities, play a critical role in reducing health inequities. For instance, if individuals do not have convenient access to grocery stores offering nutritious food, lack a safe place to exercise, and/or have limited access to safe housing, they are more likely to experience poor dietary habits, which can increase the likelihood of developing health issues like heart disease, diabetes, and obesity. To effectively assist an individual with diabetes without stable housing or an obese child with limited access to healthy food, healthcare providers must expand their focus beyond traditional medical interventions and collaborate with social services organizations to address housing and nutritional needs which can promote or prevent positive health outcomes. Ultimately, facilitating connections with non-healthcare service providers is crucial to addressing the social factors that influence well-being. Enhanced partnerships between health systems, social service providers and historically non-traditional partners are crucial to improving health outcomes in the United States.

Justice and public health are closely intertwined. Racism and discrimination contribute to inequities in healthcare access, safe affordable housing, transportation barriers, educational outcomes, and access to fresh fruits and vegetables, leading to detrimental effects on communities experiencing the greatest need. The damage caused by systemic biases and discrimination has resulted in unequal health outcomes and limited access to resources, early mortality, and higher costs. Overcoming these burdens requires a multi-faceted approach, including policies that address social determinants of health, support for underserved and disinvested communities, and programs aimed at reducing disparities in health, wealth, and

opportunities. By promoting health equity and addressing the root causes of discrimination, we can work towards a more just and inclusive healthcare system for all [33,34].

Why Chronic Disease Prevention?

Many routinely miss or ignore their body's warnings about the onset of a serious chronic disease and or live in neighborhoods where they lack affordable healthy food options or safe places for physical activity and are unable to receive preventive care due to social or economic barriers. In addition, 12.8 percent (17.0 million households) were food insecure in 2022; food-insecure households (those with low and very low food security) as defined by USDA, had difficulty at some time during the year providing enough food for all their members because of a lack of resources or are unable to receive preventive care due to social or economic barriers [9]. The result is poor collective health quality in the country that spends much more on healthcare than anywhere else. We also know there are strategies and interventions that can make a difference.

The following are some key data points and examples:

Obesity

- Adults with obesity have higher risk for developing heart disease, type-2 diabetes, and some types of cancer.
- Children with obesity are more likely to have obesity as adults.
- Obesity costs the US healthcare system nearly \$173 billion a year.
- Numerous evidence-based, cost-effective strategies are available to help prevent obesity [10].
- Hospitals can implement policies and activities that promote continuity of care for those who breastfeed.
- State licensing regulations can support healthy eating and physical activity in Early Care and Education programming.
- Communities can increase equitable and inclusive access to physical activity for everyone across sectors and settings.
- Food systems change can make healthy food available and affordable in food retail and food service settings to enable people to make healthier food choices.

Tobacco Health and Economic Burden

- Cigarette smoking is the leading cause of preventable disease, disability, and death in the United States.
- More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.
- Smoking-related illness costs the United States more

than \$600 billion in 2018, including more than \$240 billion in health care spending and nearly \$372 billion in lost productivity.

- In 2021, 11.5% of U.S. adults (an estimated 28.3 million people) currently smoked cigarettes [24-32].

Youth Tobacco Use

- Youth use of tobacco products in any form is unsafe.
- In 2023, in 2023, more than 6 of every 100 middle school students (6.6%) and about 1 of every 8 high school students (12.6%) reported current use of a tobacco product.

National Tobacco Control Program

- CDC's National Tobacco Control Program (NTCP) is the only nationwide investment that supports all 50 states, the District of Columbia, 8 U.S. territories, and 26 tribal organizations for comprehensive tobacco control efforts and quitlines.
- States that have made larger investments in comprehensive tobacco control programs have seen larger and faster declines in cigarette smoking among adults and young people.
- For every \$1 spent on strong tobacco control programs, states achieve a \$55 return on investment, mostly in averted health care costs to treat smoking related illness.

Tips from Former Smokers®

- From 2012 - 2018, the Tips From Former Smokers Campaign®(Tips®) motivated more than 16 million US adults to make a quit attempt and 1 million US adults to quit smoking for good.
- For every \$3,800 spent on the Tips campaign between 2012 - 2018, we prevented an early death. A cost-effectiveness study on the topic factored in smoking relapse, inflation, and advertising and evaluation costs [4].

Diabetes

- Healthcare costs for a person with diabetes are 2.3 times higher when compared to someone without the disease.
- Total costs of diagnosed diabetes in the United States equaled \$327 billion in 2017. This includes \$237 billion in direct medical costs and \$90 billion in lost economic productivity.
- With a focus on pre-diabetes and risk factors, the Diabetes Prevention Program (DPP) provides education for improved diabetes management and has been proven to improve well-being and reduce costs. State Public Health Diabetes Prevention and Control Programs are

essential elements in implementing and disseminating these strategies [5,7,8].

Heart Disease and Stroke

- Almost half of all American adults have high blood pressure.
- Cardiovascular disease is responsible for one in three deaths - 859,000 people - in the United States.
- Heart disease and stroke are responsible for \$216 billion in healthcare system costs and \$147 billion in lost job productivity.
- State Public Health Heart Disease and Stroke Prevention Programs provide a critical link between population-based efforts to reduce risk, community prevention efforts, and clinical care [7-9].

Cancer

Colon cancer stage 4 treatment is three times more expensive than stage 1 treatment costs [7].

Public health early detection programs for breast and cervical cancer have been responsible for identifying thousands of cancers in the early stages when treatment is more effective and less expensive. State Public Health Breast and Cervical Cancer Screening and Education efforts have been proven to increase screening rates for at-risk populations and often the entire population. The program has increased breast and cervical cancer screening by serving more than five million women with a focus on the medically underserved especially Black, Hispanic, and American Indian communities [8].

New estimates from WHO and the International Agency for Research on Cancer (IARC) show there were an estimated 20 million new cancer cases and 9.7 million deaths in 2022. The estimated number of people who were alive within 5 years following a cancer diagnosis was 53.5 million. About 1 in 5 people develop cancer in their lifetime, approximately 1 in 9 men and 1 in 12 women die from the disease, according to the latest estimates [35].

Alzheimer's Disease

- Early detection, planning, and comprehensive caregiver support have been shown to delay institutional placement for people with Alzheimer's disease by 1.5 years - while maintaining dignity, safety, and caregiver well-being [9,11,19-21].
- The cost differential for families and home and community-based care systems vs. nursing home placement varies from state to state - but is substantial everywhere.
- The Lancet Commission, echoed by the U.S. National Plan, now points out that up to 40% of the risk for Alzheimer's and other dementias are preventable or can be delayed.

We need to make this common knowledge [10].

- The National Action Plan to Address Alzheimer's Disease and accompanying recommendations call for a state-led agency to assure coordination of evidence-based high-quality services for people with dementia and their caregivers. This is consistent with the National Association of Chronic Disease Directors' Healthy Aging Council recommendations. There are clear examples of strategies that improve quality of life and reduce system costs. Resources should back up the proposal for state coordination of these efforts to implement and disseminate proven strategies.

Multiple Chronic Conditions [11,36]

Those with MCC have worse health, use more health services, and spend more on healthcare. These trends have been troublingly stable since 2008. Individuals with MCC have greater difficulties with activities of daily life and other functions that are important for maintaining independence.

Public Health Chronic Disease Prevention and Control Programs save Lives and Money

States effectively maximize federal investments and ensure the most efficient mobilization of local organizations, while at the same time avoiding duplication. The minimal investment in chronic disease prevention and control through CDC, CDC supported state and community-based programs and states, individually has resulted in developing an extensive portfolio of strategies that work. These programs are not scalable across the nation with current financial resources. This is the largest barrier we are facing with regard to preventing and controlling expensive chronic diseases. The federal investment needs to be at a meaningful level such that every state and territory has a cadre of evidence-based programs to fight chronic disease including:

- Healthy Nutrition, Increasing Physical Activity and Obesity Prevention
- Early Detection of Cancers and Cancer Survivorship Services
- Diabetes Prevention and Control (including prevention of related kidney disease)
- Heart Disease and Stroke Prevention
- Healthy Community Programs (REACH, others)
- Tobacco Prevention and Control
- Alzheimer's Disease Program (Healthy Brain Initiative -including dementia risk reduction)
- Arthritis Prevention and Control
- School Health and Oral Health Programs

America is on the precipice of great challenges and great opportunities; we need to invest in a meaningful way in prevention now, before it is too late, and we become too ill

to invest. The place to start is at CDC, with the state-based programs mentioned above. An additional investment is needed this year with an eye toward an additional \$1.5 billion in the coming year that would allow the programs listed above to have a presence in every state and for states to support activity in many communities. Primary examples include fully funding the Healthy Nutrition, Increasing Physical Activity and Obesity Prevention Programs - currently partially funded in only 17 states. Given what we know about the impact of these risk factors, these programs should have initiatives in communities across the nation. Expansion of other key programs to reach the entire nation should follow closely behind. Trust for America's Health estimates that an investment of \$10 per person per year in community-based programs tackling physical inactivity, poor nutrition, and smoking could yield more than \$16 billion in medical cost savings annually within five years. These savings represent a remarkable return of \$5.60 for every dollar spent, without considering the additional gains in worker productivity, reduced absenteeism at work and school, and enhanced quality of life [22,23]. Troublingly we see today that Appropriators in the House of Representatives are calling for elimination of funding for Tobacco Control initiatives. This would result in programs stopping at CDC and across the country. As you can see, the long-term health and financial cost of this poorly advised change isn't sustainable [37].

The Lens of Bioethics

When we look at this from the perspective of bioethics, focused on "doing the right thing", it is crystal clear that when we're addressing the multiple related crisis in healthcare, we must invest in the prevention of chronic conditions in every jurisdiction. This reflects all the principles of bioethics through respecting a person's right to be fully informed when exercising autonomy, furthering the intent to do good called for by beneficence, avoids untold harm, and increases fairness and just use of resources. This is required for all the practical reasons mentioned above, also, and maybe most importantly because it is the right thing to do.

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Congressman Buchanan,

First, I would like to thank you for your efforts on working to make American healthier. I am a military spouse and mother of three kids in the Florida public school system. I care deeply about the foods my children are exposed to particularly ultra-processed foods and foods high in added sugar. I have seen the data on how these foods are linked to ADHD and anxiety in children. I have grown concerned over the breakfast and lunch foods provided to children in school. They are given options such as donuts, flavored milk high in added sugar (24grams added), Pop Tarts, lunches high in saturated fat, etc. Kids are undereducated in nutrition and being asked to make adult decisions on what they are choosing to eat. Any kid will choose a donut over fruit when given the option, especially when parents are not around. Then they also see these adults in the school being okay with giving them these sugary treats as breakfast. This is not giving them the nutrition they need to be at their best to learn in their classes. How do you plan on changing the guidelines so kids at school are both given healthy foods and nutrition education that are in line with science rather than looking out for the meat and dairy industry?

Thank you,

Amanda Diamond, Current MPA Student



October 2, 2024

The Honorable Vern Buchanan
Chairman
Subcommittee on Health
1135 Longworth House Office Building
Washington, D.C. 20510

The Honorable Lloyd Doggett
Ranking Member
Subcommittee on Health
1135 Longworth House Office Building
Washington, D.C. 20510

Statement for the Record
Investing in a Healthier America: Chronic Disease Prevention and Treatment

Dear Chairman Buchanan and Ranking Member Doggett,

Thank you for the opportunity to provide comments for the record of your September 18, 2024, hearing, *Investing in a Healthier America: Chronic Disease Prevention and Treatment* on behalf of [the Food is Medicine Coalition \(FIMC\)](#). The Food is Medicine Coalition (FIMC) is the national coalition of nonprofit organizations that provide medically tailored meals (MTMs) and groceries (MTGs), medical nutrition therapy and nutrition counseling and education to people in communities across the country living with severe, complex, and chronic illnesses. FIMC agencies created the medically tailored meal model as a response to community need nearly 40 years ago and maintain the nutrition standards for the intervention. As we work in conjunction with you and other members of the Subcommittee to promote policies that address the connection between diet-related diseases and the food we eat, we would like to express our deep appreciation of the Subcommittee's bipartisan work to explore the proven ideas that already exist to lower rates of chronic disease, including medically tailored meals, medically tailored groceries, produce prescriptions, and other Food Is Medicine solutions. We look forward to building upon bipartisan and bicameral support for Food Is Medicine initiatives and urge you to work with colleagues to advance H.R. 8816, the American Medical and Innovation Act when Congress returns in November. This comprehensive bill includes an updated version of H.R. 6780. [H.R. 6780, the Medically Tailored Home-Delivered Demonstration Pilot Act](#), which was introduced by Representatives McGovern, Malliotakis, Evans, Fitzpatrick and Pingree, also has a companion Senate bill that has bipartisan support - [S2133](#).

The Medically Tailored Meal Demonstration Pilot

Poor diets remain one of the leading risk factors for death and disability in America, and the lack of nutritious foods in our diets cause [more health harms](#) than alcohol, tobacco, opioids, air pollution, and physical inactivity. Congress has an opportunity to implement solutions now that will immediately help the nation bend the health care cost curve and improve health care outcomes. We urge you to take the next step in this effort by working to pass H.R. 8816, which expands access to healthy and delicious home-delivered medically tailored meals for older Americans living with illness. By piloting coverage of medically tailored meals in Original Medicare - where there is currently no access - and increasing access to this important healthcare intervention, the members of the Health Subcommittee can ensure that individuals with chronic health conditions like congestive heart failure, diabetes, or COPD - who are too sick to shop or cook for themselves - can access at least two MTMs per day. Participants in MTM pilot programs funded by H.R. 8816 also would also receive personalized nutrition services from a Registered Dietitian Nutritionist (RDN).

The Evidence

We are pleased to see the Subcommittee's continued focus on the need to address diet-related diseases and how food can act as medicine, in helping Americans flourish and also in avoiding being admitted to costly health care setting like the emergency department. A [plethora of research](#) demonstrates the value of this evidence-based health care intervention and major benefits for MTM recipients: (1) improved quality of life; (2) improved mental health; (3) better diabetes management; (4) healthier eating habits; and (5) improved medication adherence, alongside robust cost savings. In fact, if everyone eligible to receive an MTM in America could benefit from this impactful health intervention today, our healthcare system would save [\\$14 billion and prevent 1.6 million hospitalizations](#) in just the first year of access.

Creating a More Equitable and Efficient Healthcare System

Establishing MTM pilot programs in urban, rural, and frontier communities across the country will allow the Centers for Medicare and Medicaid Services (CMS) to gather robust data that will help to quantify how medically tailored meals benefit diverse populations and to build the most effective access for Medicare enrollees. This data to be collected by CMS if H.R.8816 is signed into law includes: the number of inpatient admissions at hospitals and skilled nursing facilities (SNFs), Medicare expenditures, costs to run pilots, food costs, improvements in participants' health outcomes, increases in patient satisfaction, and savings attributed to the pilots. This 5-year pilot, which is similar to [FIMC's MTM Model](#) and nutrition standards, is cost efficient and budget neutral. To help improve participant's health outcomes and reduce the cost of this health care intervention that also provides nutrition education and counseling and medical nutrition therapy, H.R. 8816 permits participating hospitals to receive revenue for each enrollee in the MTM pilot, replacing the per-patient discharge payment from CMS.

Ensuring Excellence for Food Is Medicine

Alongside this groundbreaking legislation, FIMC has created a [first-in-the-nation accreditation standard](#) for medically tailored meals: The FIMC MTM Accreditation Criteria and Requirements (FIMC MTM ACR). FIMC agencies are known for the impressive outcomes our nutrition programs produce. We know these results are only possible with nutritious food, community connection and a client-centered approach – all of which the FIMC MTM ACR codifies and offers to the field as a guidebook for meeting community needs. The standard comes at a meaningful moment in the food is medicine movement, and we offer the standard as a guide in your efforts to qualify and quantify the MTM intervention as it becomes further embedded into the healthcare system in coming years.

On behalf of the agencies of the Food Is Medicine Coalition, we look forward to working with members of the Subcommittee to advance this evidence-based food is medicine solution that meets the medical and nutritional needs of recipients. We know the power and promise of food is medicine interventions, and hope that your most recent hearing sets a strong foundation for advancing food is medicine solutions. As previously offered, members of the Food Is Medicine Coalition are gladly willing to serve as experts that can speak to the real-world value of using MTMs to help vulnerable populations lead healthier lives, reduce avoidable healthcare costs, and improve the experience of care. Should you have any additional questions, please do not hesitate to reach out to me at info@fimcoalition.org.

Sincerely,



Alissa Wassung
Executive Director
Food Is Medicine Coalition



October 2, 2024

Chairman Jason Smith
House Committee on Ways and Means
1139 Longworth HOB
Washington D.C. 20515

Chairman Vern Buchanan
House Ways and Means Health Subcommittee
1139 Longworth HOB
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Ranking Member Richard Neal
House Committee on Ways and Means
1129 Longworth House Office Building
Washington D.C. 20515

Ranking Member Lloyd Doggett
House Ways and Means Health Subcommittee
1129 Longworth House Office Building
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Representative Smith, Buchanan, Neal, and Doggett,

On behalf of the National Association of Chronic Disease Directors, thank you for the opportunity to submit written testimony for the Health Subcommittee's recent hearing on "Investing in a Healthier America: Chronic Disease Prevention and Treatment." As a national non-profit representing over 7,000 chronic disease specialists in every state and territory, NACDD believes that the most effective way to address chronic diseases is through a comprehensive approach. This approach utilizes healthcare and public health to implement and support the full spectrum of prevention activities that prevent chronic diseases and promote health. By significantly reducing healthcare costs and improving quality of life, this comprehensive approach is crucial in the fight against chronic diseases.

NACDD's core membership comprises the 59 State and Territorial Chronic Disease Directors (CDDs) and their staff, who protect the public's health through primary prevention (efforts to avoid the onset or development of chronic disease) and secondary prevention (efforts to ensure early detection of chronic disease) and work on addressing "upstream" root causes of chronic conditions. In addition, NACDD unites chronic disease professionals across the United States working in state, tribal, and territorial health departments, nonprofits, academia, and private industry to promote health, reduce the burden of chronic disease, and ensure broad and equitable access to programs and services that promote health.

States have long been pivotal in preventing and detecting chronic diseases through evidence-based programs and policies. CDDs have a unique role in coordinating activity, steering resources to communities most in need, and creating linkages across systems with healthcare providers, insurers, educators, community organizations, and others. State chronic disease programs facilitate partnerships with community-based organizations, local health departments, primary care physician groups, and federally qualified health centers. State public health agencies have an integral role in supporting the evidence, coordinating programs across state governments, educating providers and the public, and employing a population-based approach that will complement individual behavior changes. They also communicate with vulnerable populations and integrate chronic disease messaging and resources to address nutrition, physical activity, tobacco use, and other underlying risk factors for chronic disease.

Impact of Chronic Disease on American's Health

Nearly 60% of adult Americans have at least one chronic disease. Chronic conditions like diabetes, cancer, and cardiovascular disease are some of the leading causes of death in the United States. More than two-thirds of all deaths are caused by one or more of five chronic diseases: heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes. A growing number of people are living with more than one chronic disease, including 42% who have two or more and 12% who have more than five. Preventable chronic diseases like heart disease, diabetes, and some cancers continue to represent a significant health burden in the United States. Seven out of the ten leading causes of death in this country are caused by chronic diseases. In 2020, COVID-19 was the third leading cause of death in the United States, but heart disease and cancer caused almost four times as many deaths in the same year. These chronic conditions require ongoing medical attention, limit activities of daily living, and cost our healthcare system approximately \$4.1 trillion annually.

Poor health and growing rates of chronic disease also endanger our nation's military readiness. Only 2 in 5 young adults are weight-eligible and physically prepared for military basic training. In 2018, 71% of young people in the United States would be unable to join the military if they wanted to. The Department of Defense spends \$1.5 billion annually on obesity-related healthcare costs. This includes costs for current and former service members and families and the cost of phy replacing unfit personnel. Keeping our population physically able to join the military and physically fit enough to serve once enlisted is critical to our national defense, emergency response, and national security.

Economic Case for Preventing Chronic Disease

Chronic diseases not only affect Americans' health and quality of life but are also a primary driver of rapidly increasing healthcare costs. According to the Centers for Disease Control and Prevention (CDC), 90% of the nation's \$4.3 trillion per year healthcare costs can be attributed to people with chronic diseases and mental health conditions.¹ A recent Partnership to Fight Chronic Disease publication determined that the treatment and management of the seven most common chronic diseases and associated productivity losses will cost the U.S. economy \$2 trillion annually—\$8,600 per person—by 2030.²

Chronic diseases also impact the affordability of private healthcare coverage. Since 2000, health insurance premiums for employer-sponsored family coverage have increased by 87%. Healthcare costs for people with a chronic condition average \$6,032 annually—five times higher than those without such a condition.³ In terms of public insurance, treating chronic diseases constitutes a significant proportion of spending, and improving prevention would result in significant cost savings. For example, increasing the colorectal cancer screening rate to 70% could reduce Medicare spending by \$14 billion in 2050.⁴

The data also show how specific chronic diseases impact healthcare costs and the entire economy. These include:

¹ [Fast Facts: Health and Economic Costs of Chronic Conditions | Chronic Disease | CDC](#)

² [PFCD US FactSheet FINAL1 \(fightchronicdisease.org\)](#)

³ [Growing Crisis of Chronic Disease in the US factsheet 81009.pdf \(fightchronicdisease.org\)](#)

⁴ [Health and Economic Benefits of Colorectal Cancer Interventions | National Center for Chronic Disease Prevention and Health Promotion \(NCCDPHP\) | CDC](#)

Alzheimer's

In 2020, an estimated 5.8 million Americans aged 65 years or older had Alzheimer's disease. This number is projected to increase to about 14 million people by 2060. According to the CDC, Alzheimer's disease is the seventh leading cause of death in the United States. It is the fifth leading cause of death for those aged 65 and older. In 2010, the costs of treating Alzheimer's disease in the US were projected at between \$159 billion and \$215 billion. By 2040, these costs are projected to jump to between \$379 billion and over \$500 billion annually.

Arthritis

About 1 in 4 U.S. adults (58.5 million people) have arthritis. By 2040, that number is expected to rise to over 78 million. Nearly two-thirds of people with arthritis are under 65 years old. Arthritis affects many adults who also have heart disease, diabetes, and obesity. Almost half of adults with diabetes (47%) or heart disease (49%), and one-third of obese adults also have arthritis.⁵

Arthritis is a leading cause of work-related disability in the United States, with 44% of the working adult population with arthritis (aged 18-64 years) reporting symptoms that may limit the type or amount of work they do or may prevent them from working at all. Pain, stiffness, and swelling from arthritis can limit function and mobility and diminish quality of life. These limitations may impact the ability to perform routine work tasks such as writing or typing, standing or sitting for long periods, or bending and walking.

According to the CDC, in 2013, the national costs of arthritis were \$304 billion overall, with arthritis-attributable medical costs accounting for \$140 billion of the total and arthritis-attributable lost wages accounting for \$164 billion.⁶

Diabetes

Currently, it is estimated that over 37 million people in the United States have type 2 diabetes (diagnosed or undiagnosed). Another 98 million adults (or approximately 38% of the adult population) are estimated to have prediabetes, which puts them at high risk for developing type 2 diabetes in the absence of intervention.⁷

The costs of treating and managing diabetes are high and continue to grow. In 2017, the total cost associated with people with diagnosed diabetes in the United States was \$327 billion, representing an increase of 26% over five years. Medical expenditures constituted \$237 billion of that total, and reduced productivity was estimated at \$90 billion. Approximately one in four healthcare dollars is spent on people with diagnosed diabetes, with most expenses tied to hospitalizations and medications to treat complications of the disease. The costs associated with diabetes have also accelerated in recent years.

On an individual level, people with diagnosed diabetes incur an average of \$16,752 per year in medical expenses (\$9,601 of which are attributable to diabetes) – about 2.3 times more than a person without diabetes.⁸ One study of commercially insured adults found that healthcare costs for

⁵ [BRFSS Statistical Brief - Arthritis](#)

⁶ <https://health.gov/healthypeople/about/workgroups/arthritis-workgroup>

⁷ [A Report Card: Diabetes in the United States Infographic | Diabetes | CDC](#)

⁸ [\\$412.9 Billion in Health Care Dollars | ADA \(diabetes.org\)](#)

an individual with prediabetes who is subsequently diagnosed with diabetes are \$8,015 more in the first three years after diagnosis than individuals with prediabetes who are not subsequently diagnosed with diabetes⁹. People with diabetes are also at higher risk for other serious health problems, including heart attack, stroke, blindness, kidney failure, and amputation of toes, feet, or legs.

Heart Disease and Stroke

Heart disease is the leading cause of death for men, women, and people of most racial and ethnic groups in the United States, and one person dies every 33 seconds in the United States from cardiovascular disease. About 702,880 people in the United States died from heart disease in 2022—that's 1 in every five deaths.¹⁰

One in 3 U.S. adults has at least one of the following major risk factors for cardiovascular disease: uncontrolled high blood pressure, uncontrolled high LDL (bad) cholesterol, tobacco product use, obesity, and diabetes. Nearly half, or 119 million, of US adults who have hypertension, yet only 1 in 4 both know of their diagnosis and have it managed.”

Currently, one in every six healthcare dollars is spent on cardiovascular disease. By 2035, direct medical costs for cardiovascular disease will be nearly \$750 billion. From 2017 to 2018, heart disease costs the United States about \$229 billion each year.¹¹ This includes the cost of healthcare services, medicines, and lost productivity due to death. Stroke-related costs in the United States came to nearly \$53 billion between 2017 and 2018.¹²

Hypertension

Hypertension is the most common chronic condition for Medicare beneficiaries, and heart disease is the leading cause of hospitalizations and deaths among Medicare beneficiaries. Poorly controlled blood pressure is the most common cause of not just heart disease but also stroke, chronic kidney disease, and dementia. Close to 50% of Medicare beneficiaries do not have their blood pressure under control, resulting in a significant health and economic burden for the beneficiaries and Medicare.¹³

Oral Health

Oral health is important to overall health but is often overlooked. Oral conditions that affect overall health and quality of life include untreated tooth decay, severe gum disease, and severe tooth loss. Tooth decay is one of the most common chronic conditions in the United States. Among adults aged 20 and over, about 90% of people have had at least one cavity.¹⁴

Cavities are one of the greatest unmet treatment needs among children. Pain and suffering associated with untreated cavities can lead to problems with eating, speaking, and learning.

⁹ [Medical Care Expenditures for Individuals with Prediabetes: The Potential Cost Savings in Reducing the Risk of Developing Diabetes - PMC \(nih.gov\)](#)

¹⁰ <https://www.cdc.gov/heart-disease/data-research/facts-stats/index.html>

¹¹ [CVD-A-Costly-Burden-for-America-Projections-Through-2035.pdf \(heart.org\)](#)

¹² <https://www.cdc.gov/stroke/data-research/facts-stats/index.html>

¹³ <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/chronic-conditions/downloads/2012chartbook.pdf>

¹⁴ <https://www.cdc.gov/oral-health/data-research/facts-stats/fast-facts-cavities.html>

Children with poor oral health are more likely to miss school and receive lower grades. About 1 in 5 (20%) children aged 5 to 11 have at least one untreated decayed tooth, and 1 in 7 (13%) adolescents aged 12 to 19 have at least one untreated decayed tooth. Almost half (46%) of adults over age 30 already show signs of gum disease, and more than 40% have felt pain in their mouth during the past year.¹⁵

Oral diseases—which range from cavities to gum disease to oral cancer—cause pain and disability for millions of Americans. On average, the nation spends more than \$124 billion a year on costs related to dental care. Over \$45 billion of productivity is lost yearly due to unplanned dental visits.

A Public Health Approach to Chronic Disease Prevention

Addressing chronic diseases requires more than changing individual behaviors. It requires effective policy and systems solutions at the population level and a comprehensive approach to prevention. Much of the policy discourse focuses on prevention activities in healthcare settings but leaves out many prevention programs and interventions that can prevent an individual from developing a chronic disease. To ensure that Americans can achieve their full health potential, policymakers must address all levels of prevention, including preventing people from developing chronic diseases, ensuring they have access to affordable healthcare and screenings to catch chronic diseases at early stages, and providing opportunities and education for chronic disease management after a diagnosis.

Primary prevention must address the root causes of health and upstream health determinants, including access to stable housing, transportation, education, and quality health care, to prevent a never-ending cycle of expensive medical management with attention divided between siloed diagnoses. Connections between clinical care, community-based prevention support, and public sector public health practice show promise that can be accelerated to greater benefit.

Across the country, CDDs have successfully partnered with other public and private collaborators (e.g., planning, transportation, agriculture, charitable food system, and aging service network) to identify shared program goals, including addressing more upstream factors and social determinants of health, that can be accomplished with combined efforts, braided funds, and creative solutions while also reducing duplication of efforts. State Health Departments (SHDs) can also work with other state government agencies to create state offices, directors, and councils for food, nutrition, and hunger policy.

Although public health approaches to prevention are widely accepted as effective, chronic disease programs have been historically underfunded. To effectively implement and sustain critical programs, State Health departments need predictable, stable funding to support long-term workforce planning and development and ongoing efforts to modernize technology and data collection. Over the last decade, the CDC's overall budget has fallen by 2% after adjusting for inflation. NCCDPHP has followed that same trend, experiencing a reduction in funding from FY2012 to FY2021, even though chronic diseases represent 7 of the ten leading causes of death.¹⁶ The lack of federal investment has resulted in CDC programs that are only available in a limited number of states (see below for CDC's State Physical Activity and Nutrition Program).

¹⁵ <https://www.cdc.gov/oral-health/data-research/facts-stats/fast-facts-gum-disease.html>

¹⁶ <https://www.tfah.org/report-details/funding-2024/>

Without federal funding, State Health Departments and Chronic Disease Directors do not have the resources to provide the programs and services that promote the health of all Americans. State funding for public health is not keeping pace with the growing challenges of chronic disease prevention and health promotion. States made extensive cuts to public health funding during the Great Recession, and that funding has not been restored.

Key Factors Impacting Chronic Disease

Nutrition is a key factor in preventing chronic disease; poor nutrition is linked to diseases like type 2 diabetes, heart disease, obesity, certain cancers, stroke, and depression. Furthermore, less than 10% of Americans eat the recommended number of daily vegetables, and 90% consume too much sodium. Individuals with limited food access face more significant challenges in managing their existing chronic diseases, particularly those that are heavily affected by diet, such as diabetes.

A more comprehensive discussion of chronic disease prevention would also include other areas that affect people's risk of developing a chronic disease. These include:

- **Physical activity:** In 2020, only a quarter of American adults and a fifth of adolescents get enough aerobic physical activity to maintain good health and avoid disease. Increasing physical activity creates significant benefits for older adults, including reducing the risk of falling, improving joint mobility, delaying the onset of cognitive decline, and preventing weak bones and muscle loss.
- **Tobacco use:** Tobacco use is the single most preventable cause of death and disease in the United States. Smoking harms nearly every organ of the body, causing many diseases and affecting the health of smokers in general. Cigarette smokers are 2-4 times more likely to develop coronary heart disease and 2-4 times more likely to have a stroke than nonsmokers. Tobacco use costs nearly \$170 billion in direct medical care for adults annually and an additional \$156 billion in lost productivity.
- **Alcohol use—** In the long term, excessive alcohol use can lead to high blood pressure, heart disease, stroke, and liver disease. Drinking is also a risk factor for developing cancer of the breast, mouth, throat, esophagus, liver, and colon.
- **Social isolation:** Social isolation and loneliness can increase a person's risk for heart disease and stroke, type 2 diabetes, dementia, and earlier death.

CDC's Role in Preventing Chronic Disease

The CDC plays a crucial role in chronic disease prevention and health promotion. For the past 30 years, the CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) has amassed the experience, skills, and knowledge to serve people who are living with chronic diseases, such as heart disease, stroke, diabetes, cancer, lung disease, and Alzheimer's disease, and to prevent the major causes of death and disability caused by chronic diseases: tobacco use, physical inactivity, poor nutrition, and excessive alcohol use. NCCDPHP sends 80% of the Center's funding to states to implement programs and interventions to prevent chronic diseases and promote health.

Examples of CDC Programs that Effectively Address Chronic Disease

[National Diabetes Prevention Program \(DPP\)](#)

In 2010, Congress authorized the CDC to establish and lead the National DPP, an initiative to provide evidence-based, cost-effective community interventions to prevent type 2 diabetes. This public-private partnership brings together community-based organizations, health insurers,

employers, healthcare systems, academia, and government agencies working to deliver the diabetes prevention lifestyle change program. Research shows that people with prediabetes who take part in this structured lifestyle change program can cut their risk of developing type 2 diabetes by 58 percent (71 percent for people over 60 years old). This is the result of the program helping people lose five percent to seven percent of their body weight through healthier eating and engaging in 150 minutes of physical activity a week. For a person who weighs 200 pounds, five percent to seven percent of their body weight is equivalent to 10 to 14 pounds. Investing in type 2 diabetes prevention can slow or prevent the development of type 2 diabetes in adults with prediabetes or who are at risk for developing type 2 diabetes—resulting in reduced costs and healthier populations. Although not a CDC program, virtual DPP platforms, such as HALT, offer a cost-effective and equitable way to help communities prioritize their positive lifestyle changes to address diabetes.

[State Physical Activity and Nutrition Program \(SPAN\)](#)

Through SPAN, the CDC's Division of Nutrition, Physical Activity, and Obesity (DNPAO) supports evidence-based interventions that promote nutrition, physical activity, and obesity prevention across the lifespan, with a special focus on young children ages 0-5 years. Priority activities include increasing access to healthy food and beverages, increasing physical activity access and outreach across all ages and ability levels, designing communities that support safe and easy places for people to walk, improving nutrition and increasing physical activity in early care and education settings, and improving support for caregivers who choose to breastfeed. Due to a lack of federal funding, only 17 states receive funding from DNPAO through SPAN to support physical activity and healthy eating through state-based public health programs. With additional funding, the CDC could expand nutrition and physical activity interventions to every state, improve health outcomes and quality of life, and help individuals maintain optimal health at every age.

[Active People, Healthy Nation \(APHN\)](#) is a national initiative led by CDC to help 27 million Americans become more physically active by 2027. The APHN website provides strategies that work to increase physical activity and ways to incorporate equity and inclusion into each.

[Walkability Action Institutes \(WAI\)](#)

WAIs convene cross-disciplinary teams representing public health, planning, transportation, elected officials, and other disciplines to participate in an intensive, applied-learning course on improving walkability, focusing on community and transportation design. Through a community of practice, [NACDD provides ongoing training to the WAI's 95 alumni teams to support ongoing transportation and environmental design efforts](#). To date, WAI teams have collectively achieved over 730 documented policy, systems, and environmental (PSE) changes and leveraged over \$530 million to make communities safer for pedestrians, cyclists, and people with disabilities.

[Family Health Weight Programs \(FHWPs\)](#): FHWPs are comprehensive, family-based lifestyle change programs. They help children with overweight or obesity make progress toward a healthier weight through positive behavior changes. FHWPs are safe, effective treatments that are designed for children and their families or caregivers. FHWPs are also known as intensive health behavior and lifestyle treatment programs. Several national organizations, including the U.S. Preventive Services Task Force (USPSTF) and the American Psychological Association, recommend FHWPs to help treat childhood obesity. American Academy of Pediatrics (AAP) recommends that clinicians refer children ages 2 to 18 years with overweight or obesity to family-based programs with a minimum of 26 contact hours.

[Building Resilient Inclusive Communities \(BRIC\) \(2021-2023\)](#): CDC funding for the BRIC program allowed NACDD to provide learning and training opportunities to 20 SHDs, 72 communities, and other multisector organizations to address food and nutrition security, safe physical activity access, and social connectedness in the context of the COVID-19 pandemic. Within the project's first two years, participating communities achieved over 200 PSE changes, including improving procurement standards and food distribution practices at local food pantries, opening new food pantries or distribution locations for local healthy food access, creating or enhancing community gardens, creating or enhancing neighborhood parks and trails or other outdoor areas for congregation and recreation, and institutionalizing new screening and referral linkages between community sites and clinical and social support services.

[State Partnerships Improving Nutrition and Equity \(SPINE\) \(2022-2023\)](#): CDC funding for the SPINE program allowed NACDD to provide intensive training to nine SHDs and their partners to sustainably and equitably address food and nutrition security. Actions focused on the economic and social conditions limiting food and nutrition security across the lifespan through a PSE lens. Notable outcomes include enacting two state-level policy changes – Michigan's Universal Free Lunch Bill that guarantees free school breakfast and lunch for the state's 1.3 million students and New Hampshire's SNAP Outreach Bill to increase awareness of food assistance programs. Five states also increased SDOH screenings in clinical and food pantry settings and access to wrap-around services such as SNAP and WIC enrollment, transportation, shelter, hygiene, and medical and behavioral supports.

Other Evidence-Based Strategies to Prevent and Control Chronic Diseases

In addition to the CDC programs above, there are many evidence-based strategies to address chronic diseases, including:

Evidence-Based Strategies to Address Alzheimer's Disease

Prevention and health promotion strategies exist to reduce many of the risk factors for unnecessary disability and death from Alzheimer's disease. Older adults often benefit the most from public health interventions, but medical care alone will not meet the needs of older adults. Advanced planning, clinical-community linkages, social supports, and interventions outside of the aging services network are crucial to responding to older adults' needs. State public health agencies have an integral role to play in supporting the evidence, coordinating programs across state governments, educating providers and the public, and employing a population-based approach that will complement the individual and small-group approaches to medical care and social care.¹⁷

Evidence-Based Strategies to Address Arthritis

People can cope with and reduce the symptoms of arthritis through self-management programs, physical activity, and weight loss, but effective interventions for arthritis are drastically underutilized. Physical activity is a crucial element of managing these conditions, and arthritis presents unique barriers to increasing physical activity, thus compounding these chronic diseases.

To increase the uptake of proven interventions, decision-makers should consider:

- Covering healthcare provider screening to assess patients' current physical activity levels.

¹⁷ <https://www.cdc.gov/aging-programs/php/bold/>

- Offering (and covering) physical activity counseling/brief advice for patients who do not meet the recommended guidelines for physical activity.
- Ensuring that evidence-based programs for physical activity and arthritis self-management are covered by employee health benefits.

Evidence-Based Strategies to Address Heart Disease and Stroke

Reducing the average population sodium intake to 2,300 mg per day could reduce cases of high blood pressure by 11 million each year and save \$18 billion in healthcare dollars annually.⁶ Almost 2 in 5 adults in the United States have high cholesterol (total blood cholesterol \geq 200 mg/dL). A 10% decrease in total cholesterol levels in the U.S. population overall may result in an estimated 30% reduction in the incidence of heart disease.⁷

Evidence-Based Strategies to Address Oral Health:

Preventing Cavities: Fluoride varnish can prevent about one-third (33%) of cavities in primary (baby) teeth. Children who brush daily with fluoride toothpaste will have fewer cavities. Applying dental sealants to the chewing surfaces of the back teeth can prevent 80% of cavities in children and last for years. Children living in communities with fluoridated tap water have fewer cavities than children whose water is not fluoridated.

Emergency Department Referral Programs: Establishing more emergency department (ED) referral programs for treating patients who present to the ED with dental pain across the United States could save billions of dollars in unnecessary medical care costs.

Medicaid Coverage: Medicaid coverage for medically necessary dental care for adults can prevent complications from untreated oral health infections and improve patient outcomes. Children covered by Medicaid receive oral health services under CHIP, but adult care varies from state to state. At a minimum, medically necessary care for adults with chronic medical conditions would save money on the medical side, including oral health services during pregnancy and preventive oral health services (cleanings) for adults with diabetes and cardiovascular disease.

Again, thank you for the opportunity to submit this statement. As the Committee continues to explore policy solutions to address chronic disease, NACDD encourages committee members to include the role of public health in prevention and the positive health and economic impacts of investing in public health programs and interventions. Collaboration between the public health and healthcare sectors is critical for effective chronic disease prevention and reducing U.S. healthcare costs. Additional funding for the CDC programs that have been proven to improve health outcomes will multiply this positive effect. NACDD and its members are always available as a resource to discuss what states are doing to prevent chronic disease. If you have any questions, please contact Liz Ruth, NACDD's Vice President of Policy, at lruth@chronicdisease.org.

Sincerely,



John W. Robitscher
Chief Executive Officer
National Association of Chronic Disease Directors



Investing in a Healthier America: Chronic Disease Prevention and Treatment
Written Testimony Submitted to
U.S. House Committee on Ways & Means Subcommittee on Health
Andrew Barnell, Co-Founder and CEO, Geneoscopy, Inc., St. Louis, Missouri

Thank you for the opportunity to provide written testimony in response to the Subcommittee's hearing on chronic disease prevention and treatment. As discussed at the hearing, diet, nutrition, food, and disease screening and detection are all intertwined. We would like to discuss these items further below, specifically, how Geneoscopy is innovating in detection and screening.

Evidence shows a significant association between a diet high in ultra-processed food and an increased risk of cancer and specifically colorectal cancer.¹ Colorectal cancer is the second deadliest cancer in the U.S., causing more than 50,000 deaths annually. Of particular concern is the significant increase in the incidence of colorectal cancer among younger Americans. Since 1994, cases of early-onset colorectal cancer (i.e., colorectal cancer diagnosed before the age of 50) have increased by 51%, and since 2004, there has been a rapid shift in mortality patterns, with colorectal cancer moving from being the fourth leading cause of cancer-related deaths among young men and women to now being the leading cause in men and the second leading cause in women.²

Fortunately, routine colorectal cancer screenings for Americans aged 45 years and older are an effective intervention to detect precancerous polyps so that they can be removed before they develop into cancer, thereby preventing colorectal cancer.³ Despite this, one in four adults aged 45 to 75 are not getting screened as recommended. In 2021, only 19.7%, or fewer than 4 million out of 19 million eligible adults aged 45-49 were up to date with their colorectal cancer screening.⁴ As such, it is essential that more colorectal cancer screening options be available to people aged 45 and older and that such tests be accessible and affordable for all who are eligible for screening.

Colon cancer is the most preventable cancer if people get screened for it regularly. Colorectal cancer almost always develops from precancerous polyps (abnormal growths, also called adenomas) in the colon or rectum. If you can find and remove the precancerous polyps through screening, you can head off cancer before it develops. A New England Journal of Medicine study concluded that the more adenomas found during screening, the less cancer is subsequently

¹ Isaksen, I. M., & Dankel, S. N. (2023). Ultra-processed food consumption and cancer risk: A systematic review and meta-analysis. *Clinical nutrition (Edinburgh, Scotland)*, 42(6), 919–928. <https://doi.org/10.1016/j.clnu.2023.03.018>

² <https://www.nbcnews.com/health/health-news/colon-cancer-deaths-younger-men-women-report-rch134084>

³ <https://www.cdc.gov/chronicdisease/programs-impact/pop/colorectal-cancer.htm>

⁴ https://www.cdc.gov/bcd/issues/2023/23_0071.htm

diagnosed.⁵ Screening can also identify early-stage cancer. When colorectal cancer is found at an early stage, before it has spread, it is more treatable, and the five-year relative survival rate is about 90%. The percentage of individuals diagnosed with advanced-stage colorectal cancer has increased from 52% in the mid-2000s to 60% in 2019.⁶ Survival rates are lower when cancer has spread outside the colon or rectum.⁷ Unfortunately, many patients avoid screening, and so their cancer is diagnosed at later stages. Approximately 40% of patients fail to get screened in part because they do not want to have a colonoscopy, which is the gold standard for colorectal cancer screening in the U.S. Colonoscopies are frequently met with patient aversion due to the required bowel preparation, sedation, and potential time away from work.⁸

An alternative to colonoscopy for average-risk patients is noninvasive screening tests, like Geneoscopy's ColoSense, which can be used at home. ColoSense can play a critical role in addressing access to care challenges by reducing barriers to early detection, particularly among underserved populations. Traditional screening methods, like colonoscopies, can be inaccessible due to cost, geographic location, or the need for specialized facilities – challenges that disproportionately affect low-income, rural, and minority communities. A noninvasive test such as ColoSense offers a more affordable, convenient, and less intimidating option, increasing the likelihood that patients will seek regular screenings given their potential to detect precancerous polyps and cancer at earlier stages when it is most treatable.

Everyone is at some risk for developing colorectal cancer, though some groups are at elevated risk. Of particular concern, in the U.S. African Americans have the highest colorectal cancer incidence and mortality rates of all racial groups. African Americans are approximately 20% more likely to develop colorectal cancer and an estimated 40% more likely to die from it than most other populations.⁹ Moreover, as noted earlier, colorectal cancer incidence and mortality rates among people ages 45-54 have increased in recent years. The percentage of individuals diagnosed with colorectal cancer who are under the age of 55 doubled from 11% in 1995 to 20% in 2019.¹⁰ In 2021, the U.S. Preventive Services Task Force (USPSTF) lowered the recommended age for people to begin colorectal cancer screening from 50 to 45.¹¹ With that change, 17 million more people entered the recommended screening cohort. Clearly, there is an urgent need to increase screening efforts.

As technological innovations in the field of preventive screening and diagnostics advance for the country's deadliest diseases, more effective screening modalities become available. For example, ColoSense uses mRNA technology that has demonstrated the potential to improve the

⁵ <https://www.nejm.org/doi/full/10.1056/NEJMoa1309086>

⁶ <https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21772>

⁷ <https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/detection.html>

⁸ <https://www.sciencedirect.com/science/article/pii/S2211335519300750>

⁹ <https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21772>

¹⁰ <https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21772>

¹¹ <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>

detection of colorectal cancer and advanced adenomas (AA) above and beyond other tests on the market. Top-line data from the CRC-PREVENT clinical study for Geneoscopy's test demonstrated 93% sensitivity for colorectal cancer and 45% sensitivity for AA.¹² In addition, ColoSense's ability to detect AA does not materially erode for the youngest screening bracket of 45-49-year-olds as occurs in other screening methods.¹³ This finding may lead physicians to choose different screening modalities for different patient demographics. When it comes to screening, more choice is better, and the best colorectal cancer screening test for a given patient is the one that physicians will use. Geneoscopy's clinical trial showed that the new technology worked successfully for people across demographic groups all over the country and has the real promise to advance the vital goal of increasing access to health care innovation for historically underserved populations. In Geneoscopy's trial, 30% of participants had an income below \$50,000 annually, 9% were on Medicaid, and 5% were from rural areas¹⁴.

There are a few key hurdles to bringing life-saving cancer screening tests to patients. First, getting approval by the Food and Drug Administration (FDA); second, qualifying for coverage and payment by the Centers for Medicare and Medicaid Services (CMS); and third, inclusion in the USPSTF screening recommendations given that commercial insurers generally will not cover a test until it is included in USPSTF guidelines. Start-up companies like Geneoscopy take risks when developing new technologies and face the "valley of death" when coverage and guidelines inclusion do not come quickly after FDA approval. To keep pace with biotech innovation and provide access to these innovations, we propose that:

- (1) There should be automatic, temporary Medicare coverage for a four year transitional period of all medical devices – including screening tests and diagnostics – that are approved under the FDA Breakthrough Devices Program. To that end, we support H.R. 1691, the Ensuring Patient Access to Critical Breakthrough Products Act of 2023, and H.R. 5389, the National Coverage Determination Transparency Act. These bills would provide the predictable pathway innovators seek for coverage and payment and expedite patient access to novel cancer screening tests like ours. It is imperative that once the FDA approves a test, CMS updates its coverage and payment policies in a timely manner. For example, ColoSense was approved by FDA in May 2024, and we promptly requested that CMS update its National Coverage Determination for colorectal cancer so Medicare beneficiaries and dually-eligible individuals could have access to it. Given feedback we have received from CMS, Medicare coverage for ColoSense likely will not be granted until the end of CY2025 or the first quarter of CY2026 – an estimated full year and a half to two years after receiving FDA approval. This means that Medicare beneficiaries and dually-eligible individuals will face a significant delay in accessing ColoSense and if not otherwise screened could develop colorectal cancer during that timeframe.

¹² <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P230001>

¹³ <https://doi.org/10.1158/1940-6207.CAPR-20-0294>

¹⁴ <https://pubmed.ncbi.nlm.nih.gov/37870871/>

- (2) We recommend temporary inclusion in the USPSTF screening guidelines when devices are approved under the FDA Breakthrough Devices Program. This would allow patients to have access to FDA breakthrough designated and approved devices until USPSTF completes the next update of its guidelines for the particular disease or condition, which could take up to six years depending on the particular review cycle.

The USPSTF plays an integral role in colorectal cancer prevention and early detection because its recommendations are used by commercial insurers to determine coverage of colorectal cancer screening tests. Further, any colorectal cancer screening modalities that receive an A or B rating from the USPSTF are fully covered by insurance thus eliminating patient cost-sharing, which facilitates access and utilization. Many commercial insurers will decline to cover a preventive screening test until it is included in the USPSTF guidelines, regardless of strong data supporting the test, endorsement by other guidelines such as from the American Cancer Society, or a positive coverage decision by CMS. The USPSTF typically updates its recommendations every five years, although it often takes longer. Once the USPSTF begins the process to update guidelines, it usually takes more than two years. Based on the standard five-year timeframe, the USPSTF should have commenced the two-year process in January 2024 to update the colorectal cancer screening guidelines, but the agency has taken no such action, despite patient advocacy groups this summer making a formal request for an update; it remains unclear when USPSTF will begin the update process.

- (3) We believe it is appropriate and good policy for Medicare quality metrics to align with Medicare coverage and payment policy; if Medicare deems something worthy of payment, then it follows that providers should receive credit for using the test. Currently, the Partnership for Quality Measurement (PQM), which establishes Stars quality metrics, relies on the measure steward, the National Committee for Quality Assurance (NCQA) to set quality measures for Medicare and commercial insurance. However, NCQA will not add a new cancer screening test to its measures – even if Medicare provides coverage and payment – until it is included in the USPSTF guidelines. As such, USPSTF guidelines dictate commercial coverage and quality metrics for prescribing clinicians, including those serving Medicare beneficiaries and dually-eligible individuals. Payment drives practice and therefore, until USPSTF includes a new test, health plans typically will not cover a test, and clinicians will not prescribe it for commercial or Medicare patients. Without quality metric credit, too many providers likely will opt to use older, less effective tests because they are already in the quality measurement system.

To address this issue, we recommend that CMS establish a new process to ensure that the latest cancer screening tests covered under Medicare are automatically considered for inclusion in the PQM Stars quality metrics. Instead of relying only on the arduous process for inclusion in USPSTF guidelines, this new process should be a dynamic collaboration between CMS, NCQA, and USPSTF to expedite the evaluation and integration of new tests into quality metrics once Medicare coverage is established. Additionally, CMS should

*Written Testimony Submitted to
U.S. House Committee on Ways & Means Subcommittee on Health
October 2, 2024*

consider incentivizing health plans and clinicians to adopt newly covered tests in quality measurement programs, which may lead to faster alignment between coverage and payment, and ultimately facilitate providers and patients in utilizing the most effective screening tests.

Individually and together, these three factors create a significant barrier to innovative, FDA-approved tests reaching patients in the U.S. health care system.

Thank you again for the opportunity to share our work on chronic disease prevention as it pertains to colorectal cancer; we urge you to take steps to address the “valley of death” that companies like ours face. These barriers not only slow access to ColoSense but will thwart access to other much-needed tests in the Geneoscopy pipeline, as well as those in development by other companies. We hope we can work together to facilitate access to innovative tests to screen, diagnose, and prevent myriad serious and life-threatening diseases for patients of all ages.

About Geneoscopy

Geneoscopy was founded in 2015 with a vision to improve how gastrointestinal diseases are prevented, detected, and treated. My sister, Dr. Erica Barnell, and I co-founded Geneoscopy after Erica developed a groundbreaking technology to isolate and interrogate mRNA while she was pursuing her MD/PhD at Washington University School of Medicine in St. Louis, Missouri. Geneoscopy’s initial product is a noninvasive colorectal cancer screening test, ColoSense, that detects colorectal cancer and high-risk precancerous polyps—advanced adenomas.¹⁴ Designated a Breakthrough Device by FDA, ColoSense received FDA approval on May 6, 2024.¹⁵

¹⁴ <https://pubmed.ncbi.nlm.nih.gov/11916153/>

¹⁵ <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P230001>



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Meaningful Lives As We Age

Monday, September 30, 2024

Chairman Jason Smith
1139 Longworth House Office Building
Washington, DC 20515

Ranking Member Richard Neal
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Smith and Ranking Member Neal,

I am writing on behalf of the Gerontological Society of America (GSA) regarding the Ways and Means Health Subcommittee hearing on Investing in a Healthier America: Chronic Disease Prevention and Treatment. We ask that this letter along with our attached report, *Insights and Implications of Obesity in Gerontology*, be submitted to the hearing record.

Any discussion about chronic disease *must* focus on obesity due to the positive correlation between obesity and other chronic diseases such as diabetes, kidney disease, high blood pressure, osteoarthritis, and more. We know that access to comprehensive obesity care can lower the severity of these diseases and in some cases cure them entirely.

GSA is supportive of comprehensive care for the treatment of obesity. We agree that nutrition is a key component of obesity care and echo calls to improve access to healthy and nutritious foods for all of us as we age. The full range of care must advance beyond simply "diet and exercise." Comprehensive obesity care includes behavioral modification through medical nutrition or intensive behavioral therapies as well as access to medical, pharmaceutical, and surgical interventions. Any true efforts to prevent or treat chronic disease must reflect clinical guidelines and ensure access to all these evidence-based elements.

Preventing and treating chronic disease for America's older people means treating obesity. We appreciate the Subcommittee's attention to the issue of preventing chronic diseases and urge you to make obesity a central part of this conversation, especially as it pertains to the care and treatment of older people.

If you have any additional questions, please contact me at jappleby@geron.org or Patricia D'Antonio, Vice President of Policy and Professional Affairs at pdantonio@geron.org.

Sincerely,

A handwritten signature in black ink that reads "James C. Appleby". The signature is written in a cursive style.

James C. Appleby, BSPHarm, MPH, ScD (Hon)
Chief Executive Officer

insights

DECEMBER 2023

& Implications

IN GERONTOLOGY

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The Chronic Disease of Obesity

Ellie: Does this mean I'm gonna get fat?

Charlie: No, it doesn't. I was always big. I just let it get out of control.

Overweight and obesity are usually nothing new for people who enter older adulthood with extra weight. Many always have been big, as Oscar-winning Brendan Fraser's character, Charlie, in *The Whale* relates in the above exchange with his daughter. Others experience midlife bulges due to stress, anxiety and/or depression, eating on the fly or on the road, and inactivity. Whatever their journey, people of larger sizes have heard the platitudes at doctors' offices: processed the prodding of parents, partners, and friends to watch their appetite and control themselves; and seen the side glances and averted looks in public. As a result, people with overweight and obesity may delay care, isolate from family and friends, and avoid social gatherings and public events.

Even in their work lives and professional careers, people with overweight or obesity are more often overlooked during hiring processes, passed by for promotions, and earn less than colleagues. Perhaps the

deepest cut for people with overweight and obesity comes when Medicare and many other third-party payers refuse to cover therapies that could stop their progression into arthritis, hypertension, obstructive sleep apnea, cardiovascular disease, diabetes, renal disease, gastric disease, nonalcoholic fatty liver disease, and cancer.

Obesity rates for adults 65 years of age and older have nearly doubled over the last 30 years increasing from 22% in 1988 to 42% in 2020. This increase has brought much needed awareness to older adults and their unique needs when it comes to discussions around and treatment options for overweight and obesity.^{1,2} The good news for today's older adults with overweight and obesity is that clinical medicine has finally recognized that obesity is a chronic disease that, like others, requires management across the lifespan. In this issue of *Insights & Implications in Gerontology*, current concepts are presented about the complex interplay among the stomach, liver, pancreas, brain, and metabolic processes of the body. Recognition of obesity as a chronic disease by medical organizations is discussed, and the need for integration of their guidelines into multifaceted and interdisciplinary care of the older adult is presented.

Starting the Body Size Conversation With Older Adults

Because of the stigma associated with overweight and obesity, people are reluctant to confront this disease in the way they do with other chronic conditions such as high blood pressure, diabetes, high cholesterol, or osteoarthritis. Body size and altered distribution of fat can be the underlying causes of other chronic diseases and key factors in the development of pain and other symptoms.

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This publication is available on www.geron.org/obesity

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Before starting the conversation, the values and goals of the older person related to weight management must be explored. Older adults with overweight or obesity are often looking for help with their body size. However older persons too often receive limited guidance from health professionals about weight and weight loss. Additionally, older adults reported that excess weight negatively impacts overall health and well-being and that maintaining or improving their health is a top priority and motivator for weight loss. Older adults, like younger adults, may be concerned about their body size and are looking for a health care provider who will partner with them rather than dismiss or diminish their concerns about the impact of obesity on their health.

In adults with overweight and obesity, an estimated 40% experienced implicit and/or explicit bias due to their weight.¹ Exposure to overweight and obesity-related weight bias is associated with increased prevalence of morbidity, psychological distress, eating disorders, social isolation, and exercise avoidance. Further, in a longitudinal study of 13,692 older adults, weight discrimination was associated with a 60% increased risk of mortality.⁴

Unfortunately, weight-biased attitudes, including the belief that individuals have obesity because they are lazy, incapable of change, uneducated, or lack motivation, are common among health care providers.¹ Health care providers who hold these biases may consciously or unconsciously spend less time with the patient, withhold or delay treatment options, show less respect, and/or associate all other health problems with overweight or obesity. Patients with overweight and obesity who experience these attitudes and behaviors are more likely to avoid clinical care and appointments that require being weighed or exposing the body and less likely to trust and have open and honest communication with health care providers.⁴ There is an urgent need for health care providers and health care organizations to confront these biases by recognizing that obesity is a multifaceted disease with specific and treatable causes and not a failure of the individual, a character flaw, or a lack of willpower.

Removing the Stigma

With obesity being a common and all-too-often misunderstood disease, health care providers and their staff members must first work to broach discussions about body size in ways that will lead to positive interactions and not shame or self-blame. Kickstarting this conversation requires education and sensitivity on the part of providers and training in the effective use of empathic, patient-centered communications.

Respect for people of all body sizes is paramount for removing the stigma of overweight and obesity and opening the door to productive conversations in the medical setting. This begins in the waiting area of clinics or medical offices, where appropriate seating for people of all sizes should be available.

To provide empathic care to people of all body sizes, health care providers and staff members must first address their own biases and misconceptions about weight. These implicit biases are difficult for people to recognize and address. They can be detected and better understood using tools such as the [Implicit Associations Test for Weight Bias](#), which is available through the Strategies to Overcome and Prevent (STOP) Obesity Alliance website.²

Behavioral change and lifestyle approaches in combination with medication and/or surgery are essential to lose weight and maintain it at the desired goal. By incorporating this knowledge into clinical practice and approaching the treatment of overweight and obesity just as they would treat an individual's high blood pressure or dyslipidemia, the health professional is able to provide the care the patient needs.

Resources are available to educate all staff in the medical office, including materials from the Gerontological Society of America (GSA), as listed at the end of this report. All medical office or clinic staff—receptionists, medical assistants, and health professionals—should learn appropriate ways of talking with patients about weight and understand the disease processes that lead to chronic weight gain and maintenance of body size at unhealthy levels.

Respecting the Patient's Preferences

During intake for their health care visits, patients should be asked what terms they prefer when referring to body size and whether it is okay to measure their weight during the visit. People with larger body sizes can find stepping on the scale one of the most stressful parts of a routine medical visit. While well-meaning, comments by health care providers and staff about



the need for weight loss or the negative impact of weight on health conditions could add to the shame and frustration that patients may already feel.

Weight should be measured in areas where other staff and patients cannot hear or see the measurements; to do otherwise violates confidentiality as well as leads patients with overweight and obesity to avoid medical visits or look elsewhere for providers who can help them address body size. Additionally, prior to taking measurements, health care providers and staff should explain what measurements are being taken and confirm with the patient consent to the measurement being collected. Weight and/or waist circumference measurements are just as confidential as other medical information and test results, and likewise this information should be managed with the utmost of privacy.

Changing the Conversation Through the Use of Destigmatizing Terms

Working with office staff to establish new systems of caring for older adults with overweight/obesity is a pivotal step in moving beyond "eat right and exercise" advice. Through education and awareness, the staff can engage people with obesity positively, use person-centered (or person-first) language, make people of all sizes feel welcome, and use current guidelines to provide evidence-based care.

Person-centered language uses destigmatized, empathic terms that keep the individual at the center of the discussion. Avoid saying "obese people" and "he is obese." Instead, terminology to use should include "people with obesity or overweight," just as patients or people may have diabetes or any other clinical condition. The transition to person-centered language is a difficult but very important process.

Rather than focusing on pounds and body mass index (BMI), physicians and the interprofessional care team should talk about what goals the older adult has and what it would mean to achieve those goals. The ultimate goal for most older adults is to engage in a healthy lifestyle, manage or prevent the development of chronic health conditions, and maintain their independence and function. Some older adults have a goal of lowering their blood pressure; others wish to decrease their knee pain. In respectively, the common avenue to achieve the goal is often weight reduction.

Health care providers and staff should have responses ready for common roadblocks that stop patients from addressing overweight and obesity. Appropriate and helpful responses to common patient statements are shown in Figure 1.

Weight and/or waist circumference measurements are just as confidential as other medical information and test results, and likewise this information should be managed with the utmost of privacy.

Figure 1. Positive Responses to Common Roadblocks to Addressing Overweight and Obesity



The 6 As Model

Motivational interviewing is an invaluable technique for helping people move toward their personal goals, whether to stop smoking, drink less alcohol, or lose weight. The 5 A's intervention used for tobacco cessation has been expanded to the 6 As for discussing overweight and obesity (Figure 2).⁸

Older adults with overweight and obesity may not be motivated by getting to a certain body size, but they are very motivated about their ability to maintain their independence. The Geriatric 5Ms framework is useful to remember what should be emphasized when talking with older adults: *mind, mobility, medications, multicomplexity, and matters most*.¹⁰

Diagnosing Overweight and Obesity: It's Not Just Weight

As the conversation moves from motivation to action, health care providers should complete a full history of the patient's weight journey (weight history, when weight was gained or lost, current and past diet and exercise patterns, and current medications), dispel incorrect notions about what defines success in body size management, and talk with the patient about personal goals and a mutually agreed-upon treatment plan that can achieve those goals.

BMI, Waist Circumference, and Diagnostic Categories

Building on previous conversations, the team should dispel the notion that BMI defines a person's diagnosis and will be the goal during treatment. This measure is used in current diagnostic criteria and is mandatory for billing purposes. The U.S. Food and Drug Administration uses BMI in its approved indications for medications. For these reasons, BMI is considered when diagnosing overweight and obesity and is tracked during treatment. However, BMI was originally developed for other purposes, is a poor measure of body size, may inaccurately assess health risks in older adults, and must be adjusted for Asian individuals. Hence, we must consider measures past BMI.

Waist circumference is a key measure in assessing a person's body shape and risk for complications. Increased waist circumference indicates the potential for excess adipose tissue around the middle of the body ("central obesity"), which is associated with a greater risk of cardiovascular disease, type 2 diabetes, and all-cause mortality. As explained in a footnote of Figure 3,¹¹⁻¹⁵ waist circumference of 102 cm (40 inches) or less in men and 88 cm (35 inches) or less in women is considered normal, but different cut points are more appropriate for people of various race and ethnicities (e.g., Asian and Latinx individuals).¹¹

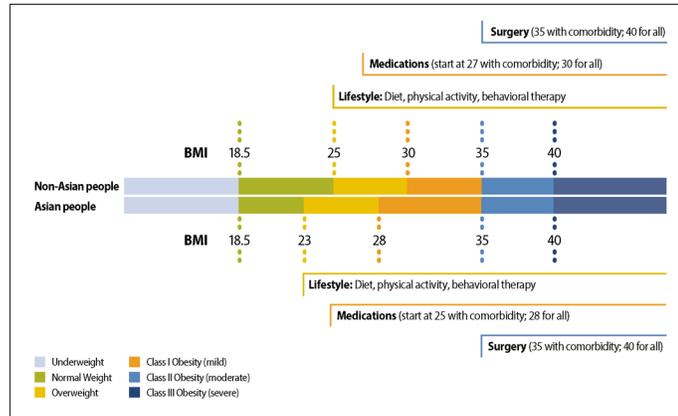
Figure 2. The 6 As Model



Other clinical information needed for developing a care plan includes the presence of concomitant chronic diseases (e.g., hypertension, prediabetes or diabetes, cardiovascular diseases, bone and joint conditions), complete medication history, information on the person's current cognitive status, ability to perform activities of daily living and instrumental activities of daily living, presence of sarcopenia, any available information on muscle mass and body fat, and the person's need for social support.

If BMI and waist circumference show that patients have overweight or obesity, the health care team works with them to design personalized approaches to treatment. During the diagnostic process, patients should have laboratory tests to provide a baseline for future assessments. Tests should include complete blood count, metabolic panel, lipid panel, liver function tests, kidney function tests, and cardiovascular tests. Periodic glucose tests are needed to determine whether a patient has prediabetes or diabetes. Baseline values of all these tests outside the normal range can be used as motivators to move patients toward treatment of overweight and obesity. During weight loss, improvements in these test results should be pointed out to patients to maintain their motivation and dedication to the body size journey.

Figure 3. Classifications of Weight and Recommended Points at Which Interventions Are Recommended in Treatment Guidelines



- Numbers in the figure represent BMIs. This measure is calculated as weight in kilograms divided by the square of height in meters (kg/m²).
- Some experts recommend using 17.5 as the cut point between underweight and normal weight for people of Asian race. Guidelines in Asian nations differ on the exact BMIs considered underweight, normal weight, and overweight. The cut point of 23.5 for normal weight and overweight recognizes that Asian individuals in general should be monitored for diabetes at lower BMIs than other race or ethnic groups. However, this is a heterogeneous group, and findings have varied among subgroups of the Asian population.
- Increased waist circumference is considered a comorbidity risk and a reason to start medications at BMIs of 25 for Asian people and 27 for non-Asian people. For people of Asian descent, the waist circumference cutoff points are appropriate: 94 cm (37 inches) and 80 cm (31.5 inches) for men and women, respectively. Waist circumference cutoff points of 94 cm (37 inches) for men and 90-92 cm (35-36 inches) for women have been identified for Latino individuals (a person of Latin American origin). For other people in the United States and Canada, waist circumference is considered normal when it is 102 cm (40 inches) or less in men and 88 cm (35 inches) or less in women.

BMI = body mass index.
Sources: References 11-15.

Sarcopenic Obesity and the Importance of Proper Nutrition While Restricting Caloric Intake

Before embarking on any effort to reduce body size, the older adult should be screened for the loss of muscle mass and strength, termed sarcopenia. When people pursue caloric reduction without consuming all the requisite protein, carbohydrates, essential fatty acids, and other nutrients, their weight loss can lead to a reduction in fat-free mass (muscle and bone mass) while concomitantly losing adipose tissue. Even though people may not appear to have frailty, they may be weak and unable to carry out essential activities such as walking or rising from a chair.¹⁶

As shown in Table 1, the SARC-F instrument—consisting of five questions related to *strength*, *assistance* walking, *rising* from a chair, *climbing* stairs, and *falls*—can be used to screen for sarcopenia in older adults with obesity and in other patients with elevated BMIs and waist circumferences. The patient responds to the five questions, and the answers are scored as shown. Scores of 4 or more indicate possible sarcopenic obesity. Diagnosis of sarcopenic obesity is made using tests of skeletal muscle function, such as chair stands

and hand-grip strength, and evaluation of body composition using dual-energy x-ray absorptiometry (preferred) or bioelectrical impedance analysis (alternative).^{17,18}

Red-Flag Conditions

Older adults often have several medical conditions. This makes it essential to screen patients of larger body sizes for certain red-flag conditions such as prediabetes, diabetes, dyslipidemia, hypertension, and liver disease. In designing a treatment plan, the health care team keeps in mind those conditions that are often improved with weight loss: prediabetes or diabetes and cardiometabolic conditions such as elevated blood pressure and cholesterol levels. Kidney and liver health, asthma, and obstructive sleep apnea also may improve with weight loss.¹⁹

Intently Addressing Obesity in Older Adults

Overweight and obesity are now recognized as chronic health conditions with specific pathophysiologic causes, complications if these conditions are not addressed, and treatments that are safe and effective. For most older adults, treating overweight and obesity can add years to their lifespan and, importantly, add quality to the years of life when they are healthy.

Management Through Diet, Lifestyle, Medications, and Surgery

People with overweight or obesity have traditionally been treated through a stepped approach, starting with changes in diet and lifestyle, adding medications if needed, and proceeding to bariatric surgery as a

Table 1. Sarcopenia Screening Assessment Using the SARC-F Instrument

Functional Component	Question	Scoring*
Strength 	How much difficulty do you have in lifting and carrying 10 pounds?	None = 0 Some = 1 A lot or unable = 2
Assistance in walking 	How much difficulty do you have walking across a room?	None = 0 Some = 1 A lot, use aids, or unable = 2
Rise from a chair 	How much difficulty do you have transferring from a chair or bed?	None = 0 Some = 1 A lot or unable without help = 2
Climb stairs 	How much difficulty do you have climbing a flight of 10 stairs?	None = 0 Some = 1 A lot or unable = 2
Falls 	How many times have you fallen in the past year?	None = 0 1-3 falls = 1 ≥4 falls = 2

*Scores on each of the 5 questions are summed. Sums of 4 or more are considered indicative of sarcopenia.

Source: Reference 18.

last resort. Current guidelines recognize that patients presenting with obesity-related conditions such as cardiovascular disease or diabetes and those with obesity are best treated initially with medications in addition to lifestyle and diet changes. For people with very large body sizes (BMI ≥ 40), referring to bariatric surgery at the beginning of the treatment journey is indicated, particularly since an appointment with a qualified surgeon may not be available for weeks or months.

These changes in the therapeutic management of overweight and obesity are the result of basic research into the mechanisms used by the brain, pancreas, and gastrointestinal system to signal the need to eat and when to stop. As these mechanisms were recognized, medications were developed to mimic or interrupt signals causing abnormal satiation ("hungry brain"), abnormal hedonic eating ("emotional hunger"), abnormal satiety ("hungry stomach"), and low energy expenditure ("slow burn").²⁵

By recognizing these abnormalities as the real causes of overweight and obesity, health professionals and medical organizations now know that this is a chronic disease requiring lifelong treatment. As with hypertension and dyslipidemia, long-term management is needed to reach and remain at the patient's chosen body size.

Shared Decision-Making and Goal-Setting With Patients

Patients must be actively involved in setting a goal for their treatment process and choosing the interventions to incorporate into their personal lifestyle. Whether it's diet, exercise, medications, or proper management after bariatric surgery, patients ultimately must be committed to their plan to be successful.

In developing a plan, addressing any myths or misinformation that the patient has about weight loss is essential. Common beliefs and sample responses are listed in Table 2.²¹⁻²⁴ Patients can also get up-to-date information about treatment by reviewing the "POWER" chart on the [American Gastroenterological Association website](#) or the part of the [American Association of Clinical Endocrinology obesity website](#) developed for non-health care professionals. An [infographic from The Obesity Society](#) on potential causes and contributors for weight gain is also a useful resource for patients.



The process of the health care provider and patient setting mutual goals and deciding together on interventions is called shared clinical decision-making. Using the latter three components of the 6 As model presented in Figure 2 (Agree, Assist, Arrange),¹⁸ clinicians describe the available options and their advantages or disadvantages, and the patients talk through what they can commit to and incorporate into daily life.

Rather than focusing on a specific weight or BMI as the goal of weight loss, the health care provider and the patient can talk about percentage reductions in body size. The provider can explain how each percentage point lost can help control diabetes, blood pressure, lipids, liver disease, and kidney disease. Progression from prediabetes to diabetes is also slowed or stopped by loss of as little as 5% or 7% of body weight.²⁵

Whatever goal is chosen, the SMART process can be applied by making goals *specific, measurable, attainable, relevant, and time-based*. After the patient and health care provider agree on a plan, the interprofessional team and patient work together to implement the behavioral and lifestyle changes, such as the following:

- Adhering to a healthy diet.
- Incorporating aerobic and resistance exercise into a daily routine.
- Using medications properly and safely.
- Working with a psychologist to identify new skills and ways of thinking about health choices.
- If needed, referring the patient to a qualified surgeon to determine whether bariatric surgery is an appropriate treatment.

Rather than focusing on a specific weight or BMI as the goal of weight loss, the health care provider and the patient can talk about percentage reductions in body size.

Follow-up visits with a relevant interdisciplinary team member should be scheduled every three months to track the patient's progress and add new interventions if needed. Since most older adults with

overweight and obesity have additional diseases, team members may include registered dietitians, nutritionists, and other qualified practitioners with experience in geriatrics.

Table 2. Top 10 Myths About Weight Loss and Sample Responses

<p>1 It's just calories in/calories out. Anyone can lose weight by eating less or exercising more.</p> <p>While weight loss does require a calorie deficit and counting calories is one way of achieving that, it is just as important to focus on the quality of foods eaten and use other interventions that can alter the complex web of hormonal and physiological systems that control the impulse to eat and how much energy the body dissipates through usual activities of life.</p>	<p>2 "Elimination" diets work best for losing weight.</p> <p>People need to use methods in losing weight that are sustainable and that they are able to maintain for the rest of their lives. Removing specific foods from one's diet may (or may not) be effective for weight management, but if the person doesn't want to live without the eliminated food forever, fad diets are not recommended.</p>	
<p>3 Cutting out carbohydrates or fat makes you lose weight.</p> <p>The Dietary Guidelines for Americans 2020–2025 recommends a healthy eating plan that emphasizes fruits, vegetables, whole grains, and fat-free or low-fat milk and milk products, includes protein sources, is low in saturated and trans fats and added sugars, and stays within the person's daily caloric needs. Eliminating any major component of a healthy diet is not healthy.</p>	<p>4 Never snack</p> <p>When healthy foods such as fruits are chosen, snacks can help get people on diets from meal to meal without hunger or symptoms of hypoglycemia. Like eliminating treats, omitting all snacking is also not an intervention most people can maintain over the long term.</p>	<p>5 You have to go hungry.</p> <p>To establish a long-term, healthy eating pattern, people actually should not go hungry. A good rule to follow is to never skip a meal and to use healthy snacks if hunger occurs between meals.</p>
<p>6 Cut out breakfast.</p> <p>This is one of the worst things a person can do while trying to lose weight. As opposed to helping, studies have shown skipping breakfast is associated with overweight and obesity—and the association is greater than with alcohol consumption or levels of inactivity.</p>	<p>7 Eating certain foods—such as pineapple, ginger, garlic, chili peppers, onions, asparagus, or avocados—will speed up the body's metabolism and help burn fats.</p> <p>No foods have been found to burn fats. People need to eat a healthy diet; if it includes these foods, that's fine, but it won't increase weight loss.</p>	<p>8 Artificial sweeteners help people lose weight.</p> <p>People who drink lots of sugar-laden teas or carbonated beverages can avoid those calories by using artificial sweeteners, but most evidence shows that use of these products is actually associated with a higher body mass index and greater cardiometabolic risks.</p>
<p>9 It is possible to focus weight loss on one part of the body.</p> <p>Exercises can be used to tone particular areas of the body where people want to lose weight, but the caloric restriction needed for weight loss affect all parts of the body.</p>	<p>10 Eliminating gluten helps with weight loss.</p> <p>This is not true, and gluten-free diets are frequently low in fiber. That causes people to feel less full after meals and thereby eat more.</p>	

Sources: References 21–24.

Incorporating Current Guidelines Into Care Plans

For the past decade, clinicians have relied on an obesity treatment guideline developed by the American Heart Association, the American College of Cardiology, and The Obesity Society. Their algorithms and guidelines provide useful guidance for many aspects of obesity management, but more recent recommendations incorporate the recently marketed antiobesity medications and other clinical advances. These include Chapter 8 of the American Diabetes Association's Standards of Care in Diabetes—2023 and the American Gastroenterological Association's clinical practice guideline on pharmacological interventions for adults with obesity.^{13,14}

When caring for older adults with overweight and obesity, the clinician must personalize treatments by considering concomitant disorders, functional deficits, exercise capabilities, dietary needs, and other factors. As discussed earlier, BMIs listed in the algorithm should be combined with waist circumference (for individuals with BMI 25–34.9), clinical assessment, body shape and size, and race/ethnicity to reach a diagnosis of overweight or obesity.^{26,27}

Health care providers should also consider other factors that can affect weight homeostasis: sleep deficits and circadian rhythm disorders, mental health (social anxiety and mood disorders), infections, smoking cessation, thyroid function, and chronic inflammation.



Patients with BMIs of 40 or higher and those unlikely to reach target BMIs with diet, exercise, and most medications (especially the older agents) can be referred for bariatric surgery while other concomitant interventions are started. Getting appointments to meet with credentialed bariatric surgeons can take months. Because bariatric surgery requires the patient to make a lifelong commitment to a special diet and exercise regimen, a detailed presurgical assessment takes several months to complete. If surgery may be needed and is an option the patient would consider, the process should be started early in treatment.

Lifestyle Interventions Through Interdisciplinary Care

Diet and exercise are the two primary lifestyle factors that are addressed in treating overweight and obesity. As with other interventions for overweight and obesity, a lifelong commitment is needed to maintain the desired body size. Choosing the right regimen for older adults can be challenging when a person's concomitant cardiovascular, musculoskeletal, and respiratory conditions are considered. Involving the complete interdisciplinary team is imperative, particularly registered dietitians, nutritionists, exercise physiologists, and in some cases, physical or occupational therapists.

Body size can often be reduced by 5% or 10% with a lower-calorie diet with or without pharmacotherapy, but maintaining the target weight often requires meeting the Centers for Disease Control and Prevention physical activity guidelines for most older adults: at least 150 minutes of moderate-intensity aerobic activity such as brisk walking, at least two days a week of resistance exercise that targets all major muscle groups, and activities to improve balance such as standing on one foot.²⁸

Certain key nutrients must be prioritized when dieting for weight loss. As individuals get older, the ability to stimulate muscle protein synthesis is blunted. To combat anabolic resistance, older adults should consume 1.0–1.2 grams of protein per day per kilogram of body weight.²⁹ Additionally, older adults undergoing weight loss are at risk of losing 25% or more of lean muscle mass.³⁰ For this reason, meeting protein and resistance training recommendations during weight loss is crucial for the maintenance of muscle mass and physical function.

The body's need for calcium and vitamin D also increases with age. The Recommended Dietary Allowances (RDA; daily dietary intake level that covers the needs of ≥97.5% of the population) of calcium and vitamin D for older adults are listed in Table 3.³¹

Table 3. Recommended Dietary Allowances of Calcium and Vitamin D for Older Adults

Sex and Age	Calcium (mg/day)	Vitamin D (IU/day)
Men 51–70 years of age	1000	600
Women 51–70 years of age	1200	600
All adults 71 years of age or older	1200	800

Source: Reference 31.

Fiber is another priority nutrient. The RDA for fiber is 21 grams for women and 30 grams for men 50 years of age and older. However, many adults fail to meet these recommendations. Fiber is essential for gut motility and maintenance of gastrointestinal health and aids in managing blood glucose control and absorption of cholesterol. Further, consuming a diet rich in fiber has been associated with a reduced risk of type 2 diabetes, colorectal cancer, and cardiovascular disease. Foods high in fiber include whole grains, fruits, vegetables, legumes, nuts, and seeds. When possible, nutrients should be obtained through foods before turning to a supplement.

While it is difficult for older adults who commonly have diseases that limit their ability to participate in aerobic and resistance exercise, an onsite, high-intensity, comprehensive lifestyle program that lasts six months or more benefits participants. Such programs are associated with the maintenance of weight loss over time.²⁹ People who are not able to access such programs can set up similar programs in the home or take advantage of programs delivered using video-based technology. Home programs can incorporate periods of exercise several times per day. This approach is useful for patients with cognitive disorders, time limitations, and/or physical limitations. Older adults in rural areas have lost weight and improved physical function using technology-based obesity interventions.³¹

Antiobesity Medications

A number of new and exciting medications and combinations of older agents have changed the landscape for people with overweight and obesity. These agents are helping older adults and others achieve the requisite net energy loss when used as adjuncts to diet and exercise. Once weight loss is achieved, medications, exercise, and diet must be continued to prevent regain of the weight.

As shown in Table 4, some older drugs have adverse effects that limit their use. Orlistat acts by reducing fat absorption in the gastrointestinal tract, which causes adverse effects unacceptable to many people:

stomach pain, diarrhea, gas with discharge, inability to control stools, and fatty or oily stools. Phentermine, pharmacologically related to amphetamines, can cause dependence, hypertension, angina, and myocardial infarction.^{15,14,32,37}

Newer medications that were originally developed and approved for the management of type 2 diabetes build on the advances in understanding the role of glucagon-like peptide-1 hormone in weight management. Liraglutide, semaglutide, and tirzepatide are glucagon-like peptide-1 receptor agonists (GLP-1 RAs) that decrease gastric emptying time (making the person feel fuller longer), inhibit hunger signals from the gastrointestinal tract to the brain's satiety center, and decrease reward behavior in the brain from eating too much.

The GLP-1 RAs have produced percentage reductions in body size beyond levels expected with orlistat and phentermine. The clinical results seen with liraglutide, semaglutide, and tirzepatide (a dual-action GLP-1 RA that is also a glucose-dependent insulinotropic polypeptide agonist) make them reasonable alternatives to bariatric surgery for some people.^{33,37}

As shown in Figure 3, medication therapy may be appropriate at the beginning of treatment in people with BMIs of 30 or more and those with BMIs of 27 to 30 who also have weight-related comorbidities such as hypertension or diabetes. The drugs may also be indicated in patients whose BMIs are between 25 and 27 after the first three months of treatment if diet and exercise do not produce weight loss of 5% or more.

Medication therapy is effective for losing weight, but it does not take the place of dietary, exercise, and lifestyle interventions delivered by an interdisciplinary team. None of the interventions are effective alone; people must have a healthy, calorie-controlled diet and adequate aerobic and resistance exercise for medications to work. Success depends on interprofessional collaboration.³⁸

Success depends on interprofessional collaboration.

Table 4. Clinical Considerations With Use of Antiobesity Medications¹³

Antiobesity Medications	Use With Caution in Patients With CVD	Adverse Effects	Comments	Expected Weight Loss			
				5%	5%–10%	10%–20%	≥20%
Long-term treatment (>12 weeks)							
Semaglutide 2.4 mg ¹		GI effects (constipation, diarrhea, stomach pain, nausea and vomiting, bloating, burping, gas, heartburn); headache; lethargy; nose or throat irritation; runny nose	Contraindicated in patients with personal or family history of medullary thyroid cancer; suicidal behaviors (particularly in younger people)		■	■	
Liraglutide 3.0 mg ¹					■		
Tirzepatide ²⁴							
Phentermine/topiramate ER	Yes; monitor BP/HR	Acute myopia with secondary angle-closure glaucoma (topiramate); phentermine adverse effects are listed below.	May be preferred in patients with comorbid migraines		■		
Naltrexone/bupropion ER	Contraindicated in uncontrolled hypertension; monitor BP	Dilation of the pupil of the eye, which can lead to angle-closure glaucoma	Could have advantages in patients attempting smoking cessation or with depression Avoid/use with caution in patients with seizure disorders Contraindicated with chronic opioid therapy		■		
Orlistat		Stomach pain; diarrhea; gas with discharge; inability to control stools; fatty or oily stools	AGA recommends against use; could be useful to small minority of patients who have low target weight loss goals and do not mind GI side effects	■			
Short-term treatment (≤12 weeks)							
Phentermine	Yes; monitor BP/HR	Dependence; hypertension; angina; myocardial infarction	While approved for 12-week treatment periods, health care providers prescribe this agent off-label for longer periods	■	■		
Diethylpropion	Yes; monitor BP/HR	Has a number of contraindications and is involved in significant drug interactions Affects the central nervous system and can cause heart failure through myocardial toxicity; primary pulmonary hypertension; associated with development of valvular heart disease	While approved for 12-week treatment periods, health care providers prescribe this agent off-label for longer periods	■	■		

¹Information based primarily on ADA and AGA recommendations and information in the product labeling.
²⁴All agents other than orlistat are contraindicated in pregnancy and individuals trying to become pregnant.
¹Also lowers blood glucose and is useful in patients with diabetes.
²This agent was approved in 2022 and is not included in the guidelines of the ADA and AGA that are current in 2023.
 ADA = American Diabetes Association; AGA = American Gastroenterological Association; BP = blood pressure; CVD = cardiovascular disease; ER = extended release; GI = gastrointestinal; HR = heart rate.

Sources: References 13, 14, and 33–37.

Once an antiobesity medication is initiated, the patient should be monitored for effectiveness and side effects; the patient should know to contact the prescriber as needed during the first three months of use. A reassessment is in order if the patient has not lost 5% or more of baseline weight by three months. Adherence with the medication should be considered, along with intolerance, cost, and other reasons the patient may not be taking the medication as directed. If these factors are not present or the patient continues not to lose weight, the medication should be stopped due to a lack of efficacy and initiation of another medication should be considered.

The combinations of older drugs introduced in recent years are extended-release formulations of phentermine/topiramate and naltrexone/bupropion. Phentermine/topiramate is effective for weight loss but has the similar adverse effects and concerns as when phentermine is used alone (Table 4).^{13,14,33-37} Topiramate is an anticonvulsant agent, and patients must taper this drug combination over one week to minimize breakthrough seizures during discontinuance.³³

When these newer antiobesity medications are used to promote profound weight loss, the importance of nutritional and exercise interventions cannot be overemphasized. Sarcopenia is a real risk when weight is lost without adequate protein intake and resistance exercise for maintaining muscle mass.¹⁵

Bariatric Surgery

The decision to proceed with bariatric surgery is not a trivial one, as patients must have an interdisciplinary assessment that includes an evaluation by the surgical team, psychologist, dietitian, and other allied health staff. Patients must be psychologically prepared and fully committed to following a regimen of exercise and special diets for the rest of their lives.³⁹

For older adults, the risk-to-benefit consideration must also include: the short-term risks of surgery; the patient's ability to recover from surgery; the type of surgical intervention; the center where the surgery is being performed; the patient's social support, cognitive health, and ability to exercise and adhere to the diet given other comorbidities; and the number of years of expected life remaining for the person to enjoy the benefits of surgery.

Bariatric surgery can be considered in patients with BMIs of 40 or higher or 35 to 40 when they have comorbidities. Because bariatric surgery can be curative for type 2 diabetes—sometimes within three days—the procedure can also be considered in those with BMIs as low as 30. Other postsurgical improve-

ments are seen in weight (up to 35% weight loss), cardiovascular function, liver health, and many other systems of the body. Bone health is adversely affected by vitamin D deficiencies and increases in parathyroid hormone levels of 40% or more.²⁶ Following bariatric surgery, individuals can tolerate only a limited amount of food at a time, putting them at risk for nutrient deficiencies. Additionally, depending on the procedure, absorption of vitamin B₁₂ may be impaired and increase the risk for vitamin B₁₂ deficiencies. Education on supplements and proper nutrients is essential to avoid micronutrient deficiencies.

As with pharmacotherapy, the need for dietary, exercise, and lifestyle interventions delivered by an interdisciplinary team continues after bariatric surgery. Notably, given the complex care needed after bariatric surgery, an interdisciplinary team must be involved to address the unique health, nutrition, exercise and lifestyle, and pharmacotherapy needs of these patients.

Lifelong Management of Overweight and Obesity

In the past decade, basic and medical research has established the physiologic and hormonal causes of overweight and obesity. This has led to its recognition as a disease and not a personal decision or character flaw. For older adults, this means that with sustained dedication, they can finally take off and keep off those extra pounds. They must understand that whatever means they use to reduce their body size must be continued for the rest of their lives.

While acknowledging the lifelong challenges that patients have experienced with obesity, clinicians should engage these individuals in positive conversations about what added years of life or greater activity would mean for them. Health care providers should also provide support and encouragement and be prepared to assist patients with quickly addressing small weight gains before they become larger ones and reinforcing weight management efforts. Patients should have office visits regularly to monitor weight and interventions; weight, waist circumference, body composition, and physical strength measurements should be routine along with standard laboratory tests; and dietary interventions should be taken if sarcopenia or other nutrient or vitamin deficiencies occur. Patients may need long-term contact with registered dietitians, exercise physiologists, physical or occupational therapists, social workers, pharmacists, and other involved members of the health care team.

Conclusion

As numbers of Americans with overweight and obesity have increased, people are entering older adulthood with another serious, progressive chronic disease to manage. This creates a need for attention and resources by both patients and the interdisciplinary team caring for them.

The good news is that it's a new day for managing body size. Health care providers have the knowledge, tools, and abilities to help people whose weight is not only associated with the development of other chronic diseases but also taking years off their lives.

When the possibility is broached with the patient of making a new weight-loss attempt using contemporary approaches, the medical team must respect the journey that older adults with overweight and obesity have had. As with Charlie in *The Whale*, older adults with larger body sizes have often endured years of criticism, insults, bias, and microaggressions. These are difficult to overcome. They have likely tried to lose weight numerous times on their weight journey through dieting, exercise, and/or pharmacotherapy—only to see the weight regained.

Each interdisciplinary team member has a special role to play in helping older adults map out a plan for getting the healthy nutrition, aerobic and resistance exercise, and health care services they need. Aligning pharmacotherapy with the person's chronic conditions can reduce the possibility of adverse effects, decrease costs, and improve quality of life. Education is needed to understand treatment choices and be ready to make the personal efforts needed to live a healthier, more productive life.

Using new knowledge and interventions now available, older adults with overweight and obesity for the first time in their lives have a realistic hope of getting to the body size they want and staying there. With overweight and obesity affecting the growing number of older adults in the United States and many other countries around the world, these new tools have arrived at a most opportune time.



Resources for the Health Care Professional, Patient, and Caregiver

Related Resources From GSA

- GSA KAER Toolkit for the Management of Obesity in Older Adults
- Obesity in Older Adults: Succeeding in a Complex Clinical Situation
- GSA KAER Toolkit for Brain Health, Cognitive Impairment, and Dementia
- Malnutrition Resources and Infographics
- Sleep Health
- GSA Momentum Discussion Podcasts on Overweight and Obesity
- GSA Journals—*The Journals of Gerontology Series A and Series B, The Gerontologist, Innovation in Aging, Public Policy & Aging Report*

Other Resources

Academy of Nutrition and Dietetics

- Dietary Intake and Physical Activity Measurement Tool (Academy members only)
- Section on Weight Management
- What Resources Are Available to Assist in Assessing Body Weight in Older Adults? (Academy members only)

American Academy of Physician Associates

- Obesity Intake Form
- Obesity Management in Primary Care Certificate Program: Practice Management and Leadership Training for PAs and NPs

American Association of Clinical Endocrinology

- Nutrition and Obesity

American Association of Nurse Practitioners

- National Obesity Care Week: Increasing Access to Care
- Obesity Specialty Practice Group

American College of Occupational and Environmental Medicine

- Books and resources on obesity in the workplace; impact on employee costs and absenteeism
- Obesity in the Workplace: Impact, Outcomes, and Recommendations

American College of Physicians

- Obesity Management Learning Series

American Council on Exercise

- Senior Fitness Specialist Certification Program
- Take 5 With Dr. Amy Bantham: Move to Live More
- Fully Vaccinated? Here Are Some Guidelines for Returning to Physical Activity
- Linking Physical Activity, Therapies and Mindfulness for Healing

American Gastroenterological Association

- Obesity Awareness Highlights—Pharmacotherapy and New Initiatives
- Obesity and How It Affects GI Patients
- White Paper AGA: POWER—Practice Guide on Obesity and Weight Management, Education, and Resources

American Medical Group Association

- Obesity Care Model Collaborative (Association members only)
- Obesity Care Model Collaborative: Resource Guide (open access)

American Psychological Association

- Obesity webpage
- Links to relevant books such as *Dieting, Overweight, and Obesity*

American Society for Metabolic and Bariatric Surgery

- General information on older adults, including articles on “older adults” in the Society’s journal, *Surgery for Obesity and Related Diseases*

American Society for Nutrition

- Rethinking the problem of long-term weight management

Black Women’s Health Imperative

- Diabetes and Prediabetes

Centers for Disease Control and Prevention

- Adding Physical Activity as an Older Adult

ConscienHealth

- Affiliates and Advocates (networking and research)

Health.gov (website coordinated by the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion)

- Move Your Way Community Resources—Materials for Older Adults
- Physical Activity Guidelines for Americans Midcourse Report: Implementation Strategies for Older Adults

MedTech Coalition for Metabolic Health

- Supports view of obesity as a **multifactorial chronic disease** requiring a comprehensive approach to prevent and treat
- Founding members are seca, KORR Medical Technologies, and LEVEL

National Alliance of Healthcare Purchaser Coalitions

- [Obesity Initiative](#); actions for employers about obesity; benefit design consideration regarding bariatric surgery

National Institute of Diabetes and Digestive and Kidney Diseases

- [Stay Fit as You Mature and Health Tips for Adults](#)
- [Strategic Plan for NIH Obesity Research](#)
- [NIDDK-sponsored clinical trials on overweight and obesity](#)
- [Definition and Facts for Adult Overweight and Obesity](#)
- [Treatment for Overweight and Obesity](#)

National Institute on Aging

- [Maintaining a Healthy Weight](#)
- [The obesity-linked gene](#)
- [Overcoming Roadblocks to Healthy Eating](#)
- [Healthy Meal Planning: Tips for Older Adults](#)
- [Summaries of studies showing relationships between obesity and conditions such as dementia, sleep, loneliness/social isolation in older people](#)
- [Four types of exercise for improving health and physical ability in older adults: endurance, strength, balance, flexibility](#)

Obesity Action Coalition

- [Position Statements](#) on a comprehensive medical approach to obesity prevention and treatment, coverage by health insurance as standard benefit, and discrimination and care issues
- [#StopWeightBias Campaign](#)
- [Overview of Advocacy in Obesity](#)

The Obesity Society

- [Position Statements](#)

Trust for America's Health

- [The State of Obesity 2020: Better Policies for a Healthier America](#)

WW

- [Weight Watchers Reimagined](#)
- [Programs](#) on food, activity, sleep, mindset, personal assessment, and behavior change

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**Investing in a Healthier America: Chronic Disease Prevention and Treatment
Written Testimony for the Record
Submitted to the U.S. House Committee on Ways and Means, Subcommittee on
Health
Wednesday, September 18, 2024
1100 Longworth House Office Building, Washington, DC**

Dear Chairman Buchanan, Ranking Member Doggett, and distinguished members of the Committee:

Thank you for the opportunity to submit this testimony for the record, expressing our commitment to supporting the Food as Medicine Movement and improving society's health and well-being.

My name is Dr. A Ray Chaudhuri. I am the President of Healthful, with Roots Food Group as one of our businesses, and a former National Institute of Health scientist with years of experience in the science of cardiometabolic diseases. Founded in 2020, Roots Food Group (RFG) is a leader in the "Food as Medicine (FAM)" industry. The Company develops, markets, and distributes branded health products, focusing on personalized nutrition and technology to improve health outcomes and reduce healthcare costs.

Having delivered millions of medically tailored meals in 2024 alone, Healthful (Roots) is a leader among a select group of food companies revolutionizing healthcare through food as medicine. It pairs medically tailored meals with targeted counseling, education, and outcome measurement. The goal is to make medically tailored meals an essential part of healthcare for all ages, driving down costs and improving outcomes with quality offerings.

Recognized as a proven and outcome-driven leader in medically-tailored meals and nutritional wellness by institutions such as Medi-Cal (State of California CMS), Healthnet (division of Elevance), United Healthcare (Medicare Advantage), in discussions with the health systems within the state of New York, New Jersey and Louisiana and some of the largest employers in the United States, Roots has already transformed healthcare through innovative and tailored nutrition solutions for countless patients.

Healthful regards Food as a Movement® (Faam), a movement that combines tailored meals, targeted nutritional counseling, digital enablement, and its IAMFIT© formula to improve and expedite desired and required medical, recovery, healing, fitness, lifestyle, and mental health outcomes.

The Company is also partnering with academic groups, e.g., Columbia University, University of California, Davis, and the University of Texas Southwestern, looking at defining positive outcome measures through the use of FAM, including a study using RFoodX foods either as a supplement or replacement after patients step down from using GLP-1 drugs for maintaining weight loss. The Company has started a partnership with the Metabolic Research Center, a prominent diabetes-focused center in Florida with over 150,000 patients, led by clinicians who

previously led the Joslin Diabetes Center. Lastly, active discussions with the military are underway to provide current warfighters and veterans with personalized, healthy meals.

Promoting "Food as Medicine" is integral to Healthful's FaaM mission. Its platform, RFoodX, designs and develops high-quality, allergen-free, health-conscious, and nutritionally balanced breakfast and entrée meals for those suffering from chronic medical conditions, recovering from surgery, childbirth, or extended hospitalizations, experiencing unexplained physical or mental changes, seeking preventative care, and aspiring to healthier lifestyles.

RFoodX develops the recipes, designs the meals, and then, via partners, manufactures the food in licensed, certified, and FSQA-approved plants to achieve the highest nutritional guardrails and most stringent healthcare requirements.

RFoodX complements its tailored meal solutions with its digital enablement tools, counseling solutions, and IAMFIT© algorithm to improve individual health outcomes and reduce healthcare costs.

THE NEXT GENERATION OF PREVENTION: FOOD, THE MICROBIOME, AND GUT HEALTH

Each life is priceless, and in economic terms, over the last two centuries, as much as 50% of all economic growth can be traced to advances in health.

A. The Current Environment

We are at a watershed moment in this country with the explosion of chronic disease, out-of-control spending on healthcare, and an inability to hit military recruitment numbers due to obesity and fitness. Nutrition and diet-related chronic diseases are skyrocketing, leading to predictions this will be the first generation of children to live shorter lives than their parents. Pressures on government and private sector budgets increase daily, with the inflationary impact on the cost of food and chronic disease approaching 90% of the healthcare spend of \$4.5 trillion in 2022.

Numerous barriers exist to access nutritious food, biopharmaceutical and device innovations, medical interventions, and diagnostic testing, making early diagnosis and treatment challenging to implement. We have a fractured infrastructure with misaligned incentives, health literacy is a concern, broadband is not universally available in rural and urban areas, and chronic disease is impacting vulnerable populations, complicating the ability to provide nutrition, early detection, prevention, and innovative treatment.

B. TOOLS TO PREVENT, DELAY, DETECT AND TREAT DISEASE

According to Mike Milken, a thought leader in public health, cancer survivor, and Chairman of the Melanoma Research Foundation and Prostate Cancer Foundation Boards, "dedicated researchers seek better treatments and cures for diabetes, kidney disease, Alzheimer's and every form of cancer. But these scientists face an array of disincentives. We can do better." As a long-time supporter of food as a medicine, he believes that good health requires healthy eating. If we follow this approach, we can avoid cancer and cardiometabolic diseases or delay their onset by starting a good diet early in life.

Gut health is critical and significantly impacts human health. The gut microbiome is a collection of nearly a trillion microorganisms, mainly bacteria, fungi, viruses, and their genes, that live primarily in the large intestine and can help prevent or delay the onset of disease.

The Merck Manual defines prevention as primary, secondary, and tertiary. In primary prevention, a disorder is unable to develop. With secondary prevention, disease detection, and early treatment, often before symptoms are present, severe consequences are minimized. In tertiary prevention, managing an existing, usually chronic, disease prevents complications or further damage. For example, efforts to treat Covid found an increased risk to infected patients who lived a sedentary lifestyle or were living with one or more cardiometabolic diseases. Many of these risks, such as obesity, diabetes, and cardiometabolic disease, were preventable and treatable.

C. FOOD AS A MEDICINE

A study published in a January 2021 [Nature Medicine Journal](#) identified the associations between microbes, specific foods, and food groups and how they can impact disease. The gut microbiome, however, is unique to everyone, making this a complex but solvable health issue by including the right foods for the individual.

Today, we can help many with medically tailored meals and others by offering innovative ways to deliver food to meet the needs of those in food deserts. Healthy and nutritious foods are a simple and, for many, low-cost remedy for preventing or delaying the onset of many diseases, leading many to suggest and promote the concept that supermarkets will become the pharmacy of the 21st Century.

D. MEDICAL INTERVENTIONS, EARLY DETECTION AND DIAGNOSIS

The promise of science and technology has never been more significant. The discovery and development of breakthrough innovations will continue to support the treatment and prevention efforts of providers, the medical community, and payers to offer appropriate interventions for a diagnosed disease. Several biopharmaceutical companies are addressing conditions of the gut microbiome, and most recently, a biopharmaceutical company received FDA approval to treat C- Diff infections.

New screening models, state-of-the-art testing capabilities developed by the diagnostics industry for cancers and infectious diseases, and innovative medical devices for patients and medical practitioners will help deliver earlier detection and more accurate diagnosis.

E. WINNING THE BATTLE TO WELLNESS

It is critical to provide the medical community and patients with the right tools to reduce the health and economic burden of illness. Although the reasons for the increased prevalence are complex and differ from community to community, one thing is clear: our current treatment-focused approach to improving health rather than utilizing prevention tools isn't working, and the toll in economic costs and human suffering is untenable.

The traditional tools to treat or delay the acceleration of disease that are part of our medical toolkit today will continue in the future as long as the biopharmaceutical, diagnostic, and device

industries enjoy the necessary patent protection, and the medical community receives the appropriate reimbursement for its contribution.

To reduce future costs and improve wellness, we need to include gut health and the microbiome in the conversation. We must accelerate access to healthy foods, prioritize prevention efforts, elevate the role of community health workers, provide innovative therapeutic and medical interventions to patients, and improve diagnostic testing and early detection. Educating the public about gut health and the importance of eating healthy foods will prevent or delay illness and reduce the cost of disease.

F. THE PROBLEM

Most healthcare industries focus on "sick care" rather than disease prevention and "well care." With insurance costs escalating and outcomes marginally improving, nearly 200 million people in the United States are chronically ill, resulting in 90% of our healthcare expenditures of \$4.5 trillion used to treat chronic disease. With the growing obesity epidemic and the increased number of individuals with other cardiometabolic diseases, these costs are not sustainable.

G. HEALTHFUL'S SOLUTION

Healthful deploys RFoodX across the United States to improve individual health and reduce healthcare costs. These meal-based offerings are long-term health investments that are endorsed by health experts and insurers and supported by state governments. While food is a medicine, it is essential to emphasize that "food drives healthcare," and our diet impacts our health and wellness. With nutritional foods and innovative drug treatments, we offer patients, physicians, and payors the tools needed to prevent or delay the onset of disease, improve health outcomes, and reduce healthcare spending.

At Roots, we have achieved several measurable outcomes: 32% net healthcare savings, 50% medication adherence, a 63% reduction in hospitalization, and 23% more likely discharge to home. As a socially committed company, Roots donates 10% of its net profits to initiatives that address food insecurity and SDOH disparities.

H. CONCLUSION:

Healthful appreciates the bipartisan approach by the Committee to this healthcare crisis. We view this hearing as a call to action for the country to proactively address the unmet medical needs of the population, reduce the burden of chronic disease, and protect our national security.

While the United States has one of the sickest populations in the world we continue to embrace a sick care delivery system. This way of delivering health must change, and over the next decade, we need to adopt health policies and prevention tools that transition us to a well-care system.

Health education is critical to identifying the necessary solutions. We need to adopt a sense of urgency across the country to educate current and future medical professionals, payers, and the patient population on the health value of a healthy and nutritional diet. Some of this will take

place in an academic setting, while most of the education will take place in the local communities.

Medically Tailored Meal pilots with state and local medical facilities and employers can accelerate improvements in health outcomes, provide essential insights, and engage patients in their health outcomes.

The recent creation of the Prevention and Wellness Caucus can offer innovative policies that lead to solutions that will prevent or delay the onset of chronic diseases and result in healthy aging.

Thank you for the opportunity to submit my testimony. Healthful looks forward to working closely with the Committee to deliver policies supporting Food as Medicine, Healthy Eating, and the next generation of prevention focused on oral, gut, and brain health.



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October 2, 2024

US House Committee on Ways and Means
Subcommittee on Health
1100 Longworth House Office Building
Washington D.C. 20515

Dear Chairman Smith (MO-08), Health Subcommittee Chairman Buchanan (FL-16), and members of the Committee,

Thank you for the opportunity to provide comment on innovative ways to reduce and prevent chronic disease in America. As a nonprofit organization and a provider of ACCME-accredited continuing education for more than 30 years, The Institute for Functional Medicine (IFM) has a unique perspective on ways to improve the current healthcare system and position the next generation of clinicians to reduce the epidemic of chronic disease.

Background and Current Challenges

Scientific advances in medicine continue to provide life-changing options in acute care. However, in the United States, life expectancy continues to decline, mental health needs are rapidly increasing, chronic disease is on the rise, and **Americans are more “health-vulnerable” than ever before due to nutrient-poor diets, increasingly sedentary lifestyles, chronic stress, environmental toxins, and poor sleep habits.** Over the last several years, a number of approaches for solving the healthcare crisis have emerged. Thoughtful review of publications from the National Academies of Sciences, Engineering, and Medicine (NASEM), including *Improving Diagnosis in Health Care*¹ and the *Achieving Whole Health: A New Approach for Veterans and the Nation*,² succinctly highlight key areas of failure in our system **and** outline the benefits of taking a whole health approach to patient care. Identified failures include:

- Failure of the “disease model” of care, which is focused on living with or managing chronic disease rather than disease prevention or reversal and the promotion of overall health and well-being.
- Inequities in access and delivery of care due to a disproportionate focus on economics rather than health outcomes.

¹National Academies of Sciences, Engineering, and Medicine. *Improving Diagnosis in Health Care*. The National Academies Press; 2015. doi:[10.17226/21794](https://doi.org/10.17226/21794)

²National Academies of Sciences, Engineering, and Medicine. *Achieving Whole Health: A New Approach for Veterans and the Nation*. The National Academies Press; 2023. doi:[10.17226/26854](https://doi.org/10.17226/26854)

- Failure to truly understand upstream causes of chronic disease (social determinants of health, lifestyle behaviors, and poor nutrition, etc.) and how to develop personalized therapeutic interventions that modulate the impact of these factors.
- Failure to understand how care delivered through interprofessional teams improves outcomes and how to train clinicians in this approach.

Whole Health and the Role of Functional Medicine in Reducing Chronic Disease

Since 2020, IFM has worked in [partnership](#) with the VA New Jersey Whole Health Flagship in the development of education and patient content for the functional medicine-supported Whole Health Initiative working with diverse veterans who are living with poorly controlled type 2 diabetes. Through this program, we are changing the conversation to focus on what matters to the veteran, increasing self-awareness, building health skills, and implementing interventions designed to treat the whole veteran, not just the illness. Grounded in the question, “What matters to you?” the VA’s Whole Health Initiative takes a collective impact approach to health by bringing together conventional and complementary (including functional and integrative medicine) approaches to care with social services and public health in order to provide the best possible care for our growing veteran population. The NASEM report champions the VA’s Whole Health Initiative through its recommendations to expand and scale this approach across the nation by leaning into five foundational elements for effective whole health systems. These elements include:

1. Be **whole-person centered** by focusing on each person’s individual needs, goals, and priorities in the context of family, community, and cultural environments.
2. Be **comprehensive and holistic** in the provision of services that address each person’s well-being by incorporating conventional and complementary (functional and integrative) medical care models that assess and address not only physical health but also the mental health, spiritual health, and the social needs of the patient.
3. Be **upstream-focused**, addressing health behaviors, the root causes of poor health, and the social and structural determinants of health.
4. Be **equitable and accountable** for people, families, and communities while proactively engaging them and their existing resources in addressing their individual prioritized needs
5. Be **attentive to the well-being** of the entire interprofessional care team.

The information provided below specifically highlights how functional medicine is supporting change in these areas.

How Does Functional Medicine Provide Support?

Functional medicine is a personalized, systems-based approach to health care that seeks to identify and address root causes of disease and dysfunction. It considers the complex interactions between genetics, environment, and lifestyle for each individual, targets the underlying imbalances causing symptoms, and seeks to restore balance to promote optimal health and well-being. This healthcare approach promotes cost-effective, preventive care based on current science, evidence, and clinical reasoning. Functional medicine addresses the root causes of chronic diseases, thereby reducing the long-term burden on the healthcare system through personalized, patient-centered strategies.

More specifically, the functional medicine approach provides a clinical method for practitioners to:

1. **Gather** and organize information about the patient through questions, physical exams and testing that probe beyond diagnosing disease and enable clinicians **to discern and evaluate** the root causes (antecedents, triggers, and mediators) of the individual's physiological dysfunction and imbalances (the underlying cause of their condition/symptoms), regardless of disease label.
2. **Communicate** and convey to the patient, in understandable language, **how the root causes are leading to their physiological condition**.
3. Go beyond "what is the matter with the patient" to **discover "what matters to the patient" to inform the appropriate care path of therapeutic interventions** in support of their desired health journey and goals.
4. Go beyond treating symptoms by **deploying personalized therapeutic interventions** (including functional, integrative, and naturopathic medicine, use of nutraceuticals and botanicals, modifiable lifestyle factors, conventional medicine, and pharmaceuticals) **that modulate physiological disturbances** in order to restore healthy function and reach their "what matters to them" health goal.

Studies from the [Cleveland Clinic Center for Functional Medicine](#) indicate a functional medicine approach, including involvement of an interprofessional care team, improves patient outcomes and reduces the costs of health care. Please see the link provided here for more information about [functional medicine](#).

What Else Is Needed?

Changing the trajectory of patient care by fully embracing the recommendations of the NASEM report on whole health² requires systemic changes in healthcare in several areas including practitioner education, delivery of care, patient accessibility, insurance coverage, and support of overall provider well-being. Concrete steps to ensure these changes require lawmakers and all truly interested in health equity, improved patient outcomes, and lower healthcare costs to:

- **Support provider education that trains clinicians in root-cause models of care.** As a provider of functional medicine education, [IFM](#) supports requiring education (pre-licensure and continuing education) for practitioners about root-cause models of care provided by functional, naturopathic, and integrative medicine, including nutrition, lifestyle, non-pharmaceutical interventions, and a deeper understanding of social determinants of health alongside conventional standards of care.
- **Support the role of interprofessional care teams and the use of shared medical appointments in the delivery of patient care.** Studies show that patient care delivered by all members of the interprofessional care team supports effective and efficient patient care and better patient outcomes.
- **Ensure the ability of health professionals to perform at the top of their scope of practice.** At the State level, ensure all clinician types are able to practice at the top of their scope of practice or licensure, including naturopaths, pharmacists, physician assistants, etc.
- **Require insurance coverage that supports the financial sustainability of whole health care and that places the highest value on improved health outcomes.** Ensuring payor support and coverage for true preventive/root-cause approaches to health restoration and wellness alongside screening is critical. Payor policies that require patient education to build the skills of health and incentivize wellness will lead to patient success and sustainable programs.

- **Lead changes in food policy that align with the benefits of nutrient-dense food.** Support nutrition access programs that deliver nutrient-dense (NOT calorie-dense) food for patients and patient education programs that develop skills for how to access and prepare nutritious food.
- **Support health equity programming and policy that ensures access to health and wellness for families and community wrap-around services.** To truly change public health for individuals and families requires more support for the individual. Health care extends past the therapeutic encounter with a provider. Support the creation of communities of impact by involving community leaders, hospitals, academic institutions, nonprofits, businesses, and providers investing in the health of the individual and the community.
- **Support healthcare providers by requiring whole health approaches to care for both the practitioner and patients.** Whole health/root-cause approaches to care allow practitioners to focus on the art of healing patients, not the business health.

Today, fewer young people are enrolling in health professions, and practitioner death by suicide is on the rise. This, along with the declining health of Americans and the rising cost of health care, makes the current model unsustainable. Real systems change is critical to reversing these catastrophic trends. Supporting the recommendations of the NASEM for the whole health model of health and well-being provides a road map for necessary and required change. Please let us know if you have questions about the provided materials. We stand ready to support and serve in moving this vital work forward.

###

About The Institute for Functional Medicine (IFM)

As the leading voice for functional medicine for more than 30 years, IFM is advancing the transformation of health care for patients and practitioners worldwide. IFM supports the confident and competent practice of functional medicine through high-quality education, industry-leading certification programs, partnerships across medical disciplines, and advocating on behalf of functional medicine clinicians and patients around the globe. IFM is a 501(c)(3) nonprofit organization, providing education directly accredited by the Accreditation Council for Continuing Medical Education (ACCME). For more information, read our [IFM one-pager](#) or visit [IFM.org](https://www.ifm.org).

Chairman Jason Smith
1139 Longworth House Office Building
Washington, DC 20515

Ranking Member Richard Neal
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Smith and Ranking Member Neal,

I am writing to you today as co-chair of the Health Equity Coalition for Chronic Disease to request that the attached reports *Coverage of AOMs is Cost-Effective and a Smart Investment* and *Comprehensive Care Necessary to Successfully Treat Disease of Obesity* be submitted to the hearing record as part of the Health Subcommittee's hearing, *Health Subcommittee Hearing on Investing in a Healthier America: Chronic Disease Prevention and Treatment*.

We applaud the subcommittee's attention to the critical need for preventative chronic disease care and we echo the subcommittee's call for increased access for nutritious foods for vulnerable communities. However, any conversation about chronic disease must include a discussion about obesity. Obesity has been recognized as a progressive and chronic disease state by the American Medical Association since 2013. Additionally, obesity increases the risk of other chronic diseases such as diabetes and kidney disease.

Preventing chronic disease means treating obesity. By treating the underlying disease of obesity, we can reduce the increased risk of chronic disease or other comorbid conditions such as cardiovascular disease. Preventative care could reap as much as \$100 billion per year of social benefit in the form of reduced healthcare spending and improvements in quality of life. Furthermore, a USC Schaffer Report found that Medicare coverage of weight loss therapies would save the program \$175 billion in the first ten years alone.

We ask the subcommittee to please submit to the record two reports written by the Health Equity Coalition for Chronic Disease which demonstrate the high cost of inaction and the need for both expanded access to nutritious foods as a part of comprehensive obesity care.

Sincerely,



Dr. Elena Rios, MD, MSPH, MACP

President

HECCD



Comprehensive Care Necessary to Successfully Treat Disease of Obesity

September 2024

To treat obesity we need to first treat hunger.

In 2023, [42.4%](#) of the United States' adult population had obesity and [9.2%](#) had severe obesity. The rates of obesity increased substantially over recent decades and have [continued to climb since the COVID-19 pandemic](#). A December 2023 [Gallup survey](#) showed the obesity rate increased by 6 percentage points from 2019 to its current level of 38.4%. Similarly, the [prevalence of Type 2 diabetes](#) — a known consequence of obesity in many individuals—increased from 10.3% of U.S. adults between 2001-2004 to 13.2% in the 2017-2020 time period.

Significant [lifetime racial disparities](#) in the prevalence of obesity are apparent in early childhood and progress through adulthood. "An analysis of the National Health and Nutrition Examination (NHANES) survey from [1999 to 2016](#) demonstrates that Black and Hispanic children and adolescents had the highest prevalence of obesity for all years between 1999 and 2016". Approximately 4 out of 5 African American women have obesity—a body mass index (BMI) over 30—making obesity one of the most [urgent and growing health epidemics](#) in the Black community. "Millions of Black people are facing the physical, emotional, and financial impacts of living with obesity, [more so than any community nationwide](#)," notes Martha A. Dawson, President/CEO of the National Black Nurses Association. Approximately [45.6% of Hispanic adults](#) live with obesity—the second highest rate of obesity when compared to other ethnic or racial minority groups in the U.S. Furthermore, [78.8% of Hispanic American women](#) are overweight or obese, as compared to 64% of non-Hispanic white women.

Low Income Increases Obesity Risk

[Healthy eating](#) is associated with lower rates of obesity. However, people experiencing poverty struggle to regularly afford critical healthy food items such as proteins, raw fruits, and vegetables. Additionally, an unbalanced diet and lack of access to safe places to exercise limits opportunities for physical development and increases the risk of obesity. A League of United Latin American Citizens report noted that the higher rates of obesity in the Latino community are linked to several factors, "including [lack of access to affordable healthy foods](#), safe places to exercise/play, stable and affordable housing and access to quality health care and social or cultural attitudes about body weight."

"Obesity rates among Latino kids are skyrocketing, way ahead of any other racial/ethnic group, and it's a serious problem. Low-income families are struggling hard with slashed SNAP/EBT benefits. Because of these cuts, they're eating fewer fruits and vegetables and opting more for calorie-heavy foods. If we don't tackle both hunger and offer better obesity management tools like AOMs, we can expect these troubling trends to keep climbing and obesity rates among Latino youth to keep soaring."

-Dr. Ray Serrano, LULAC



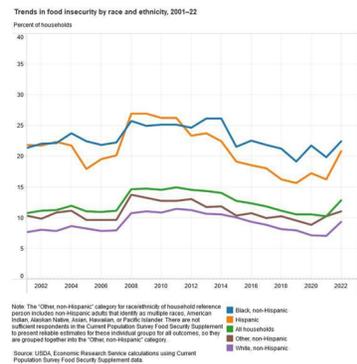
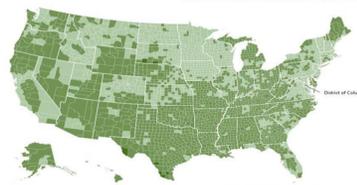
High rates of consumption of low-nutritional value and high calorie food is often a function of the lack of financially and geographically feasible access to more nutritious options. Furthermore, there is a growing body of evidence of the [link between the consumption of ultra-processed foods and an increased risk of obesity](#) along with other adverse health outcomes. While it may seem counterintuitive that people who struggle to maintain access to sufficient or nutritious food are at higher risk for obesity and malnutrition, the reality is that due to limited options and the expense, "highly energy-dense processed foods that are [high in saturated fats, sugars, and sodium are consumed more often](#) than micronutrient-dense quality foods ... energy-dense foods may help meet daily caloric requirements, but essential nutrients are missing." This results in a range of issues including micronutrient deficiencies and obesity in adulthood.

"The [coexistence of both obesity and food insecurity](#) has drawn the attention of researchers since it seems contradictory that people with limited access to food can become obese."
 -Diana Carvajal-Aldaz, Gabriela Cuccalon, and Carlos Ordóñez

Increased Rates of Food Insecurity in Vulnerable Communities

Food insecurity occurs when a supermarket is too far away or the food sold is too expensive to purchase. Insufficient [food environments](#) (such as food deserts or high fast-food density) which contribute to obesity are [disproportionately present](#) in areas with a larger population of racial or ethnic minorities. Groceries sold in food deserts are often more expensive and low-income families spend a larger percentage of their income — [2 out of every 6 dollars](#) — on food each year. These factors further increase the risk of food insecurity. [8 of the 10 counties](#) with the highest food insecurity rates in the nation are at least 60% Black. "In 2022, 12.8 % percent—or 17 million—of U.S. households were food insecure. ... [some groups are more likely to have food insecurity than others](#), including households with children (17.3% food insecure), Black households (22% food insecure), and Hispanic households (21% food insecure)." According to the League of United Latin American Citizens, nearly one-third of Latinos reported eating two or fewer servings of fruit and vegetables a day and [40% said that fruits and vegetables are too expensive](#).

When focusing on America's youth, the disparities are stark: [Forty-six percent](#) of Hispanic/Latino youth in the United States are food insecure; which is double the national average. Furthermore, "youth living in those food insecure households had a [higher mean body mass index \(BMI\)](#) ... than their food-secure peers".



Lifestyle Change and its Role in Treating Obesity

"New anti-obesity medicines are an important tool. But true health is not just about a number on the scale. Widespread adoption of the principles of lifestyle medicine would [reduce health care costs, reverse recent declines in U.S. life expectancy and transform lives](#)." It has been shown that when [combined with lifestyle changes](#), beneficiaries who take anti-obesity medications (AOMs) lose 5% to 12% more weight than those whose obesity treatment protocol does not include prescription medications.

Nutritional counseling and sustained access to healthy food options play important roles in a comprehensive approach to treating obesity. Additionally, package inserts for GLP-1s explicitly state that AOMs should be prescribed in combination with increased physical activity and a reduced-calorie diet. "[GLP1s] can take care of weight loss for us, so our focus should not be on how much activity we need to do to lose more weight; it should be about all the [other things the activity does that the weight loss medications don't do](#)." To achieve the best results, the standard of care should include patient [access to nutrition information and personalized physical activity plans](#).

Improved Outcomes Achieved When Pairing Nutrition and Lifestyle Changes with AOMs

Obesity is an epidemic, but it doesn't have to be. It is a preventable and treatable disease. "Groups with the highest rates, often populations of color, typically [face structural barriers to healthy eating](#), including food cost and access, and a lack of opportunities and places to be physically active." It is unacceptable and tragic that not all patients receive the standard of care for the disease of obesity which includes a range of interventions beginning with nutritional counseling and exercise plans and when necessary, extending to surgery and the use of Food and Drug Administration (FDA)-approved AOMs. "Medical approaches [to the treatment of obesity] impact physiologic pathways to [support the success](#) of behavioral approaches." Similarly, behavioral approaches to treating obesity can improve weight loss-adjacent outcomes that are not addressed by medication. Thus, the ["two approaches are complementary and must coexist"](#) if we are to make a significant, population-level impact on the obesity epidemic." Research has shown that patients who "received [combined supervised exercise and GLP-1 receptor agonist treatment](#) had maintained weight loss and body-fat reduction, in contrast to weight regain for participants who had previously received GLP-1 receptor agonist alone". For example, those who engaged in [exercise after terminating](#) a GLP-1 maintained a weight loss of 5.1 kg and had 3% less body fat. Additionally, those who make positive lifestyle decisions, including exercising, eating well and not smoking, may reduce their [incidence of coronary artery disease](#) by over 80% and Type 2 diabetes by more than 90%.



To achieve long-term, sustained outcomes it is crucial to pair medical and behavioral interventions by combining nutrition and lifestyle changes with the use of AOMs. The use of lifestyle-based treatments alone “do not address [the physiology of obesity](#)” and it is similarly insufficient to simply prescribe AOMs and exercise without addressing [environmental factors](#) such as economic stability, access to resources and the built environment. Addressing more [malleable targets](#) such as nutritional knowledge, self-monitoring, and cooking skills can be effective, but sustained patient success is often contingent upon patient’s being able to fend off additional social determinants of health, available food, and lived environments.

Legislative Avenues to Address Disparities and Improve Outcomes

While considering how to address our nation’s obesity crisis it is imperative to also note that policies which singularly address “more malleable targets such as [nutritional knowledge, self-monitoring, and cooking skills](#) can be effective”, but sustained improvement is often contingent upon patient’s being able to access nutrition and affordable food, transportation, and personal safety. Put simply, we can not solely rely on individual behavior changes when underlying inequities prevent individuals from the ability to change their own behavior. Without environmental changes that address social determinants of health relying on individual behavior changes will only widen disparities.

Nutrition Benefits

As laid out above, obesity and [food insecurity](#) are intertwined contributors to the current obesity epidemic. Policy makers are beginning to respond. A number of bills have been introduced this Congress which seek to provide increased support for sustained access to healthy foods.

Expanding access to healthy foods starts with expanding access to crucial nutrition services such as USDA’s Supplemental Nutrition Assistance Program (SNAP). Lawmakers should pass the Improving Access to Nutrition Act ([H.R. 1510](#)) which would repeal benefit-limiting work requirements for adults on SNAP who have no dependent children; restrictions which limit SNAP benefits to 3 months over a 3-year period are short-sighted as food insecurity clearly leads to poorer health outcomes and increased public costs. Within SNAP are additional programs such as the Gus Schumacher Nutrition Incentive Program (GusNIP), which incentivize the purchase of fruits and vegetables by income eligible consumers. The *OH SNAP, Close the Fruit and Vegetable Gap Act* ([H.R. 4149/S. 2015](#)) and the *GusNIP Expansion Act of 2023* ([H.R. 4856](#)) would expand the GusNIP program by increasing overall funding to the program and expanding grant opportunities.

There are additional ways beyond SNAP that the federal government can and should utilize to provide healthy foods. The bipartisan *Medically Tailored Home-Delivered Meal Demonstration Pilot Act* ([H.R. 6780/S. 2133](#)) would provide medically tailored, home-delivered meals to Medicare beneficiaries who have diet-impacted disease after they are discharged from the hospital. The intent of the pilot is to evaluate clinical outcomes and costs as well as its impact on hospital readmissions. The DINE Act ([S. 4731](#)), which expands Food is Medicine as

“Our patients will benefit most if we can learn to [pair lifestyle interventions with pharmacotherapy](#) to both optimize health outcomes and help them maintain lower body weights.”

– Kristina Lewis,
Justin Moore, and Jamy Ard.



part of the Older Americans Act, would also help expand nutrition coverage. Additionally, the Bipartisan Primary Care and Health Workforce Act ([S.2840](#)) would also support Food is Medicine programs at Community Health Centers.

In addition to ensuring that people will be able to purchase nutritious food, policymakers should also enact laws to expand coverage of medical nutrition therapy—treatment that uses nutrition education and behavioral counseling to prevent or manage a medical condition. The bipartisan *Medical Nutrition Therapy Act* ([H.R. 6407/S. 3297](#)) seeks to include obesity in the list of diseases eligible for nutrition therapy services covered under Medicare and provided by a registered dietitian or nutrition professional.

Coverage of AOMs

In addition to stigma and bias, additional road-blocks to care for the disease of chronic obesity include gaps in health care coverage and limits on Medicare beneficiary access to standard of care treatment options such as effective, life-changing AOMs/GLP-1 medications. FDA- approved AOMs are a covered treatment option for individuals who receive health benefits from the [Veterans Health Administration](#), [TRICARE](#), all [Federal Health Employee Benefit \(FEHB\) plans](#), and through the [Indian Health Service](#). While Medicaid, and commercial payer coverage of AOMs varies by state and plan, a growing number of private and state-run plans have recognized the impact and value of medicines used to treat the disease of obesity and offer coverage for AOMs. These coverage gains are impactful and life-changing. It is unreasonable for patients on these plans to lose coverage for — and therefore access to — the AOMs they need when they turn 65 and enroll in Medicare. To achieve parity in coverage and expanded access to intensive behavioral therapy for obesity, Congress must pass the bipartisan *Treat and Reduce Obesity Act* (H.R.4818/S.2407).

Successful Treatment of Obesity Requires Comprehensive Approach

The chronic disease of obesity is treatable, yet results in [staggering costs](#) to society and the health care system. Additionally, clinical evidence [suggests treating obesity](#) would reduce the risk of other complications of the disease and costly comorbidities. Medications are very effective for the treatment of this [21st century epidemic](#)—the disease of obesity—but they alone will not be able to address the root causes nor permanently reverse the trends.

The Obesity Medicine Association makes it clear that, "obesity is a chronic disease that requires comprehensive care, [including nutrition, physical activity, behavioral modification, and medical management](#)." However, effective tools are not available to all who would benefit from them. Insightful policies and interventions should build upon [the understanding](#) that individuals in food insecure households are at risk of developing obesity. Furthermore, it is important to recognize that due to limited access to care and cost, current treatment options for the disease of obesity which "include nutrition, physical activity, behavior modification, pharmacotherapy, and surgery [are underutilized in communities of color](#)". HECCD encourages policy makers to consider these risk factors and obstacles when developing the more comprehensive policies needed to address our nation's obesity crisis.



Coverage of AOMs is Cost-Effective and a Smart Investment

June 2024

The cost of inaction on obesity care is over **\$100 billion** a year.

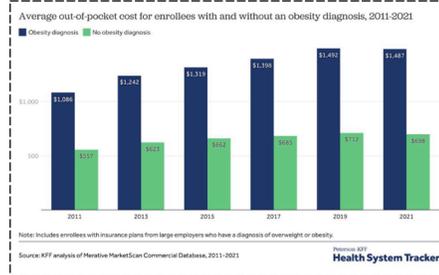
Obesity is a chronic disease with enormous impacts on a person's health that also increases economic challenges for patients and their dependents. The standard of care in obesity medicine has improved dramatically in recent years. In addition to intensive behavioral therapy and bariatric surgery, there are now more non-surgical alternatives. Access to these treatments is limited by insurance.

Rather than focusing on what can be gained by increasing access to treatment, the current policy conversation is overly focused on the cost of treatment alone and not the savings associated with treatment. Providing coverage to treat the disease of obesity will ultimately drive down costs for patients and our health care system. Obesity treatment is an investment in the well-being and health of patients, their families, and their caregivers, as well as the American economy. Policies that continue to pose barriers to treatment impose devastating costs on the health care system, the economy, and people living with the disease of obesity. This must change.

Obesity Leads to Significant Financial Strain on Individuals Living with the Disease

People living with obesity earn less and are also less likely to be hired—the impact of which is [most stark for women](#) living with the disease. While U.S. law protects against workplace discrimination on the basis of race, religion, age, and gender, discrimination on the basis of weight is legal. [This kind of discrimination and stigma](#) is not uncommon and has a significant financial impact on people with obesity and their families. The cost to individuals of living with the disease of obesity has reached record highs. For those with insurance, out-of-pocket expenses, particularly copays and high deductibles for the range of treatments available for the disease of obesity, pose a significant financial burden on patients.

This burden is compounded by additional out-of-pocket costs for the treatment of common comorbid conditions, such as diabetes, hypertension, and musculoskeletal pain and dysfunction. [Out-of-pocket health care costs](#) for patients diagnosed with obesity rose by 37% over the last decade—and that's just for those with private insurance. Sadly, many Americans' insurance provides little to no coverage for leading obesity treatments.



Health System Tracker



Costs of Obesity on the Health System are Devastating and Growing

In 2016, an estimated [180.5 million people](#)—or 60.7 percent of the U.S. population ages 2 and over—had obesity or overweight; as a result, the total cost of chronic diseases due to the disease of obesity and overweight was [\\$1.72 trillion—which is equivalent to 9.3 percent](#) of the U.S. gross domestic product.

Obesity places a tremendous strain on the healthcare system. The Centers for Disease Control and Prevention (CDC) reports that annual medical [costs for adults with obesity were \\$1,861 higher per person](#) compared to adults without obesity or overweight. Further, annual medical costs increased with the severity of the disease. For adults with severe obesity, annual costs were an [additional \\$3,097 per person](#). The average one-year cost of coverage [for a patient with obesity was \\$56,468](#), compared to the average cost of [\\$4,674 for the other 90% of patients](#). A study in the Journal of Managed Care and Specialty Pharmacy showed "the effects of obesity [raised costs in every category of care](#): inpatient, outpatient, and prescription drugs."

"The effects of obesity raised costs in all major categories of medical care ... which represents an economic rationale for government intervention."

-Cawley et al. Journal of Managed Care and Specialty Pharmacy

Coverage of Obesity Care would Save Lives and Resources

Disparities in access to medically necessary obesity treatments is a major health equity issue. If all eligible Americans were able to access weight-loss therapies to treat obesity, the resulting reduced disability and pain could enable society to reap as much as [\\$100 billion per year of social benefit](#) in the form of [reduced healthcare spending](#) and improvements in quality of life.

Coverage of obesity care would profoundly reduce costs to the healthcare system. A reduction in the prevalence of obesity would reduce the prevalence of the numerous comorbidities linked to obesity. Comorbidities themselves have enormous costs: direct medical costs for diabetes totaled [\\$306.6 billion in 2022](#), and loss of income due to cardiovascular disease (heart attack or strokes) cost a total of [\\$266.9 billion in 2018](#).

Furthermore, providing coverage upon a diagnosis of obesity for necessary and standard-of-care treatments will improve outcomes and address the related comorbidities—thereby reducing the overall costs to payors—whether that is the federal government or a private insurer.

A USC Schaeffer Center white paper, "Benefits of Medicare Coverage for Weight Loss Drugs," finds that, "in the first 10 years alone, Medicare coverage of weight-loss therapies would [save the program \\$175 billion](#)" (and up to \$248 billion if private insurance would also cover the treatments). "Over 60% of these savings would accrue to Medicare Part A by reducing hospital inpatient care demands and the demand for skilled nursing care. Given these findings, policymakers should [consider the societal benefits of lifting the moratorium on Medicare coverage](#) for weight-loss drugs."

New Information on the Actual Costs of Anti-Obesity Medications

Too often we see analyses that overestimate the costs of anti-obesity medicines (AOMs) to the health care system and to patients. News articles and analyses often frame the discussion by suggesting that the ultimate cost of AOMs is their list price. For example, a recent [Kaiser Family Foundation analysis used gross costs](#), without considering commonly used rebates or other price concessions which lower costs. However, it is well known that manufacturers negotiate price concessions or offer rebates which reduce the cost for payers.

Net Price vs. List Price

[Research](#) conducted by Benedic N. Ippolito, an economist at the American Enterprise Institute (AEI), and Joseph F. Levy, a health economist at Johns Hopkins Bloomberg School of Public Health, estimated the net prices of various AOMs. For Wegovy, the estimated net price is around [\\$700 a month which is \\$650 less than the list price](#).

The number of specialized AOM products available is only growing. This class of medications is increasingly competitive with new therapies expected to enter the market over the next several years.

“My prediction is that as competition increases, prices will decrease accordingly.”

*~Jalpa Doshi
professor of medicine and director of
the economics evaluation unit at
The University of Pennsylvania*

CMS Has Tools to Manage Costs

Drug utilization management tools are used by Medicare to help ensure cost-effective use of prescription drugs. This point is often left out of the debate over Medicare coverage of AOMs. A [recent Kaiser Family Foundation study](#) found that of the few Marketplace plans that cover GLP-1 drugs approved for obesity, all require prior authorization. Medicare plans would likely use prior authorization and other utilization management tools. In addition, the Inflation Reduction Act (IRA), enacted in 2022, empowers Medicare to [negotiate prescription drug prices directly with drug companies](#), similar to the U.S. Department of Veterans Affairs and other federal agencies that already negotiate drug prices.”

Medicare Prohibition is Inequitable

Medicare’s prohibition on coverage of “weight loss” drugs, as directed by the Medicare Modernization Act, is based on an outdated understanding of obesity. When this statute was passed over 20 years ago, it was believed that obesity was based on individual choices and the pharmaceutical interventions that were available at the time were either ineffective or outright dangerous. Today, medications for the treatment of obesity have improved significantly and our understanding of the science of obesity has evolved. The American Medical Association (AMA) and science are clear—obesity is a chronic disease.



Medicare currently provides coverage for some GLP-1s to treat comorbidities associated with obesity. Under current policy, Medicare covers GLP-1s for diabetes, and [Wegovy for the treatment of cardiovascular disease](#) and overweight. However Medicare will not cover these treatments solely for obesity. Thus, the patients who are excluded from treatment are those with obesity and no other qualifying health conditions. This is deeply troubling from a health equity perspective, as this policy tells patients they must get sicker before Medicare will pay for the treatment.

Legislative Solution

The [Treat and Reduce Obesity Act](#) (TROA) is a bipartisan solution that would respond to developments in the scientific understanding of and treatment for obesity. The bill would allow Medicare to cover FDA approved therapies such as AOMs and expand coverage for screenings and treatment from providers specializing in obesity care.

Saving Lives is Worth the Cost of Coverage

The cost of inaction is catastrophic for both individuals and our health care system. Providing Medicare coverage for the full continuum of care – including anti-obesity medications (AOMs) and intensive behavioral therapy (IBT) – is an important investment for Medicare beneficiaries and our health care system.

As the Office of Personnel Management stated when providing AOM coverage for federal employees, "Obesity disproportionately affects some ethnic and/or racial groups with non-Hispanic Black adults having the highest prevalence, followed by Hispanic adults."

Medicare's outdated, misinformed and biased prohibition on weight-loss medications must change.

*"Black Americans are paying
the price with their lives."*

*-Dr. Virginia A. Caine,
[How we can bridge the obesity-care
gap for Black Americans](#)*



HEALTHCARE NUTRITION COUNCIL

Improving outcomes through awareness and action

Submitted via WMSubmission@mail.house.gov

September 30, 2024

The Honorable Rep. Vern Buchanan
Chairman of the Health Subcommittee
House Ways & Means Committee

The Honorable Rep. Lloyd Doggett
Ranking Member of the Health Subcommittee
House Ways & Means Committee

Re: Subcommittee Hearing on Investing in a Healthier America: Chronic Disease Prevention and Treatment

Dear Chair Buchanan and Ranking Member Doggett,

The Healthcare Nutrition Council (HNC) is providing comments on the House Ways & Means Subcommittee on Health's hearing "Investing in a Healthier America: Chronic Disease Prevention and Treatment." HNC is an association representing manufacturers¹ of enteral nutrition (EN) formulas and oral nutrition supplements (ONS), including those categorized as medical foods, and parenteral nutrition (PN). Our mission is to improve patient outcomes by advancing nutrition policies and actions that raise awareness and optimize access of essential nutrition support therapies across the continuum of care.

HNC urges the Committee to support the Medical Nutrition Therapy Act ([H.R. 6407](#)) and consider the impact of medical nutrition therapy (MNT) for individuals with chronic illnesses such as cancer, heart disease, and obesity. MNT is an evidence-based, cost-effective component of treatment that can help combat many of the nation's most prevalent and costly chronic conditions. The MNT Act would expand Medicare coverage for medical nutrition therapy services and we urge its passage. Currently, Medicare covers such services for individuals with diabetes or kidney disease that are provided by a registered dietitian or nutrition professional pursuant to a physician's referral. The bill extends coverage to individuals with other diseases and conditions with important nutrition implications, such as cancer, heart disease, obesity, and malnutrition, and expands who may refer patients to MNT services, including physician's assistants, nurse practitioners, clinical nurse specialists, or clinical psychologists.

HNC strongly supports the comments provided by former United States Senate Majority Leader and Chairman of the Executives Council at Cressey & Company, Bill Frist, in his witness testimony urging the Committee to pass the MNT Act. HNC strongly reiterates the former Leader's position that MNT is an evidence-based and cost-effective means of treating a variety of chronic conditions.

MNT is characterized by treating chronic conditions through an individually tailored nutrition plan recommended by a Registered Dietitian Nutritionist (RDN). This may include recommendations to use an oral nutrition supplement (ONS). ONS are high quality, scientifically based and nutrient dense foods for special dietary use (FSDU), and are typically available as ready-to-drink liquids. ONS can also be part of the food is medicine approach when it is included in medically tailored meals to help prevent, manage, and treat chronic diet-related diseases. For individuals with or at risk of malnutrition, consumption of adequate nutrition, including protein, is not always possible due

¹ HNC members are Abbott Nutrition, Nestle Health Science, and Nutricia North America.



HEALTHCARE NUTRITION COUNCIL

Improving outcomes through awareness and action

to poor appetite, reduced food intake, increase in nutrition needs, and/or poor absorption of nutrients caused by illness or chronic conditions. ONS products have been shown to improve daily intake of calories, protein, and other recommended nutrients without reduction of regular food intake² and contribute to maintaining and increasing muscle mass.³

HNC supports MNT and other forms of treatment for patients at risk of malnutrition. Malnutrition is a public health issue that burdens health care providers, hospital readmission rates, institutionalization, and utilization of costly health care services. According to the CDC, tragically, the national deaths related to malnutrition have doubled from 9,300 deaths in 2018 to 20,500 deaths in 2022.⁴ The financial costs of malnutrition are substantial in the United States; malnutrition costs associated with adults aged 65 years and older who are the most at risk for malnutrition are estimated at \$51.3 billion annually.⁵ In addition, malnourished patients and patients with nutrition-related or metabolic issues are frequently readmitted to the hospital.⁶ The average costs per readmission for patients with malnutrition were found to be 26-34 percent higher (\$16,900 to \$17,900) compared to those without malnutrition (\$13,400).⁷ Minority populations have long faced chronic disease health disparities due to socioeconomic inequalities and reduced access to health care, healthy foods, and safe places to be active. The compounding impacts of systemic inequalities, food insecurity, reduced access to care, and COVID-19 complications, underscore the need to provide equitable access to medical nutrition therapy in Medicare.

HNC further supports comments made by Representative Judy Chu on MNT. In her remarks, Rep. Chu correctly asserted that MNT is an evidence-based approach to treating chronic conditions through an individualized plan, but Medicare does not cover MNT as a treatment for individuals with eating disorders. MNT is a proven and effective means of helping patients with restoring body weight, achieving adequate nutrient intake to meet daily requirements through regular meal patterns and portions and reducing negative beliefs and fears surrounding food.^{8,9,10,11} Rep. Chu

² Smith TR, Cawood AL, Walters ER, Guildford N, Stratton RJ. Ready-Made Oral Nutritional Supplements Improve Nutritional Outcomes and Reduce Health Care Use-A Randomised Trial in Older Malnourished People in Primary Care. *Nutrients*. 2020 Feb 18;12(2):517. doi: 10.3390/nu12020517. PMID: 32085537; PMCID: PMC7071441.

³ Lauque S, Arnaud-Battandier F, Gillette S, Plaze JM, Andrieu S, Cantet C, Vellas B. Improvement of weight and fat-free mass with oral nutritional supplementation in patients with Alzheimer's disease at risk of malnutrition: a prospective randomized study. *J Am Geriatr Soc*. 2004 Oct;52(10):1702-7. doi: 10.1111/j.1532-5415.2004.52464.x. PMID: 15450048.

⁴ Kaiser Health News. U.S. Malnutrition Deaths Have More Than Doubled. U.S. News and World Report. April 13, 2023. Retrieved from: <https://www.usnews.com/news/health-news/articles/2023-04-13/deaths-from-malnutrition-have-more-than-doubled-in-the-us#:~:text=By%20Phillip%20Reese%20%7C%20KFF%20Health%20News&text=The%20same%20trend%20occurred%20nationwide,for%20Disease%20Control%20and%20Prevention>

⁵ Snider J, et al: Economic burden of community-based disease-associated malnutrition in the United States. *JPEN J Parenteral Enteral Nutr*. 2014;38:55-165

⁶ Braunschweig C, Gomez S, Sheean PM. Impact of declines in nutritional status on outcomes in adult patients hospitalized for more than 7 days. *J Am Diet Assoc*. 2000;100:1316-1322.

⁷ Finger K, Weiss A, Barrett M, Elixhauser A, Steiner C, Guenter P, and Hise Brown M. All-Cause Readmissions Following Hospital Stays for Patients with Malnutrition, 2013. *HCUP Statistical Brief #218*. 2018. 1-18.

⁸ Mitchell SL, Klein J, Maduramante A. Assessing the impact of an eating disorders treatment team approach with college students. *Eat Disord*. 2015;23(1):45-59.

⁹ Cockfield A, Philpot U. Feeding size 0: the challenges of anorexia nervosa. *Managing anorexia from a dietitian's perspective*. *Proc Nutr Soc*. 2009;69(3):281-288.

¹⁰ Reiter CS, Graves L. Nutrition therapy for eating disorders. *Nutr Clin Pract*. 2010;25(2):122-136.

¹¹ Ozier AD, Henry BW. Position of the American dietetic association: nutrition intervention in the treatment of eating disorders. *J Am Diet Assoc*. 2011;111(8):1236-1241.



HEALTHCARE NUTRITION COUNCIL

Improving outcomes through awareness and action

questioned witness Ashley Gearhardt, Professor of Psychology, Food and Addiction Science and Treatment, on how MNT can help to ensure that seniors receive adequate nutrition to support long term health and well-being. Dr. Gearhardt answered that eating disorders are overlooked despite having the highest mortality among mental health conditions. As part of her answer, Dr. Gearhardt claimed that improving access to healthy and nutritious food for older adults will provide benefits across multiple domains. HNC concurs with Dr. Gearhardt's claim. Up to one in two older adults are at risk for malnutrition^{12,13} and the World Health Organization recognizes malnutrition as a major problem affecting older adults and has published a strong recommendation that ONS with dietary advice should be recommended to older people affected by undernutrition.¹⁴ ONS often provide a complete and balanced profile of macro- and micronutrients to help them meet their nutrition goals and move toward a healthy dietary pattern.

We urge the Committee to pass the Medical Nutrition Therapy Act to expand access to essential nutrition support therapies and address chronic diseases. If you have any questions, please contact Peter Sahagian, Healthcare Nutrition Council, at psahagian@healthcarenutrition.org or 202-207-1120.

Sincerely,

A handwritten signature in black ink that reads "Carla A. Saunders".

Carla Saunders
Executive Director

¹² The Malnutrition Quality Collaborative. National Blueprint: Achieving Quality Malnutrition Care for Older Adults. Washington, DC: Avalere and Defeat Malnutrition Today. March 2017.

¹³ Kaiser, MJ; Bauer, JM; Ramsch, C; Uter, W; Guigoz, Y; Cederholm, T; Thomas, DR; Anthony, PS; Charlton, KE; Maggio, M; Tsai, AC; Vellas, B; and Sieber, CC. Frequency of malnutrition in older adults: a multinational perspective using the mini nutritional assessment. *Journal of the American Geriatrics Society*, 2010; 58(9): 1734-1738.

¹⁴ World Health Organization. Integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity. Geneva: World Health Organization; 2017. License: CC BY-NC-SA 3.0 IGO. Retrieved from <https://www.who.int/ageing/publications/guidelines-icope/en/>.



Subject: Hearing on Investing in a Healthier America: Chronic Disease Prevention and Treatment

HealthyWomen, an independent nonprofit health information source for women, supports the committee's examination of the prevalence of chronic disease in the U.S. and the value of investing in prevention and innovative treatment options. Supporting and passing bills like HR4818, the Treat and Reduce Obesity Act (TROA), would expand access to the full continuum of treatment options for Medicare beneficiaries living with obesity. We believe HR4818 (TROA) is essential to treatments for obesity.

HealthyWomen is dedicated to educating women in midlife — ages 35-64 — so that they can make informed health decisions, advocate for themselves and prioritize their health and wellness. We achieve our mission by connecting women with fact-based, expert-sourced content and creative evidence-based programming. Further, we keep women's health part of the national dialogue by raising awareness to decision-makers about the impact health policy has on women and families.

According to the National Institutes of Health (NIH), nearly [42%](#) of adult women in the U.S. are living with obesity. For years, we have been working to [educate women, reduce stigma and advocate](#) for better treatment options and healthcare coverage for obesity.

Obesity is a chronic disease, and its causes go beyond lifestyle choices. Like most chronic diseases, obesity requires a full continuum of care for effective treatment. Obesity is also a known risk factor for other significant health conditions and is associated with more than 200 chronic diseases including diabetes, heart disease and certain cancers. Effectively treating obesity can reduce the adverse impacts of these additional diseases as well.

For more resources and education about obesity and its impacts on women's health, please visit <https://www.healthywomen.org/programs/help-us-increase-access-to-obesity-treatment>.

As a leader in women's health education, HealthyWomen urges you to support legislation that expands access to critical treatments for people living with chronic diseases such as HR4818, the Treat and Reduce Obesity Act (TROA).

Sincerely,

Beth Battaglino, RN-C
CEO, HealthyWomen
beth@healthywomen.org



Sparian Biosciences
180 Varick Street Suite 615
NY, NY 10014

September 27, 2024

The Honorable Vern Buchanan
U.S. House of Representatives
2110 Rayburn House Office Building
Washington, DC 20515

The Honorable Lloyd Doggett
U.S. House of Representatives
2307 Rayburn House Office Building
Washington, DC 20515

Re: Statement for the Record—Ways and Means Health Subcommittee Hearing

Dear Chairman Vern Buchanan and Ranking Member Lloyd Doggett

Overview

We are grateful for the opportunity to submit a statement for the record for the Ways and Means Health Subcommittee hearing on September 18, 2024, entitled, “Investing in a Healthier America: Chronic Disease Prevention and Treatment.”

About Sparian Biosciences

Sparian Biosciences is a clinical stage biopharmaceutical company that is developing innovative medications to combat substance use disorders (SUDs), a public health crisis that the congressional Joint Economic Committee estimates costs the United States nearly \$1.5 trillion annually.¹ As the Ways and Means Committee heard in its 2022 hearing, entitled “Substance Use, Suicide Risk, and the American Health System,” there is a significant unmet medical need in addiction medicine. To address this gap, Sparian is developing four novel medications. Sparian’s AEA agonists (SBS-1000 and SBS-147) are first-in-class drug candidates that offer a non-opioid treatment for patients requiring both acute and chronic pain management. The company’s second program (SBS-226) is a pre-clinical drug candidate that has potential to treat opioid use disorder, which if successful, would provide clinicians with a new pharmacological treatment and an incremental advance over the current therapies such as buprenorphine and methadone. Sparian is also developing a third drug candidate (SBS-371) that could vastly improve how first responders reverse drug overdoses from fentanyl and other powerful synthetic opioids. Lastly, Sparian is developing a new therapeutic (SBS-518) for stimulant use disorders. Currently, there are no FDA approved treatments for methamphetamine and cocaine. SBS-518 represents an opportunity to address a large unmet medical and public health need. Sparian is proud to acknowledge that we have built this impressive and innovative pipeline with over \$58 million in NIH/NIDA grant funding. Sparian Biosciences is a prime example of a successful public-private partnership

¹ [The Economic Toll of the Opioid Crisis Reached Nearly \\$1.5 Trillion in 2020 - The Economic Toll of the Opioid Crisis Reached Nearly \\$1.5 Trillion in 2020 - United States Joint Economic Committee \(senate.gov\)](#)



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Introduction

As the committee noted at the September 18th hearing, “nearly 90% of the \$4.1 trillion spent on health care in America each year is attributable to chronic disease.”² The hearing witnesses discussed a variety of risk factors that are associated with a range of chronic diseases. For example, former U.S. Senate Majority Leader, Dr. William Frist, MD, stated in his statement for the record, “poor nutrition is the leading risk factor for death and disability in the United States.”³ Another witness, Dr. Anne Peters, MD of the University of Southern California, wrote in her hearing statement that “obesity is at the core of the chronic disease crisis.”⁴ Other witnesses mentioned risk factors such as lack of exercise, food insecurity, lack of access to care, among other contributors to chronic disease. Sparian Biosciences recognizes and agrees with the witnesses that addressing these factors is of significant public health importance; however, Sparian would encourage the committee to also consider the role of SUDs in contributing to the nation’s chronic disease burden.

SUDs and Chronic Disease

Along with SUDs being chronic diseases themselves,⁵ they are risk factors associated with other costly chronic conditions that were highlighted during the hearing, including diabetes, hypertension, chronic obstructive pulmonary disease, cancer and hepatitis.^{6,7} Addressing SUDs is an upstream, preventive intervention for chronic conditions that could help the committee achieve its goal of “sav[ing] taxpayers up to \$500 billion annually, and improve the nation’s physical and fiscal health.”⁸ As the committee knows from its bipartisan work on the opioid epidemic legislation, *SUPPORT for Patients and Communities Act* (P.L. 115-76), there has been limited biomedical innovation to combat SUDs. Hearing witness, Dr. Anne Peters, rightfully noted it “is crucial to incentivize continued innovation in areas with high societal impact. Ensuring that innovators are paid socially desirable returns for their investments in biomedical research and development can help us find new solutions to promoting prevention.”⁹ In that spirit, Sparian Biosciences urges the committee to consider and adopt the following recommendations to prevent and treat SUDs to curb the rising cost of chronic conditions.

Recommendations

- 1. Empower the National Institutes of Health (NIH) to catalyze the biomedical innovation ecosystem:** The Ways and Means Committee has a longstanding bipartisan history of supporting policy mechanisms to drive innovation. On June 24, 2024, the committee made an investment in America’s future by advancing bipartisan legislation to encourage research in next generation cancer screening tools, breakthrough medical devices, among other aspects

² [Four Key Moments: Hearing on Chronic Disease Prevention and Treatment – Ways and Means \(house.gov\)](#)

³ [Frist-Testimony.pdf \(house.gov\)](#)

⁴ [Peters-Testimony.pdf \(house.gov\)](#)

⁵ [Drug Misuse and Addiction | National Institute on Drug Abuse \(NIDA\) \(nih.gov\)](#)

⁶ [Multimorbidity of chronic diseases and substance use disorders and their association with hospitalization: Results from electronic health records data* - PMC \(nih.gov\)](#)

⁷ [Part 2: Co-occurring Substance Use Disorder and Physical Comorbidities | National Institute on Drug Abuse \(NIDA\) \(nih.gov\)](#)

⁸ [Four Key Moments: Hearing on Chronic Disease Prevention and Treatment – Ways and Means \(house.gov\)](#)

⁹ [Peters-Testimony.pdf \(house.gov\)](#)



Sparian Biosciences
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of healthcare.¹⁰ To continue this legacy of public health leadership, committee Members should push for additional resources for NIH's Helping to End Addiction Long-term (HEAL) Initiative. This initiative represents NIH's largest commitment to combatting SUDs and currently supports more than 1,800 projects in all 50 states. Some of these projects are aimed at addressing the nexus of SUDs and chronic conditions. For example, the HEAL Initiative is currently supporting a project to "improve pain management with kidney disease" called the Hemodialysis Opioid Prescription Effort (HOPE) research program.¹¹ Similarly, the HEAL Initiative has supported studies into novel pain management techniques for those living with diabetes.¹² The HEAL Initiative has a demonstrated track record of success and should receive additional resources to combat a key risk factor for expensive chronic diseases.

2. **Support a whole-of-government initiative to combat SUDs:** Republican and Democratic presidential administrations have both recognized that SUDs are chronic diseases that require a coordinated and disciplined public health effort. To that end, presidents from both parties have consistently declared SUDs a public health emergency.¹³ While these declarations have helped marshal additional resources, they have failed to materialize in a whole-of-government effort analogous to Operation Warp Speed, a public-private partnership that delivered lifesaving COVID-19 vaccines in record time. Given the rising toll of SUDs, Sparian would urge the committee to direct agencies under its jurisdiction such as the Centers for Medicare and Medicaid (CMS) to take a leadership role in developing and implementing a whole-of-government SUD initiative. Sparian Biosciences would also encourage committee Members to convey to their congressional colleagues, the Food and Drug Administration (FDA), the White House, and other relevant stakeholders on the pressing need for such a program.
3. **Strengthen the SUD workforce to improve access to care:** Multiple hearing witnesses spoke about disparities and inequities in access to healthcare services. Dr. Anne Peters noted that for patients living with diabetes, "access is disparate and dependent largely on socioeconomic factors."¹⁴ Patients with SUDs also face numerous hurdles in accessing care, one of which is a shortage of qualified physicians certified in addiction medicine. The American Society of Addiction Medicine reports the U.S. needs an additional 1,600 physicians to adequately meet its current demand for SUD care. To address this workforce shortfall, Sparian Biosciences urges the committee to advance the bipartisan *Substance Use Disorder Workforce Act* (H.R. 7050), which would add 1,000 residency slots for pain and addiction medicine over five years.¹⁵ This legislation is supported by several committee Members from both sides of the aisle.

¹⁰ [Ways and Means Committee to Markup Legislation to Promote Medical Innovation, Access to Care, and Lower Long-Term Healthcare Costs – Ways and Means \(house.gov\)](#)

¹¹ [NIH Heal Initiative 2024 Annual Report: Research in Action](#)

¹² [Funded Projects | NIH HEAL Initiative](#)

¹³ <https://aspr.hhs.gov/legal/PHE/Pages/default.aspx>

¹⁴ [Peters-Testimony.pdf \(house.gov\)](#)

¹⁵ [H.R. 7050 - 118th Congress \(2023-2024\): Substance Use Disorder Workforce Act | Congress.gov | Library of Congress](#)



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- 4. Accelerate access to cutting-edge therapeutics through novel incentives:** Committee Members and hearing witnesses discussed the importance of new incentives to encourage innovation and paradigm shifts. As the committee knows well from its recent work on the *American Medical Innovation and Investment Act* (H.R. 8816) and *Ensuring Patient Access to Critical Breakthrough Products Act* (H.R. 1691), federal incentives can spur innovation for unmet medical needs. Many innovators have abandoned the SUD space, leaving few medical options for patients with SUDs. Sparian Biosciences urges the committee to broaden its work to include new incentives for SUD therapies such as prize funds, joint agency regulatory programs, guaranteed federal procurement contracts, among other efforts.

Thank you for the opportunity to share Sparian's perspective. Sparian Biosciences shares the committee's mission of improving care for all Americans. If Sparian can serve as a resource on these matters, please do not hesitate to reach out to Sahil Chaudhary at sahil@sparianbiosciences.com.

Thank you,

A handwritten signature in black ink, appearing to read "JR MD".

Jeffrey B Reich, MD
CEO, Sparian Biosciences, Inc

Re: House Ways and Means Health Subcommittee Hearing on Investing in a Healthier America: Chronic Disease Prevention and Treatment

Chairman Smith, Ranking Member Neal, Health Subcommittee Chairman Buchanan, Health Subcommittee Ranking Member Doggett, and Members of the Committee:

Thank you for convening this important hearing on opportunities to invest in American health given the great severity and scope of our chronic disease epidemic. As a trained health economist, I study what makes national policies to improve diets and reduce associated poor health outcomes successful and am submitting this written comment backed by data and evidence for your consideration.

Diet-Related Chronic Disease: A Costly Epidemic

The US is facing a worsening crisis of preventable, diet-related chronic disease. 129 million Americans, nearly half our national population, are diagnosed with a chronic illness such as heart disease, diabetes, or hypertension.¹ One in four adults are diagnosed with multiple chronic conditions.¹ This epidemic is fueled by a parallel rise in obesity, a major risk factor for the development of chronic disease, which now impacts 42% of adults in the US.²

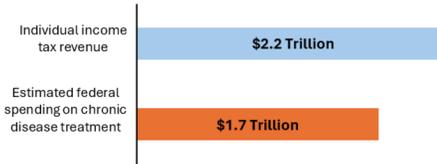
Concerningly, American youth have not escaped worsening health trends; 20% of children in the US are considered obese, a figure that has tripled since the 1970s.³ The incidence of type 2 diabetes among youth has also nearly doubled in the last 20 years.⁴ Additionally, the burden of chronic disease and healthcare costs is not shared equally among Americans. Black and Hispanic children and youth have recently faced greater increases in the rate of diabetes⁴ and along with American Indian/Alaska Native youth are more likely to present with obesity.⁵

The rise in chronic illness has vast consequences for our nation. In 2016 alone, a staggering \$1.24 trillion in lost economic productivity was attributed to chronic disease caused by obesity and being overweight.⁶ Not only does chronic disease impact the economic vitality of our nation, it is also a defense and national security issue. Over 1 in 3 young adults aged 17-24 do not currently qualify to serve in the US military because they are too heavy.⁷

Unsurprisingly, the chronic disease epidemic is generating ballooning associated healthcare costs for American taxpayers and the federal government. Chronic disease treatment, including mental health conditions, accounts for 90% of healthcare expenditures in the US.⁸ This epidemic puts an even greater strain on the Medicare budget, with 96 cents per dollar paid by the program estimated to be spent on chronic disease care.⁹ 60% of the “Baby Boomers” generation (born between 1946 and 1964) have already been diagnosed with at least one chronic illness since 2014,¹⁰ placing a worsening financial burden on Medicare.¹¹ Meanwhile for Medicaid beneficiaries, having cardiovascular disease is associated with an excess out-of-pocket spending of \$317 per year, followed by diabetes at \$237 per year.¹²

Based on estimations that 90% of healthcare costs go towards treating chronic disease,⁹ in fiscal year 2023 the US spent an estimated \$1.7 trillion on this epidemic (Figure 1).¹³ This represents almost the entire sum collected by the federal government on individual income taxes in 2023, the largest source of revenue for the US government.¹⁴

Figure 1. Income tax revenue vs. spending on chronic disease treatment (FFY 2023)



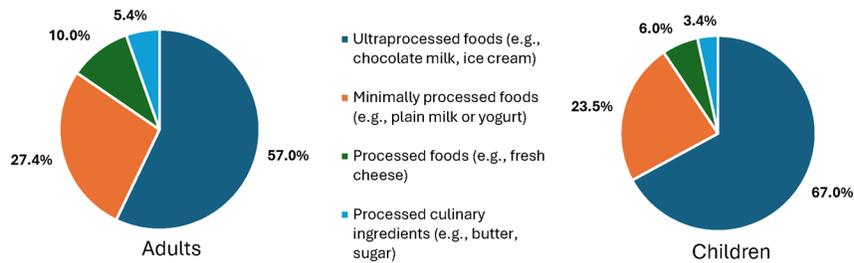
Effectively, the vast majority of individual taxpayer dollars are being spent treating preventable chronic illnesses, with no clear end in sight—unless policy makers take necessary steps to stop and reverse these trends.

Ultra-processed Foods: Our Unhealthy Food Environment

Americans today encounter a food environment vastly different than a century ago, with great consequences for our epidemic of diet-related disease. 73% of the US food supply is estimated to consist of “ultra-processed” food products (UPFs).¹⁵ While almost all foods require some level of processing to reach supermarket shelves, typical “processed” foods can still be made at home by combining whole, unprocessed foods (i.e. fresh produce, milk, or eggs) with culinary ingredients (i.e. salt, olive oil, or sugar). Ultra-processed foods, however, are formulated with industrial additives and processing methods that typical home kitchens lack, allowing such products to achieve “hyperpalatability” while maintaining an artificially inflated shelf life.¹⁶

Ultra-processed foods (UPFs) comprise over half of the calories consumed by adults and two-thirds consumed by children in the US (Figure 2).^{17, 18} The largest increases in UPF consumption since the turn of the century have been observed among Black youth,¹⁹ who already experience a greater prevalence of chronic disease compared to their peers.²⁰ This is cause for concern as researchers have identified connections between the global trend in increased intake of UPFs and rise in obesity and other diet-related diseases.²¹

Figure 2: Ultraprocessed food consumption among American children and adults



UPFs contribute to poor national diet and health outcomes by several different mechanisms:

- UPFs facilitate overconsumption of added sugars, sodium, and saturated fats**
 Compared to minimally processed or unprocessed foods, UPFs in the US food supply are more concentrated with added sugars, sodium, and saturated fats^{22, 23}—excess amounts of which are known to increase risk of type 2 diabetes, hypertension, and cardiovascular disease respectively. Food manufacturers further fuel overconsumption of these nutrients by deliberately engineering their products to achieve a “bliss point” combination of salt, sugar, and fat ingredients that make it hard to stop eating.²⁴ In fact, recent research suggests that UPFs exhibit all the hallmarks of addictive substances (more below).²⁵
- UPFs displace healthier meals and nutrients from the diet**
 Ready-to-heat meals and other UPF products displace healthier meals prepared from fresh, unprocessed ingredients and traditional cooking practices.²⁶ A study of American cooking habits found that UPF consumption was higher among participants who were less likely to cook dinner.²⁷ This is of concern because compared to minimally processed foods and meals, UPFs contain fewer essential nutrients such as fiber, calcium, and vitamins.^{23, 28}
- UPFs and their packaging contain potentially harmful substances**
 Used to preserve and enhance product flavor, color, and texture, additive ingredients such as non-sugar sweeteners, artificial dyes, and emulsifiers are ubiquitous in UPFs—and have been found to be increasing in products in the US.²⁹ Meanwhile, compounds used in plastic packaging of UPFs can leach into the food or beverage product, creating exposures particularly concerning for youth at critical stages of development.^{30, 31} Even at the levels at which they are present in these products, these substances have been found to negatively influence both physical and mental health by interfering with hormones,³⁰⁻³² disrupting the gut microbiome,^{33, 34} and contributing to inflammation.³⁴ Further research is also needed on how complex interactions between additive ingredients may also contribute to the negative health impacts of UPFs.³⁵
- Sensory attributes of UPFs also play a role in their overconsumption**
 High levels of processing often result in UPFs barely requiring any chewing to break down, making it easy to down a whole container of a product without feeling full in much less time than it would take to feel full working through a kale salad. This is supported by findings that UPFs are less satiating than minimally processed foods because they can be eaten more quickly (i.e. have a faster “energy intake rate” in calories consumed per minute).^{36, 37} Even for products that do have more of a bite, that perfectly engineered “crunch” in combination with flavoring ingredients keeps us reaching for another chip, perhaps because our brain has been primed to receive more nutrients than are actually coming from a can of Pringles.³⁸

Ultra-processed foods and chronic disease

Given the evidence above, it is unsurprising that UPFs are linked to a scourge of poor health outcomes. First, high consumption of UPFs substantially increases risk of obesity, including in youth.³⁹⁻⁴¹ The most compelling evidence to date demonstrating that UPFs may uniquely drive weight gain came from a rigorous randomized crossover trial conducted by Kevin Hall at the National Institutes of Health.⁴² In the study, participants offered meals based on either UPF or minimally processed foods **ate 500 more calories per day when on the UPF diet**, even when the total calorie and nutrient composition of foods available to participants on both diets was the same. The participants also gained weight during the UPF phase of the diet, and lost weight on the minimally processed diet. This finding matters because obesity is a risk factor for development of many chronic diseases, some of which have been associated with UPF intake.

In adults and in some cases children, increased UPF intake is associated with increased risk of:

- Diabetes⁴³
- Hypertension⁴⁴
- Cardiovascular disease^{45, 46}
- Unhealthy total and LDL cholesterol⁴⁷
- Cancer^{48, 49}
- Dementia and Alzheimer's⁵⁰

While the federal government loses vast amounts of money each year to treating preventable, diet-related chronic disease, the food industry continues to profit. The top 25 companies in the food and beverage sector raked in a combined \$160 billion in profits in the last year alone.⁵¹ Many of the food brands most represented among our ultra-processed food supply started out as offshoots of the tobacco industry. The food industry essentially followed the same “playbook” as Big Tobacco in making their products irresistible, and is now once again trying to deny the addictive potential of their products.⁵² But food brands owned by US tobacco companies have been found to be 80% more likely to be hyperpalatable than non-tobacco owned foods.⁵³ Researchers theorize that “the speed at which UPFs deliver carbohydrates and fats to the gut may also be important to their addictive potential.”⁵⁴ And many who stop consuming UPFs report experiencing a form of withdrawal,⁵⁵ a finding borne out in laboratory research with animals.⁵⁶ A recent review of 281 studies reported that 14% of adults and 12% of youth worldwide may experience food addiction— about the same share of adults estimated to be addicted to tobacco.⁵⁴

Just as the tobacco industry was implicated in a nationwide epidemic of lung cancer, chronic obstructive pulmonary disease (COPD), and cardiovascular disease, the food industry bears responsibility for profiting off of ultra-processed food products that make Americans fatter and sicker— all while the federal government is footing the bill. Congressional action to improve the food environment is necessary because given their incredible profit margins and limited threat of competition, the food industry has no reason to change their approach.

Opportunities for Action

Policymakers have an opportunity to improve American health by improving the food environment that we interact with every day. There are several key strategies at the disposal of Congress to regulate the food supply and encourage Americans to choose healthier options: mandatory front-of-package labeling, sweetened beverage taxes, fiscal incentives for healthy products, and restrictions on marketing unhealthy products to youth.

Front-of-package labeling

Front-of-package (FOP) labeling is an evidence-based strategy endorsed by the World Health Organization to encourage consumers to purchase and companies to manufacture healthier food and beverage products.⁵⁷ FOP labels successfully in use include Chile and Mexico's mandatory “stop-sign” warning label applied to products high in nutrients linked to chronic disease, including added sugars, sodium, and saturated fat. Other labels such as France's Nutri-Score and Australia's Health Star Rating attempt to summarize nutritional value on a graded scale, while the traffic-light inspired Guided Daily Amounts formerly used in the UK utilizes color-coding to indicate amounts of critical nutrients present in a product. Compared to warning labels, each of these other schemes have found to be less effective at improving diet quality by reducing purchases of added sugars,

saturated fats, or sodium.⁵⁷ Scoring or color-coding systems that reward products for “positive” qualities such as higher fiber or protein may still contain harmful amounts of added sugar, saturated fat, or sodium. This “health halo” impact interferes with goals to reduce intake of nutrients linked to chronic disease.^{58, 59}

Both real-world and experimental evidence supports warning labeling over other front-of-package labels as most effective at improving healthfulness of food and beverage purchases.

Real-world evidence for FOP warning labels:

- **Chile** (introduced 2016)
In just the first year of Chile’s warning label law, there was a 24% drop in sugary drink purchases,⁶⁰ and declines in sodium (–37%), total calories (–24%), and calories from sugar (–27%) and saturated fat (–16%).⁶¹ This was achieved with no reductions to employment or average wages in the food and beverage sector compared to other sectors.⁶²
- **Israel** (2020)
A survey of Israeli healthcare workers reported that 40% of nurses, 35% of physicians, and 60% of nutritionists instruct patients to utilize the labels to improve their diet.⁶³

Experimental evidence for FOP warning labels:

- A 2020 meta-analysis of 14 experimental studies found that out of the major front-of-package labels in use worldwide, only “high in” warning labels significantly reduced the calorie and sugar content of purchased products compared to no front-of-package label.⁶⁴
- A 2021 meta-analysis of over 100 studies examining the effects of different labeling schemes found that consumers who viewed warning labels had higher odds of choosing healthier products than those who saw traffic light or Nutri-Score labels and the lowest odds of choosing less-healthy products to purchase, compared to those who saw no FOP label.⁶⁵

Concerns with the FDA’s front-of-package labeling proposal

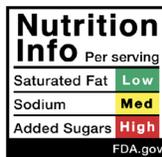


Figure 3. Front-of-package labels proposed by the FDA and Pan American Health Organization

While I strongly commend the Food and Drug Administration for taking the necessary step of proposing mandatory FOP labeling, many experts including myself are concerned that the impact of the labels will be limited if they rely on a traffic-light style labeling of each nutrient (**Figure 3**). Products that earn both green “low” and red “high” designations may lead consumers to misunderstand the overall healthfulness of a product and fail to reduce purchases of added sugars, saturated fats, and sodium; **what would you do if you pulled up to a traffic light and the red and green lights were both signaling at once?** Furthermore, relying on textual information as opposed to a simpler, stop-sign shaped label may limit the label’s impact among populations with lower-levels of literacy, who also tend to be disproportionately impacted by chronic-disease.⁶⁶ I therefore urge members of Congress to push the FDA to propose the evidence-based black, octagonal warning labels endorsed by the Pan American Health Organization⁶⁷ and currently in use in seven countries.²⁴ This is the only label that has been found in real-world and experimental settings to meaningfully reduce purchase of nutrients linked to long-term health problems.

I also recommend consideration of an additional warning label to specifically declare a food as “ultraprocessed.” A study conducted of 600 US adults found that the inclusion of such a label alongside nutrient warning labels more effectively encouraged consideration of the long term health risks of their food purchases.⁶⁸ A current point of contention, however, is whether all UPFs are “bad” for you and how policy makers could reasonably define which UPFs to subject to regulation. In order to capture only the UPFs that tend to contribute to poor diet outcomes, regulation could be limited to food or beverages that are both high in salt, sugar, or fat, *and* contain additives.⁶⁹ This approach would help exclude certain yogurts, packaged breads and cereals that due to presence of additives are categorized as “UPFs,”⁷⁰ but despite this classification have still been found to generally contribute to a healthy dietary pattern.⁷¹

Fiscal Policies

While mandatory FOP warning labeling would go far in imposing standards for food manufacturers and providing transparency to consumers, at the end of the day what gets put in the shopping cart has far more to do with the cost than nutrition. A combination of fiscal policies to promote healthy purchases and discourage unhealthy ones could be the next step to building an American diet that prevents instead of fuels chronic disease.

Sweetened drink taxes

Taxes on sweetened beverages in the form of a levy on manufacturers and distributors is one strong option to invoke changes in purchasing that benefit health. Sugary drinks are one of the top sources of added and free sugars in the diet,⁷² and are associated with increased risk of many types of chronic disease. Recent research estimated an almost 20% increase in risk of type 2 diabetes from each additional 250 mL serving of a sweetened drink per day.⁷³ Passing the SWEET Act (H.R.2772) would be a first step towards bringing the price of sweetened beverages closer to the true cost the federal government ends up bearing in terms of chronic disease attributable to excess sweetened drink consumption.⁷⁴ The effect of a sweetened beverage tax could also be multiplied by directing the revenue generated towards programs to promote health.^{139,142}

To date, 47 countries and 16 smaller jurisdictions have already implemented taxes on sugary drinks with an aim towards improving population health.⁷⁵ Local governments in the US as well as federal-level policies around the globe have seen great progress in implementing sweetened drink taxes; a recent meta analysis reviewing sugary drink taxes worldwide showed that the policy works to improve healthfulness of beverage purchases.¹³³

Real-world evidence of sweetened drink taxes

- **Mexico (2014)**
The introduction of a modest tax of **1 peso per liter** on sugary drinks in 2014 (roughly a 10% tax by volume) led to reduced purchases of taxed drinks and increased bottled water purchases, with no change in total employment.⁷⁶⁻⁸² From 2012 to 2016, purchases of taxed beverages dropped by an estimated 37% in Mexico.⁸¹
- **United Kingdom (2018)**
In the UK, drinks below a certain level of sugar are exempt from the levy, which prompted industry to reduce the sugar content in taxable beverages by 44%.⁸³ In a success story for health but also for

business, the amount of sugar purchased from taxed beverages dropped 35% while overall sales of these drinks still increased 15%.⁸³

- **Philadelphia (2017)**
Philadelphia's 1.5¢-per-ounce tax on sweetened drinks was associated with a drop in taxed beverage purchases of up to 38%,^{84,85} but a net positive impact on the city's employment and economy.⁸⁶⁻⁸⁸ The tax has generated \$385 million in total revenue since it began.⁸⁹

Healthy grocery incentives

Rising grocery costs is one issue that is top of mind for many Americans today. While processed food items may be cheaper than fresh products in the short term, in the long run we shoulder the additional costs of unhealthy diets in the form of growing taxpayer dollars to treat diet-related chronic disease. In an effort to make a healthy diet in reach of families, Congress should support the reauthorization of the Gus Schumacher Nutrition Incentive Program (GusNIP) via passage of the OH SNAP Bill (S.2015 and H.R.4149).^{90,91} This initiative has been shown to significantly increase fruit and vegetable intake among SNAP participants via incentive programs such as "Double Up Food Bucks," in which SNAP benefits go twice as far on purchases of fresh produce.⁹² Such a policy may also more effectively combat our nation's diet-related chronic disease epidemic by supporting low-income, Black and Hispanic Americans who disproportionately experience chronic illness and rely on SNAP.⁹³

Healthy incentives policies also help support small farmers that provide nutritious food to communities, strengthening local economies. California estimated a return of \$1.60 to their economy for every \$1 spent through their "Double Up Food Bucks" program.⁹⁴ If implemented nationally, produce incentive programs could generate between \$1.6 billion to \$3.2 billion in economic activity, with a multiplier effect of 2.4 to 3.1 for incentives spent on farm-direct sales (i.e., farmers' markets, farm stands, community supported agriculture).⁹⁴ Healthy food incentive policies are a wise investment in our nation's health and economy.

Marketing regulations

Food marketing and school food regulations play an essential part in supporting child health and nutrition. American youth are heavily exposed to unhealthy food marketing on a daily basis, a major risk factor for childhood obesity.⁹⁵ Evidence shows that on average, children view over 2,200 food ads each year, the majority of which are for ultraprocessed food and beverage products.^{96,97} The food industry spends nearly \$2 billion a year on food marketing to children, incorporating cartoons, toys, celebrities, music, and games into product packaging and advertising.⁹⁸ The majority of these advertisements include unregulated and misleading health claims that misrepresent the healthfulness of products.⁹⁹ Increasingly, food manufacturers are using highly targeted digital marketing, product placements, and influencers to direct attention from youth towards their unhealthy products. Studies also consistently find higher unhealthy food marketing exposure among low-income and Black and Hispanic youth, evidence of targeted advertising towards children already most at-risk for developing chronic disease.¹⁰⁰

Implementing regulations on traditional and digital marketing can significantly reduce children's exposure to unhealthy food, as seen with Chile's Law of Food Labeling and Advertising.¹⁰¹ Importantly, partial and voluntary industry measures have been found to be ineffective, as industry finds loopholes to avoid restrictions.¹⁰²⁻¹⁰⁶ Regulations must be enforced rigorously with tangible penalties to have a meaningful and lasting impact. Some policies to consider include adopting a

standardized nutrient profiling model,^{105, 107-110} prohibiting the use of positive health and nutrient claims on unhealthy products,¹¹⁰⁻¹¹³ and expanding TV and social media restrictions.^{110, 114, 115} Policies with stricter nutritional criteria for competitive foods that participate in school food programs can foster healthier settings and choices for children.¹¹⁶ Robust marketing regulations are crucial to protect children from overexposure to harmful food and beverage products and reduce the rates of childhood obesity and chronic disease.

A Call to Invest in Our Nation's Health

The House Ways and Means Committee can play an important leadership role in driving federal policies to slow current trends in diet-related chronic disease; if accompanied by state and local actions, the potential to reverse these trends is even greater. Achieving meaningful change will require whole-of-government approaches and the concerted involvement of both private and non-profit sectors. The time to start investing in our nation's physical and financial health is now.

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Investing in a Healthier America: Chronic Disease Prevention and Treatment
Written Statement submitted Tuesday, October 1, 2024
U.S. House Committee on Ways and Means, Subcommittee on Health
1100 Longworth House Office Building

Statement of Dariush Mozaffarian, MD, DrPH

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Dear Chairman Buchanan, Ranking Member Doggett, and distinguished members of the Subcommittee:

I appreciate the opportunity to provide a written statement for consideration by the Committee and for inclusion in the printed record of the hearing held September 18, 2024, titled, Investing in a Healthier America: Chronic Disease Prevention and Treatment. I would like to personally thank the House Ways and Means Committee for voting out of Committee H.R. 8816, the *American Medical Innovation and Investment Act*, which contains an updated version of H.R. 6780, the *Medically Tailored Home-Delivered Meals Demonstration Pilot Act*. I urge the full House to pass H.R. 8816 (and the core provisions of H.R. 8816) during this Congress and to otherwise work with your congressional colleagues to ensure the measure is enacted into law.

The following statement reflects my expertise and experiences as a cardiologist, scientist, and public health expert. I serve as Director of the Food is Medicine Institute at Tufts University, a first of its kind institute dedicated to generating and disseminating trusted evidence around Food is Medicine and advancing its implementation to transform healthcare, policy, and population health. As a doctor, I see firsthand people of all ages and backgrounds suffering from diet-related illnesses. As a public health scientist, I see the incredible challenges Americans face, every day, to obtain and eat nourishing food. As a researcher, I focus on the science and practice of what we need to eat to keep our bodies healthy; and on the most effective policy and systems changes to support good nutrition, well-being, and health equity.

Over the course of any given year, I see and speak with thousands of people who are not as healthy as they could be. They are doing their best to care for themselves, and their families, patients, constituents, and employees. Most feel a vague unease about the harm our food is doing—and have no idea what the remedy is. Ordinary Americans face food-fad whiplash. Doctors watch their patients grow heavier and increasingly ill. Policymakers with good intentions continue to make decisions based on dangerously outdated science. Social media adds to the confusion, as thousands of influencers are now paid by the worst elements of the food industry to cynically pitch anti-nutrition messages – “advice” that can be literally lethal.

I'm here to say: This is not okay, and we should be alarmed about it. At the same time, we can fix this. And you and your colleagues across the House and Senate have a responsibility to do so.

Some ask me: how did a cardiologist become so focused on food and nutrition? My response: why isn't every cardiologist focused on food and nutrition? During my years of training in medical school, internal

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medicine residency, and cardiology fellowship, it was obvious that poor nutrition was the top driver of disease in most of my patients. And yet, we didn’t learn anything meaningful on nutrition and health throughout my medical school training.

Think about that: the top cause of poor health in the United States – nutrition – is largely ignored by our healthcare system. This explains so many of the problems we face today.

The Problem

Today, *being healthy is the exception*. More Americans are sick than well. Americans of all incomes, races, and ethnicities —and all political parties, states, and cities — are experiencing high and rising levels of diet-related diseases. Individuals with lower incomes, living in rural communities, and from historically marginalized racial and ethnic groups are at even higher risk. Poor diets are the primary reason that 7 in 10 adults have overweight or obesity, and 1 in 2 have diabetes or prediabetes.¹ Adding blood pressure and cholesterol levels, only 1 in 15 adults has optimal cardiometabolic health.² For the first time in U.S. history, life expectancy has recently declined – and diet-related chronic diseases are a leading contributor.

- **The United States has a failing grade for nutrition.** The average score on the Healthy Eating Index (HEI) — a measure of adherence with the Dietary Guidelines — is 58 out of 100.³ Americans eat too many refined grains, added sugars, salt, and other additives from highly processed foods; and too few fruits, vegetables, nuts, beans, whole grains, seafood, and yogurt products that are minimally processed and rich in fermentable fibers, bioactive phytonutrients, and other compounds that nourish our bodies and our gut bacteria. While both problems are important, *the lack of healthy foods* causes more health problems than the excess of harmful components.
- **In the United States, more than 47 million Americans lived in food-insecure households in 2023.**⁴ Food insecurity is associated with worse nutrition, higher rates of diet-related diseases, and greater healthcare spending.
- **In the United States, poor nutrition is the leading cause of death and disability.**⁵ The food we eat is estimated to kill 10,000 Americans each week, cause 1,500 new cases of cancer each week, and cause 16,000 new cases of diabetes each week.⁶ These statistics likely *underestimate* the harms of poor diets, given what we are learning about effects of nutrition on the gut microbiome,

¹ Task Force on Hunger, Nutrition, and Health. Ambitious, Actionable Recommendations to End Hunger Advance Nutrition, and Improve Health in the United States: Executive Summary. 2022. https://informingwhc.org/wp-content/uploads/2022/08/Informing_White_House_Conference_Task_Force_Report_Aug22-Executive-Summary.pdf

² O’Hearn M, Lauren BN, Wong JB, Kim DD, Mozaffarian D. Trends and Disparities in Cardiometabolic Health Among U.S. Adults, 1999-2018. *J Am Coll Cardiol*. 2022;80(2):138-151.

³ <https://www.fns.usda.gov/cnpp/hei-scores-americans>

⁴ <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/key-statistics-graphics/>

⁵ U.S. Burden of Disease Collaborators, Mokdad AH, Ballestros K, et al. The State of US Health, 1990-2016: Burden of Diseases, Injuries, and Risk Factors Among US States. *JAMA*. 2018;319(14):1444-1472. <https://jamanetwork.com/journals/jama/fullarticle/2678018>

⁶ U. S. Burden of Disease Collaborators, Mokdad AH, Ballestros K, et al. The State of US Health, 1990-2016: Burden of Diseases, Injuries, and Risk Factors Among US States. *JAMA*. 2018;319(14):1444-1472.; Zhang FF, Cudhea F, Shan Z, et al. Preventable Cancer Burden Associated With Poor Diet in the United States. *JNCI Cancer Spectr*. 2019;3(2):pkz034.; O’Hearn M, Lara-Castor L, Cudhea F, et al. Incident type 2 diabetes attributable to suboptimal diet in 184 countries. *Nature Medicine*. 2023;29(4):982-995.

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brain health, depression, child development, autoimmune diseases, immune function, and more.

- **In the United States, the costs of diet-related diseases are crushing families, U.S. businesses, the federal budget, and national debt.** Poor nutrition is estimated to rack up *\$1.1 trillion in economic losses* every year from preventable healthcare spending and lost productivity.⁷
- **In the United States, the top medical disqualifier for military service is overweight and obesity.**⁸ [Mission: Readiness](#) has been making this case for more than a decade.
- **Large gaps exist between the top causes of poor health and the research funding allocated to address them—with poor nutrition at the top**—according to a [2019 NIH analysis](#) that compared the amount of dedicated NIH prevention research funding for risk factors of death and disability. Despite this conclusion, and while rates of diet-related disease and associated health care spending continue to rise, funding levels for nutrition research and training (as a percentage of total NIH spending) have been flat at approximately [5% since FY 2015](#). Exciting scientific breakthroughs are on the horizon, but robust investment in federal nutrition research is critical to allow our nation to pursue exciting new fundamental, clinical, and translational discoveries to address these problems.

We can't fix food just by using the same playbook that has been used to fight tobacco, which centers around regulating, taxing, and penalizing unhealthy items. *We must also reward, incentivize, and value healthy food for its true health and economic benefits.*

A Solution: Food is Medicine

Having devoted my career to understanding what we need to eat to stay healthy, and to studying private and public food systems changes to empower people to eat that way, I've been on the front lines helping people sort through the confusion and make better decisions. My work brings me face to face with everyday Americans, patients, doctors, and healthcare executives. I meet CEOs and dynamic entrepreneurs who grow, package, and prepare our food; community activists fighting for health and food justice; and elected officials charged with fixing our food and health problems. This written input brings together my training, the newest science, and these real-world experiences to provide effective, practical solutions to our national nutrition crisis. One of the top solutions sweeping the nation is: Food is Medicine.

Food is Medicine (FIM) refers to food-based nutritional therapies to manage disease within healthcare⁹ including:

- Physician screening and referral for appropriate medical conditions.
- Treatment with medically tailored meals, medically tailored groceries, or produce prescriptions.
- Accompanying nutrition and culinary education, delivered by Registered Dietitian Nutritionists (RDNs), telehealth, or digital counseling.
- Electronic Medical Record (EMR) screening for food and nutrition insecurity.
- Links to healthcare payers and reimbursement.

⁷ The Rockefeller Foundation. True Cost of Food: Measuring What Matters to Transform the U.S. Food System. 2021. <https://www.rockefellerfoundation.org/report/true-cost-of-food-measuring-what-matters-to-transform-the-u-s-food-system/>.

⁸ <https://www.strongnation.org/articles/2006-77-percent-of-american-youth-can-t-qualify-for-militaryservice>

⁹ Mozaffarian D, Aspry KE, Garfield K, et al. “Food is Medicine” Strategies for Nutrition Security and Cardiometabolic Health Equity: JACC State-of-the-Art Review. *J Am Coll Cardiol*. 2024;83(8):843-864. doi:10.1016/j.jacc.2023.12.023

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- Medical nutrition education for doctors.

FIM interventions reflect the critical link between nutrition and health, integrated into health care delivery. These include programs that provide nutritionally tailored meals, groceries, and produce to support disease management, prevention, or optimal health and are linked to the health care system as part of a patient’s treatment plan. Three core FIM interventions include:

- 1) Medically tailored meals (MTMs): home-delivered, nutritious meals customized for patients with severe chronic conditions and limitations in activities of daily living (ADLs). Patients are identified and referred by a medical professional or health care plan. The meals are designed by an RDN and tailored to the patient’s nutritional and medical needs.
- 2) Medically tailored groceries (MTG): healthy, curated food products that aim to treat specific diet-sensitive conditions and support health. These may be picked up in the clinic, purchased with an electronic debit card in the grocery store, or delivered to patients at home.
- 3) Produce prescriptions (PRx): free or discounted produce (fruits, vegetables, and sometimes other healthy foods) to ambulatory patients based on a range of eligibility criteria. The financial support can be implemented using a paper voucher or electronic cards redeemable at local farmers’ markets or retail grocery stores, with delivered food packages, or with online grocery ordering.

Whether using meals, groceries, or produce, FIM provides nutritionally curated items, covered in part or full by healthcare, to treat a patient’s diet-sensitive condition. Eligibility criteria generally include the presence of a diet-sensitive condition (e.g., diabetes, heart failure, obesity, hypertension, kidney disease, cancer, high risk pregnancy), as well as social stressors like low income, food insecurity, or housing instability. Nutrition and culinary education are an important part of FIM interventions, and can be delivered through one-on-one, group, or telehealth RDN or community health worker counseling; cooking classes; and online, email, and SMS text and videos. These programs can cut through barriers such as cost, transportation, and lack of knowledge around healthy food.

At the Food is Medicine Institute we conduct cutting-edge, community-engaged research on the impact of FIM on patients, communities, health systems, and employers, through a health equity lens. Research we and others have conducted shows that FIM programs work to address the many issues laid out at the beginning of this statement, as well as support local food systems, farmers, and rural communities. FIM programs have been shown to reduce food insecurity, increase intake of healthy foods, and improve health outcomes (lower hemoglobin A1c, body mass index, and blood pressure; improved mental health and disease self-management) through the provision of nutritionally curated food items paired with nutrition and culinary education. Further, it is estimated that FIM programs will be either *highly cost-effective or even cost-saving* compared to many other common medical interventions.

Our research estimates:

- MTMs: National implementation of MTMs in Medicare, Medicaid, and private insurance for the estimated 6.3 million Americans who have both a major diet-related condition and limited ability to perform ADLs could avert approximately 1.6 million hospitalizations and result in net savings of \$13.6 billion in health care costs in the first year alone, after accounting for program implementation and meal costs (Figure 1).¹⁰

¹⁰ Hager K, Cudhea FP, Wong JB, et al. Association of National Expansion of Insurance Coverage of Medically Tailored Meals

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- PRx: National implementation of produce prescription programs for the estimated 6.5 million Americans who have both diabetes and food insecurity could avert 292,000 cardiovascular events and add 260,000 quality-adjusted life years — a measure of how well a treatment lengthens or improves patients’ lives — over a lifetime, while being highly cost effective from a health care system perspective and cost-saving from a societal perspective (Figure 1).¹¹

For more information about Food is Medicine, please reference the Food is Medicine Institute [website](#) and our Food is Medicine [fact sheet](#).

Based on these health and cost benefits, FIM is accelerating across the nation. However, much more is needed. With the evidence and progress, the nation is at a tipping point to accelerate FIM.

- More research and implementation projects are critical to assess which FIM programs work best for which patients — especially in Community Health Centers, Medicare, Medicaid, and the VA. This includes:
 - Optimal dose (\$/month), program duration, and intensity of nutrition and culinary education.
 - Meals vs. groceries vs. produce; hospital pick-up vs. retail shopping vs. home delivery.
 - Eligible disease conditions and social criteria.
- Major barriers exist that inhibit most Americans from accessing FIM therapies. These include:
 - Most states have not applied for Medicaid 1115 waivers to implement FIM.
 - Medicare Part A & B — which cover more than two-thirds of Medicare enrollees — do not cover FIM.
 - Many commercial plans are awaiting greater clarity in federal healthcare around FIM.
 - FIM vendors and suppliers are not available in most parts of the country.
 - Most doctors remain poorly educated around nutrition and FIM.

Policy Implications

It’s time for Congressional action to catalyze the scaling and success of FIM. The Ways and Means Committee’s jurisdiction is relevant for advancing sensible FIM policies such as:

- Authorizing pilot programs to treat qualified individuals with medically tailored meals (MTMs) and produce prescriptions through Medicare. At the end of June this committee advanced H.R. 8816, the American Medical Innovation and Investment Act, which contains an updated version of H.R. 6780, the Medically Tailored Home-Delivered Meals Demonstration Pilot Act. This would pilot MTMs in 40 hospitals and be funded through the Medicare Trust Fund. I urge the full House to pass H.R. 8816 during this Congress.
- Encouraging CMMI to incorporate and test FIM approaches in their existing and/or new demonstration pilots.
- Incorporating report language and encouraging/directing CMS to accelerate food and nutrition security screening and clinical care and referral pathways in the EMR.

With Estimated Hospitalizations and Health Care Expenditures in the US. *JAMA Netw Open*. 2022;5(10):e2236898.

¹¹ 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

Written Statement of Dr. Dariush Mozaffarian, Food is Medicine Institute at Tufts University, re: hearing titled “Investing in a Healthier America: Chronic Disease Prevention and Treatment”

- Incorporating report language and working to clarify that Health Savings Account can be used for accepted FIM therapies, with clear language on what qualifies.
- Expanding nutrition counseling in healthcare. This should include passing [H.R. 6407](#), the *Medical Nutrition Therapy Act of 2023*. This bill would expand Medicare Part B coverage of medical nutrition therapy (MNT) services for a variety of chronic conditions. Medical nutrition therapy includes nutritional diagnostic, therapy, and counseling services furnished by a registered dietitian for the purpose of disease prevention, management, or treatment. Currently, MNT is covered for only diabetes and kidney disease, but a much longer list of conditions (such as prediabetes, obesity, cancer, and high blood pressure) would benefit from MNT, which is evidence-based and cost-effective.

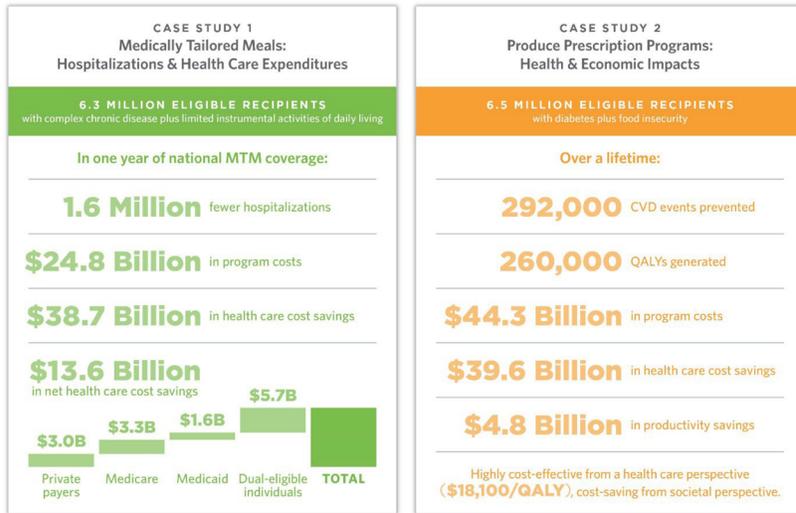
Beyond the Ways and Means Committee, plenty of additional policy solutions exist. I provided many of these ideas in my [written testimony](#) for the May 21, 2024 Senate HELP Committee hearing, Feeding a Healthier America: Current Efforts and Potential Opportunities for Food is Medicine, and reiterate them here:

- Appropriate at least \$40 million to the NIH Office of the Director for the specific purpose of launching the Food is Medicine Networks or Centers of Excellence, a concept which has already received clearance at NIH. This initiative will combine cutting-edge research with patient care, advancing FIM just as the NIH Cancer Centers of Excellence have advanced cancer treatment and control.
- Include support for FIM programs at Community Health Centers that serve the most vulnerable Americans and are most likely to benefit from collaborations and support in this space.
- Encourage CMS to continue to release guidance and toolkits to make it easier for states to apply for Medicaid 1115 waivers that include FIM.
- Provide a meaningful increase in support for the NIH Office of Nutrition Research, which is today woefully underfunded compared to other NIH Office of the Director offices despite the pressing importance of its research mission for the American people.
- Support continuing FIM pilots at the Department of Veterans Affairs and Indian Health Service.
- Initiate FIM pilots for military personnel and their families at the Department of Defense.
- Expand support for produce prescriptions within the USDA GusNIP program.
- Ensure meaningful nutrition education for doctors by contacting accreditation and licensing bodies to indicate that it’s time for change, including the American Association of Medical Colleges (AAMC), Accreditation Council for Graduate Medical Education (ACGME), Accreditation Council for Continuing Medical Education (ACCME), and American Board of Internal Medicine (ABIM).
- Incorporate report language to encourage NIH to implement FIM research across its institutes and centers, coordinated by the Office of Nutrition Research.

Healthcare systems, payers, doctors, patients, public and private sector vendors, and advocacy and clinical groups all support FIM. It’s time for Congress to do its part to make FIM available for more people so that our country can prosper physically and economically. Thank you for the opportunity to provide a written statement and for your consideration of these recommendations. Please consider me and FIMI a resource if you have any questions or require further information.

Written Statement of Dr. Dariush Mozaffarian, Food is Medicine Institute at Tufts University, re: hearing titled "Investing in a Healthier America: Chronic Disease Prevention and Treatment"

Figure 1. Key results from two FIM case studies. Source: <https://tuftsfoodismedicine.org/true-cost-fim-case-study-report/>



September 12, 2024

RE: Investing in a Healthier America: Chronic Disease Prevention and Treatment

To the Honorable Vern Buchanan and members of the Health Subcommittee:

We are long-time Bradenton residents. We are glad to see our U.S. Representative chairing this important and timely hearing on Chronic Disease Prevention and Treatment.

We have some personal and successful experience in losing weight and fighting chronic issues like cancer, high blood pressure and high cholesterol by adopting a healthy lifestyle. It is heartening to see our leaders taking an interest in helping the American people get healthy, rather than solely relying on pharmaceutical interventions once they are sick.

We would like to suggest your committee talk with Mr. Calley Means and his sister Dr. Casey Means. Mr. Means has been a consultant to both President Trump and Robert F. Kennedy, Jr. on ways to help make America healthy again. For a primer on what they are focused on please watch Tucker Carlson's interview with Calley and Casey Means.

It would also be incredibly powerful if the Committee were to include a one-on-one interview with Robert F. Kennedy, Jr. who has made this issue an important focus of his life's work and brought the severity of the chronic disease crises to the forefront of our national conversation.

Please focus the committee's efforts on prevention. Look at issues in improving FARMING and reducing America's reliance on PHARMA.

Thank you,
Susan & Dave Clouse
1702 Point Pleasant Avenue West
Bradenton, FL 34205
Cell: 941-447-9876
Susieq1066@hotmail.com



October 2, 2024

The Honorable Jason Smith
Chairman
Committee on Ways and Means
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
Washington, DC 20515

The Honorable Vern Buchanan
Chairman
Subcommittee on Health for Ways and
Means
Washington, DC 20515

The Honorable Lloyd Doggett
Ranking Member
Subcommittee on Health for Ways and
Means
Washington, DC 20515

Dear Chairman Smith, Chairman Buchanan, Ranking Member Neal and Ranking Member Doggett:

Thank you for the opportunity to provide comments in response to the Ways and Means Health Subcommittee Hearing on Investing in a Health America: Chronic Disease Prevention and Treatment.

The American Lung Association is the oldest voluntary public health association in the United States, representing the more than 34 million individuals living with lung disease. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

Preventing, reducing and managing the chronic disease is imperative to addressing the nation's growing health needs. Chronic diseases represent seven of the 10 leading causes of death¹ and are leading drivers of the nation's \$4.3 trillion in annual healthcare costs.² Six in ten individuals in the U.S. live with at least one chronic disease, like asthma and chronic obstructive pulmonary disorder (COPD)³ and nearly half of all U.S. residents ages 55 or older have two or more chronic health conditions.⁴ The burden of chronic disease is growing faster than our ability to ease it, putting an increasing strain on the healthcare system, healthcare costs, productivity, educational outcomes, military readiness, and well-being.

Despite the rising prevalence of chronic diseases, most chronic diseases can be prevented with supportive, evidence-based public health programs. Public health programs focused on prevention are lifesaving and cost effective: a 2017 systematic review of the return on investment of public health interventions in high-income countries found a median return of 14 to 1.⁵ Yet, the burden of chronic disease is growing faster than our ability to ease it, putting an increasing strain on the healthcare system, healthcare costs, productivity, educational outcomes, military readiness, and well-being. For this reason, the Lung Association urges Congress to focus on prevention efforts as we move forward.

Advocacy Office:
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55 West Wacker Drive, Suite 1150 | Chicago, IL 60601 | 1-800-LUNGUSA | Lung.org

120 Years

Efforts to improve the nation's health status and ultimately reduce healthcare spending must prioritize robust prevention efforts outside of clinical settings at the community level. A 2012 Institute of Medicine (now the National Academy of Medicine) report stated clearly that prevention of disease is the "most efficient and effective" way of achieving community health:

"Although some clinical care interventions can help to prevent a disease process in an individual, they cannot be used efficiently throughout a population to address pressing community health challenges. Those challenges, such as growing rates of obesity and diabetes, increase health care costs, diminish American productivity and competitiveness, and probably limit the opportunities available to the next generation of Americans because of increasingly poor health. Taking action early and at the level of population, long before diabetes is diagnosed in one obese person, or chronic bronchitis is diagnosed in one smoker, is the most efficient and effective route to disease prevention."⁶

Good underlying health is a critical component to preventing severe infection and death from communicable diseases. The nation's lack of consistent and adequate funding for the prevention of chronic diseases and conditions has made our nation more vulnerable to severe illness and death from both chronic disease and infectious disease given how inextricably linked that these are. It also jeopardizes people's economic and personal well-being and is not sustainable for individuals, families, communities, employers and policymakers. Members of this Committee have the unique ability to change this paradigm by focusing on prevention. Prioritization of programs that help people quit using tobacco; promote asthma control; support prevention and treatment of lung and other chronic diseases, including COPD and lung cancer are vital. This will ultimately pay dividends, resulting in lower healthcare costs, better security and readiness, and a healthier nation. For these reasons, the Lung Association urges Congress to focus on and invest in chronic disease prevention efforts as we move forward.

One example of one of the nation's most successful – both in terms of impact and cost efficiency – efforts in preventing and managing chronic disease is its work on tobacco through the Office on Smoking and Health (OSH) and its "Tips from Former Smokers" campaign. This media campaign has proven to be highly effective in aiding individuals to quit smoking. From 2012 to 2018, CDC estimates that more than 16.4 million people who smoke attempted to quit and approximately one million quit for good because of the Tips campaign.⁷ During that timeframe, the Tips campaign also helped prevent an estimated 129,000 early deaths and helped save an estimated \$7.3 billion in smoking-related healthcare costs.

This Committee additionally has a unique opportunity to improve access to supplemental oxygen by supporting the Supplemental Oxygen Access Reform (SOAR) Act (HR 7829). Supplemental oxygen is a critical treatment for approximately 1.5 million individuals in the U.S. who have advanced lung disease, heart disease or may be awaiting a transplant. Despite supplemental oxygen's crucial role in maintaining patient health and quality of life, many Medicare beneficiaries are homebound due to not having access to the appropriate modality of oxygen as prescribed by their providers, especially individuals who require higher levels of oxygen. For years, portable oxygen, especially portable liquid oxygen for those individuals who require higher levels, has not been available for people who work outside the home, attend school events with their kids, travel, or attend doctor's visits. This restricted access to appropriate supplemental oxygen means that individuals are at high risk for worsening health, avoidable emergency room visits and hospitalizations.

The Soar Act seeks to tackle the challenges associated with accessing supplemental oxygen by making supplemental oxygen patient-centric, moving away from "home" oxygen to "supplemental" oxygen. This legislation would remove all oxygen services and equipment from the competitive bidding reimbursement system and create a new reimbursement system for this benefit based on current payment rates so that people can access the appropriate modality of oxygen. Additionally, the SOAR Act would also ensure patients have access to respiratory therapist services through their oxygen supplier. It would also establish national standardized documentation requirements that rely upon a template rather than prescriber medical records to support claims for supplemental oxygen suppliers to ensure predictable and adequate reimbursement and to protect against fraud and abuse.

The Lung Association urges the Committee to support the SOAR Act and secure its passage by the end of this year. Supplemental oxygen is a lifeline for so many people – decreasing mortality, reducing shortness of breath and increasing exercise capacity. This legislation will ensure that millions of people in the U.S. with chronic diseases can have the freedom to live healthier, fuller lives untethered to their homes.

Thank you for the opportunity to provide comments.

Sincerely,



Harold P. Wimmer
President and CEO

¹ Centers for Disease Control and Prevention. Leading causes of death. *Mortality in the United States*, 2019.

² Buttorff C, Ruder T, Bauman M. *Multiple Chronic Conditions in the United States*. Santa Monica, CA: Rand Corp.; 2017 and National Health Expenditure Data: Historical. Center for Medicare & Medicaid Services. December 15, 2021.

³ Centers for Disease Control and Prevention. Living with a chronic condition. May 15, 2024. Available at: <https://www.cdc.gov/chronic-disease/living-with/index.html#:~:text=Chronic%20conditions%20like%20high%20blood,feel%20well%20and%20avoid%20complications>.

⁴ Centers for Disease Control and Prevention. "Percentage of U.S. Adults 55 and over with Chronic Conditions." National Center for Health Statistics. Updated November 6, 2015. https://www.cdc.gov/nchs/health_policy/adult_chronic_conditions.htm

⁵ Masters R, Anwar E, Collins B, Cookson R, Capewell S. Return on investment of public health interventions: a systematic review. *J Epidemiol Community Health* 71 (8):827-34, 2017.

⁶ Committee on Public Health Strategies to Improve Health; Institute of Medicine. *For the Public's Health: Investing in a Healthier Future*. Washington (DC): National Academies Press (US); 2012 Apr 10. 2, Reforming Public Health and Its Financing. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK201015/>

Statement for the Record
The Diabetes Technology Access Coalition

U.S. House of Representatives Committee on Ways and Means – Subcommittee on Health
Investing in a Healthier America: Chronic Disease Prevention and Treatment
Wednesday, September 18, 2024, 2:00PM

The Diabetes Technology Access Coalition (DTAC) appreciates the opportunity to provide a statement for the record in response to the U.S. House of Representatives Committee on Ways and Means – Subcommittee on Health hearing entitled *Investing in a Healthier America: Chronic Disease Prevention and Treatment*. DTAC is a cross-industry group of diabetes stakeholders. Collectively, the coalition members represent millions of Americans with diabetes, health care professionals who treat them, and major manufacturers that develop diabetes therapies, equipment, and supplies. Thus, our coalition represents those who manufacture and develop diabetes technology, the health care professionals who rely on this technology to best treat their patients, and the patients who benefit from the technologies.

We applaud the Subcommittee for holding this hearing and for recognizing the need for increased investment in chronic disease prevention and treatment. As the Subcommittee noted, diabetes is one of the most common chronic diseases in the United States and the prevalence of both type 1 and type 2 diabetes has been rising over the last 20 years, largely driven by new cases of type 2 diabetes.¹ The prevalence of type 2 diabetes is only expected to grow in the coming years, as an estimated 54.9 million Americans will have diabetes in 2030,² compared to the estimated 38.4 million individuals who currently have diabetes.³ Likewise, the prevalence of type 1 diabetes has increased in the last two decades, which was mostly driven by new cases among our nation's youth.⁴ Both type 1 and type 2 diabetes can have devastating effects on long term health, as they are associated with an increased risk of cancer, hospitalization, heart disease, chronic kidney disease, amputations, blindness, and other severe health consequences.

As Congress examines the impact and burdens of diabetes, it is important to consider access barriers to interventions that have become the standard of care for individuals with diabetes. Of particular importance for people with diabetes are continuous glucose monitors (CGMs), insulin pumps, and other administration devices. CGMs, which are frequently paired with insulin pumps have been proven to achieve optimal glycemic control. Insulin pumps, used with or without a CGM, have been shown to

¹ *National Diabetes Statistics Report*, Ctrs. for Disease Control and Prevention, <https://www.cdc.gov/diabetes/php/data-research/index.html>. According to the Centers for Disease Control and Prevention (CDC), their reports and estimates of diabetes typically do not differentiate between type 1 and type 2 diabetes, but that type 2 diabetes accounts for 90 to 95 percent of all diabetes cases, see *Methods: National Diabetes Statistics Report*, Ctrs. for Disease Control and Prevention, <https://www.cdc.gov/diabetes/data/statistics-report/methods.html>.

² William Rowley, et. al., *Diabetes 2030: Insights from Yesterday, Today, and Future Trends*, 20 *Population Health Mgmt.* 6 (2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5278808/>.

³ *National Diabetes Statistics Report*, Ctrs. for Disease Control and Prevention, <https://www.cdc.gov/diabetes/php/data-research/index.html>.

⁴ Jasmine Divers, et. al., *Trends in Incidence of Type 1 and Type 2 Diabetes Among Youths — Selected Counties and Indian Reservations, United States, 2002–2015*, 69 *Morbidity and Mortality Weekly Report* 161 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6906a3.htm?cid=mm6906a3_w.

effectively manage an individual's type 1 or type 2 diabetes.⁵ All insulin pumps currently available in the United States pair with a CGM, and through the use of an algorithm can control the flow of insulin provided. This combination of technologies, often called automated insulin delivery (AID) systems, can both improve overall glycemic control and reduce hypoglycemia, which numerous studies have shown to be common occurrences and a significant risk factor for hospitalizations and mortality among individuals with diabetes.⁶ Given this evidence base, both the American Diabetes Association and the American Association of Clinical Endocrinology incorporate CGMs, insulin pumps, and AID systems into their standards of care for individuals with diabetes. Unfortunately, various segments of the population experience disproportionately poor access to diabetes technologies, including those who live in rural areas,⁷ and Medicare beneficiaries. For instance, Medicare beneficiaries experience limited access to CGMs, as a 2022 study using 2018 Medicare data showed that among the more than 1.3 million Medicare beneficiaries using rapid-acting insulin, 38 percent have no record of glucose monitoring – meaning they are administering insulin without glucose measurements – and only three percent obtained a CGM.⁸

DTAC supports efforts to remove unnecessary coverage and access barriers for all individuals with diabetes. To that end, we encourage Congress to consider the following recommendations to ensure that individuals with diabetes can appropriately monitor and manage their chronic condition.

Reforming Medicare Payment Policies

As Representative Adrian Smith recognized during the hearing, the Medicare program can lack treatment flexibility and has outdated payment policies, which lead to increased spending while also making it more difficult for Medicare beneficiaries to access necessary care. DTAC agrees with Representative Smith, especially as it relates to (1) the access barriers newly enrolled Medicare beneficiaries have in accessing their preferred diabetes technology, (2) the outdated and dangerous Medicare coverage policies for Part B insulin pumps, (3) current Medicare payment policies that hinder innovation and patient access to new and groundbreaking diabetes technologies, and (4) inflexible and limited diabetes education interventions that have been proven to improve diabetes management.

Diabetes technologies have been available for decades and manufacturers are continuing to innovate to improve quality of life and overall glucose management. Despite these improvements, Medicare

⁵ See, e.g., Alanna Weisman, et. al., *Effect of artificial pancreas systems on glycaemic control in patients with type 1 diabetes: a systematic review and meta-analysis of outpatient randomised controlled trials*, 5 *The Lancet Diabetes & Endocrinology* P501 (2017), [https://www.thelancet.com/journals/landia/article/PIIS2213-8587\(17\)30167-5/fulltext](https://www.thelancet.com/journals/landia/article/PIIS2213-8587(17)30167-5/fulltext).

⁶ See, e.g., Richard Silbert, et. al., *Hypoglycemia among Patients with Type 2 Diabetes: Epidemiology, Risk Factors, and Prevention Strategies*, 18 *Current Diabetes Reps.* (2018), <https://link.springer.com/article/10.1007/s11892-018-1018-0>; Rozalina McCoy, et. al., *Increased Mortality of Patients With Diabetes Reporting Severe Hypoglycemia*, 35 *Diabetes Care* 1897 (2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3425008/>;

⁷ See, e.g., Lauren Mitchell and Elbert Huang, *Diffusion and Disparities: Rural Uptake of Continuous Glucose Monitors*, 47 *Diabetes Care* 344 (2024), <https://diabetesjournals.org/care/article/47/3/344/154266/Diffusion-and-Disparities-Rural-Uptake-of>; Arashpreet Gill, et.al., *Glycemic outcomes among rural patients in the type 1 diabetes T1D Exchange registry, January 2016–March 2018: a cross-sectional cohort study*, 10 *BMJ Open Diabetes Research and Care* 1 (2022), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8768930/>.

⁸ Gary Puckerin, et. al., *Assessment of Glucose Monitoring Adherence in Medicare Beneficiaries with Insulin-Treated Diabetes*, 25 *Diabetes Tech. & Therapeutics* 1 (2022), <https://www.liebertpub.com/doi/abs/10.1089/dia.2022.0377?j> (Of the beneficiaries who did gain access to CGMs, 90 percent were White, less than 8 percent were Black, and less than 2 percent were Hispanic.).

beneficiaries face significant challenges in accessing diabetes technologies, especially for those who newly enroll into Medicare fee-for-service (FFS), who must “re-prove” that they have diabetes to continue using their current diabetes technology when they enter Medicare. This creates an unnecessary, burdensome, and dangerous situation where individuals might face a disruption in care in using diabetes technologies they could have been using for decades, and we urge Congress to remedy this important gap in care.

We recognize recent and important changes to modernize the coverage criteria for CGMs to bring those requirements into alignment with the latest clinical evidence and standard of care. We note that the clinical evidence demonstrating the value of CGM to anyone with diabetes, regardless of whether they use insulin, is continuing to build, and CMS will need to revisit the CGM coverage criteria in the near future to ensure the policy is kept current. DTAC is working with CMS on parallel updates to the National Coverage Determination (NCD) for Part B insulin pumps, which was first released in 2004 and has not been updated since. DTAC submitted a reconsideration request in February 2022, and despite being accepted as a valid request, CMS has taken no action to date. The current NCD relies on outdated evidence and dangerous processes, such as requiring beneficiaries to “fail first” (i.e., experience an adverse diabetes-related health event) before obtaining an insulin pump. As Medicare coverage for CGMs continues to be updated with the latest clinical guidelines, the outdated nature of the Part B insulin pump NCD creates a growing divergence between coverage criteria for CGMs and insulin pumps. This growing disparity creates an unnecessary burden for the beneficiaries who use both technologies, including as an AID system in conjunction with an algorithm. Additionally, CMS must reform its NCD process to ensure that it quickly and efficiently assesses new clinical evidence and incorporate it into new coverage criteria so Medicare beneficiaries can receive access to interventions that reflect the current standards of care.

Relatedly, developers and innovators continue to create new software and algorithms that enable CGMs and insulin pumps to administer an appropriate insulin dosage automatically and to learn from the individual’s behavior and physiological responses to meals, exercise, and insulin. However, Medicare does not separately pay for the software or algorithm that is the “brain” of the AID system despite the fact that the other two parts of an AID system, the insulin pump and CGM, are already covered and paid by Medicare. AID systems are part of the standards of care established by both the American Diabetes Association and the American Association of Clinical Endocrinology. The Food and Drug Administration (FDA) has also established a unique device category for algorithms used in AID systems and recognizes them as a “device.” We believe CMS has an existing pathway to ensure payment of the AID system-enabling algorithm, but this has neither been communicated nor stated clearly by CMS. We share Representative Adrian Smith’s concern that the lack of a clear and long-term reimbursement strategy will limit beneficiary access to innovative technologies that become the standard of care.

As many members of the Subcommittee noted, education is essential to improved health and management of chronic diseases. We agree and believe that holistic and comprehensive care, which includes diabetes technologies, pharmacological interventions, and education programs, such as diabetes self-management training (DSMT), must be available for all individuals with diabetes. DSMT educates individuals on how to use diabetes technologies, administer medications, and incorporate healthy lifestyle changes, ultimately leading to improved diabetes management and overall health. However, Medicare beneficiaries face numerous challenges in accessing this proven intervention including: (1) the benefit is capped at two hours per year after the first year; (2) there is a shortage of qualified DSMT providers; (3) the DSMT referral criteria is overly complicated and restricted to a narrow subset of providers; and (4) beneficiary cost-sharing. We recommend Congress make necessary changes to the DSMT benefit to address these concerns.

We also note that Medicare does not acknowledge or provide separate payment to practitioners who provide insulin pump set-up or training, despite having a payment mechanism for CGM set-up and training. Thus, Medicare beneficiaries must use their limited Medicare DSMT benefit to obtain necessary insulin pump training instead of receiving other necessary education and training. DTAC urges Congress to reform the Medicare DSMT benefit as to make it more accessible to all individuals with diabetes as well as to reform payment policies for insulin pump set-up and training. Separate payment for set-up and training is essential for all diabetes technologies and will be needed for the algorithm component of AID systems.

Removing Barriers Under Managed Care Plans

As the Subcommittee noted, reforms to health care plans like Medicare Advantage (MA) and Medicaid managed care can meaningfully improve access to care. Similarly, DTAC supports equitable access to all forms of diabetes care, including for people with diabetes enrolled in such plans. However, we have learned that some enrollees face onerous barriers in accessing diabetes care, such as through the use of utilization management techniques and participating healthcare providers inappropriately telling enrollees that they are not eligible for certain diabetes technologies. We urge Congress to take steps to ensure that all beneficiaries of MA and Medicaid managed care plans have ready access to the appropriate and medically necessary diabetes care.

* * *

We look forward to working with the Subcommittee to advance our common goal of improving care for individuals with diabetes. Please do not hesitate to reach out to Brian Lee at brian.lee@alston.com with any questions or concerns.



Statement for the Record from the Society for Women's Health Research to the U.S. House Ways and Means Health Subcommittee Hearing on Investing in a Healthier America: Chronic Disease Prevention and Treatment

Submitted on behalf of Kathryn G. Schubert, President & CEO

October 2, 2024

The Society for Women's Health Research (SWHR) is pleased to offer the following statement for the record to the U.S. House Ways and Means Subcommittee Hearing on "Investing in a Healthier America: Chronic Disease Prevention and Treatment". As a more than 30-year-old national nonprofit dedicated to advancing women's health through science, policy, and education while promoting research on sex differences to optimize women's health, SWHR has a long history of advocating for policies that advance the health of women across the lifespan, and obesity is one chronic disease which, in spite of its increasing prevalence and disparate impacts, urgently requires the attention and action of legislators.

Medical professionals and associations once debated whether obesity met the definition for a disease; however, this is no longer the case. The National Institutes of Health (NIH) first recognized obesity as a "complex multifactorial chronic disease" in 1998, and in 2013, the American Medical Association (AMA) recognized obesity as a chronic disease.^{1,2} Obesity can be attributed to a variety of causes, including but not limited to genetic factors, physical inactivity, excessive caloric intake, medical conditions, insufficient sleep, certain therapeutic drugs like antidepressants, socioeconomic status, stress, and endocrine-disrupting chemicals, among others.³ As a chronic disease, obesity can also raise the risk for other diseases and health conditions, including heart diseases, high blood pressure, type 2 diabetes, sleep apnea, stroke, and mental illness. Between 4-8% of cancers can be attributed to obesity, and obesity has also been linked to premature death and decline in life expectancy.^{4,5}

Presently, approximately 35% of adults in the United States are living with obesity, and these rates are rising.⁶ Young people are likewise seeing a rise in obesity rates. According to 2022 data from the

¹ Kyle TK, Dhurandhar EJ, Allison DB. Regarding Obesity as a Disease: Evolving Policies and Their Implications. *Endocrinol Metab Clin North Am.* 2016;45(3):511-520. doi:10.1016/j.ecl.2016.04.004

² Funk LM, Jolles SA, Voils CI. Obesity as a disease: has the AMA resolution had an impact on how physicians view obesity? *Surg Obes Relat Dis.* 2016;12(7):1431-1435. doi:10.1016/j.soard.2016.05.009

³ Masood B, Moorthy M. Causes of obesity: a review. *Clinical Medicine.* 2023;23(4):284-291. doi:https://doi.org/10.7861/clinmed.2023-0168

⁴ Pati S, Irfan W, Jameel A, Ahmed S, Shahid RK. Obesity and Cancer: A Current Overview of Epidemiology, Pathogenesis, Outcomes, and Management. *Cancers (Basel).* 2023;15(2):485. Published 2023 Jan 12. doi:10.3390/cancers15020485

⁵ Ward Z. Simulation Results: Excess mortality associated with elevated body weight in the USA by state and demographic subgroup. *Harvard Dataverse.* 2022;48. doi:https://doi.org/10.7910/dvn/h0owkn

⁶ CDC. New CDC Data Show Adult Obesity Prevalence Remains High. CDC Newsroom. Published 2024. <https://www.cdc.gov/media/releases/2024/p0912-adult-obesity.html>

National Survey of Children's Health, one in six young people between the ages of 10-17 is living with obesity.⁷

Not only are obesity rates rising across the U.S. population, but sex and gender disparities are also evident. While there is no significant difference in the prevalence of obesity between men and women, "women are at higher risk for developing obesity-related physical and psychological comorbidities and have a twofold higher mortality risk than overweight men."⁸ Women are also disproportionately impacted by the disease due to higher levels of medical comorbidities and increased stigma concerning health-related quality of life.⁹

As the Subcommittee examines policies to enhance chronic care, SWHR urges you to consider the following measures to improve patient access to high-quality services and to ensure that all patients receive the comprehensive care they need to manage their health effectively.

Address Current Policies within Centers for Medicare & Medicaid Services (CMS)

As mentioned in the hearing, the cost of treating obesity is becoming increasingly burdensome for taxpayers. According to a report by the Milken Institute, the estimated cost of obesity is nearly 7% of the nation's gross domestic product, a number which appears to be increasing.¹⁰ However, what is often overlooked is how women bear a greater economic burden when it comes to obesity. According to one 2018 study, women account for nearly 70% of the cost of obesity, including direct health care costs and indirect costs.¹¹ These costs are further exacerbated for the millions of Americans who are Medicaid covered, which covers 19% of adult women.¹²

Several policies within CMS, if modified, could better support women living with obesity, and, by extension, women living with other chronic diseases.

First, updating Medicare Part D policy to provide coverage for drugs used for weight management. Under current Medicare law, drugs labeled as "weight loss" or "weight gain" agents are excluded from the Medicare Part D program and, therefore, do not receive coverage. This provision overlooks the fact that medications treating obesity are not only used for weight loss purposes; they may also be used for chronic weight management. In April 2024, CMS made a significant advancement by permitting Medicare to cover FDA-approved GLP-1 agonists for patients with obesity and a history of heart disease, aimed at

⁷ Williams E, Burns A, Rudowitz R. Obesity Rates Among Children: A Closer Look at Implications for Children Covered by Medicaid. KFF. Published August 17, 2023. <https://www.kff.org/medicaid/issue-brief/obesity-rates-among-children-a-closer-look-at-implications-for-children-covered-by-medicaid/>

⁸ Kapoor N, Arora S, Kalra S. Gender disparities in people living with obesity: an uncharted territory. *J Mid-life Health*. 2021;12(2): 103-107. doi:10.4103/jmh.jmh_48_21.

⁹ Mond J, Baune B. Overweight, Medical Comorbidity and Health-related Quality of Life in a Community Sample of Women and Men. *The Obesity Society*. 2012;17(8). doi:<https://doi.org/10.1038/oby.2009.27>

¹⁰ Economic Impact of Obesity increased to \$1.4 Trillion. Milken Institute. Published December 6, 2020.

<https://milkeninstitute.org/content-hub/news-releases/economic-impact-obesity-increased-14-trillion-says-milken-institute>

¹¹ Graf M. *America's Obesity Crisis: The Health and Economic Costs of Excess Weight*; 2018.

https://milkeninstitute.org/sites/default/files/reports-pdf/Mi-Americas-Obesity-Crisis-WEB_2.pdf

¹² Kaiser Family Foundation. Women's Health Insurance Coverage. KFF. Published January 12, 2021.

<https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage/>

reducing the risk of heart attacks and strokes. However, many older Americans may lose access to life saving obesity treatments when they transition to Medicare, highlighting the need for policy solutions to address this gap.

Second, reexamining the Medicare Part B National Coverage Decision. Intensive behavioral therapy (IBT) is an evidence-based treatment program that teaches patients with obesity methods for adjusting eating and exercise habits. In 2011, CMS issued a National Coverage Decision ([NCD 210.12](#)) that approves coverage for intensive behavioral therapy (IBT) for treating patients with obesity. The NCD, however, includes provisions that can restrict patient access, such as limiting coverage to when IBT is billed by primary care providers in primary care settings and requiring patients to lose a specific amount of weight in the first six months to maintain access to care. This could prevent patients from seeing other qualified health professionals, like obesity specialists and dietitians. Additionally, the weight loss requirement may disproportionately affect populations with limited access to resources like healthy food and spaces for physical activity.

Lastly, Medicare Part B does not currently cover nutrition therapy services for patients diagnosed with diabetes or kidney disease, or for patients who have had a kidney transplant within the last 36 months. While Part B covers weight-loss counseling for those with a BMI of 30 or higher, nutritionists are likewise not covered for obesity. Covering nutrition therapy services can be a valuable step toward improving health outcomes for these patients. By including coverage for nutrition therapy, Medicare could enhance support for managing diabetes, kidney disease, and obesity, ultimately leading to better overall health and potentially reducing long-term health care costs. Expanding these services would empower patients to make informed dietary choices and facilitate more comprehensive care. The Medical Nutrition Therapy Act (S.3297/H.R.6407) shows promise in this area, as it would expand Medicare coverage of medical nutrition therapy services to include conditions, including obesity, eating disorders, cancer, and HIV/AIDS.

Expand Access to Telehealth Services

Telehealth services play a key role in improving access to care for all populations, particularly for those residing in rural areas, and those experiencing debilitating chronic diseases and/or disabilities. Telehealth services can positively shape the approach to obesity care by improving patient access. Some findings suggest that telemedicine interventions have been successful for obesity care, particularly access to specialized obesity care.¹³

One way to expand access to telehealth services is through the Telehealth Modernization Act of 2024. Currently making its way through the Energy & Commerce committee, the Telehealth Modernization Act extends some of the flexibilities that were authorized during the COVID-19 pandemic. Among the bill's provisions are allowing the home of a beneficiary to serve as the originating site for all services and allowing rural health clinics and federally qualified health centers to serve as distant sites (i.e., the location of the health care practitioner).

¹³Finchcliffe N, Capehorn MS, Bewick M, Feenie J. The Potential Role of Digital Health in Obesity Care. *Adv Ther.* 2022;39(10):4397-4412. doi:10.1007/s12325-022-02265-4

Support Other Legislation That Could Assist Individuals Living with Obesity

There are several bills that have been introduced in the 118th Congress that are directly related to obesity or that have potential to support women living with obesity across their lifespans. Among them, we strongly urge Congress to pass the Treat and Reduce Obesity Act (HR 4818/S 114). We were pleased that the Committee marked up this legislation, and hope that Congress will include it in any end-of-year legislative package. This legislation is an essential first step to addressing this nation's obesity epidemic, which requires a commitment to comprehensive and accessible treatment and care. A multifaceted approach that combines medical, psychological, and lifestyle interventions is essential for confronting the complexities of obesity, and ensuring equitable access to these resources will help women to achieve sustainable health outcomes.

If you have questions about the content above, or if you would like to discuss these topics further, please contact me at (202) 496-5004 or at kathryn@swhr.org.

**Statement for the Record**

Submitted by: J. Nadine Gracia, MD, MSCE
President and CEO
Trust for America's Health

**Prepared for United States House Committee on Ways & Means Hearing
"Investing in a Healthier America: Chronic Disease Prevention and Treatment"
September 18, 2024**

Chairmen Smith and Buchanan, and Ranking Members Neal and Doggett: Trust for America's Health (TFAH) appreciates the opportunity to submit comments for the record for the Committee's hearing "Investing in a Healthier America: Chronic Disease Prevention and Treatment" held on September 18, 2024. TFAH is a non-profit, non-partisan organization dedicated to public health policy, research, and advocacy. We aim to promote optimal health for every person and community and make the prevention of illness and injury a national priority.

Public health principles of prevention must be prioritized to reach populations that are most impacted by chronic diseases. To achieve these goals, TFAH recommends the Committee concentrate on efforts to improve nutrition to prevent diet-related diseases, addressing adverse childhood experiences, and supporting older adults as they age, which will help the American population live healthier, more productive lives and strengthen our national and economic security.

Improving Nutrition to Prevent Chronic Diseases

Each year TFAH releases an annual report entitled *The State of Obesity* that analyzes national and state data on rates of obesity and provides policy recommendations to address this public health crisis. This year's *State of Obesity* report demonstrates how obesity in the United States is a serious and growing public health threat—with rising rates across states, ages, sexes, racial/ethnic groups, and income over decades.¹ Nationally, over four in 10 U.S. adults have obesity. While obesity rates have increased for all population groups, groups with the highest rates, often populations of color and people living in rural areas, typically face structural barriers to healthy eating, including food cost and access, and a lack of opportunities and places to be physically active. Black and Latino adults and people living in rural communities tend to have the highest rates of obesity.² Obesity is not only a health concern on its own, but also increases the risk of developing other chronic conditions, including type 2 diabetes, high blood pressure, heart disease, stroke, COVID-19, arthritis, depression, sleep apnea, liver disease, kidney disease,

¹ Trust for America's Health (TFAH). *State of Obesity 2024: Better Policies for A Healthier America*. September 2024. Available at <https://www.tfah.org/wp-content/uploads/2024/09/SOO-2024-FINAL-R-Sept-12.pdf>

² *Ibid*.



gallbladder disease, pregnancy complications, and many types of cancer, and an overall risk of higher mortality.³

Obesity rates are also increasing among children and adolescents, with nearly 20 percent of U.S. children and adolescents, ages 2 to 19, having obesity. These rates have more than tripled since the mid-1970s.⁴ Developing obesity during childhood is a foremost concern because if children are overweight or obese they are more likely to live with obesity as adults and experience increased healthcare costs and economic burden. Indeed, chronic diseases and mental health conditions account for more than 90% of the nation's \$4.5 trillion in annual healthcare costs,⁵ including billions in extra costs to Medicare and Medicaid.^{6,7} The economic costs of increasing rates of obesity are concerning but also, as Chairman Buchanan cited in his opening statement, has an impact on national security. Among the military-aged U.S. population, slightly under half were eligible to enter the military on the basis of their body mass index (BMI), and only 1 in 3 met BMI eligibility and were adequately physically active.⁸

As Senator Bill Frist pointed out in his written testimony, poor nutrition is at the root of many of these preventable chronic conditions.⁹ Food insecurity, inaccessibility of healthy food options, and food affordability are contributing to the nation's chronic disease crisis.¹⁰ Given the widespread nature of diet-related chronic diseases and their far-reaching consequences, it is necessary to target prevention efforts at the broader population level. For example, the Committee can work to ensure that qualifying insurance plans follow the law and cover recommended preventive services with an A or B grade from the U.S. Preventive Services Task Force (USPSTF) without cost sharing.¹¹

Additionally, TFAH recommends Congress significantly increase funding for the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention (CDC) to improve the nation's prevention of obesity and related chronic diseases.

³ Ibid.

⁴ Ibid.

⁵ https://www.cdc.gov/chronic-disease/data-research/facts-stats/?CDC_AAref_Val=https://www.cdc.gov/chronicdisease/about/costs/index.htm

⁶ Wang, Y. Claire, John Pamplin, Michael W. Long, et al. "Severe Obesity in Adults Cost State Medicaid Programs Nearly \$8 Billion in 2013." *Health Affairs*, 34(11), November 2015. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0633>.

⁷ Cawley J, Biener A, Meyerhoefer C, Ding Y, Zvenyach T, Smolarz BG, Ramasamy A. Direct medical costs of obesity in the United States and the most populous states. *J Manag Care Spec Pharm*. 2021 Mar;27(3):354-366. doi: 10.18553/jmcp.2021.20410. Epub 2021 Jan 20. PMID: 33470881; PMCID: PMC10394178.

⁸ Bryant J, Webber, Daniel B, Bornstein, Patricia A, Deuster, Francis G, O'Connor, Sohyun Park, Kenneth M. Rose, Geoffrey P. Whitfield, BMI and Physical Activity, Military-Aged U.S. Population 2015–2020, *American Journal of Preventive Medicine*, Volume 64, Issue 1, 2023, Pages 66-75, ISSN 0749-3797, <https://doi.org/10.1016/j.amepre.2022.08.008>.

⁹ Written testimony of Senator William H. Frist, MD. "Investing in a Healthier America: Chronic Disease Prevention and Treatment." Hearing of the U.S. House Ways & Means Subcommittee on Health. Sept 18, 2024. <https://waysandmeans.house.gov/wp-content/uploads/2024/09/Frist-Testimony.pdf>

¹⁰ Trust for America's Health (TFAH). *State of Obesity 2024: Better Policies for A Healthier America*. September 2024. Available at <https://www.tfah.org/wp-content/uploads/2024/09/SOO-2024-FINAL-R-Sept-12.pdf>

¹¹ Ibid.

In particular, programs based at the CDC's Division of Nutrition, Physical Activity, and Obesity (DNPAO) have established trusted relationships with state, local, and tribal leaders to implement community-specific programs to increase access to safe places to be physically active and nutritious and affordable foods. For example, the state of Missouri receives \$888,000 per year through the State Physical Activity and Nutrition (SPAN) program to improve nutrition by supporting breastfeeding mothers, increasing nutrition education in early care and education settings, and expanding fruit and vegetable voucher incentives and produce prescription programs.¹² Unfortunately, due to limited funding, only 17 states are currently supported by DNPAO to implement these evidence-based programs.¹³ By increasing funding for DNPAO to \$130.42 million in fiscal year 2025, the SPAN program could reach all 50 states and the territories, and Congress can make an investment that will help promote health and wellness for Americans most impacted by chronic diseases.

In addition to prevention programs, public health is also a critical partner in implementing treatment programs like Food is Medicine (FIM). Programs and initiatives in the FIM framework range from population-level to individual level and are all complementary. Population-level programs and policies in the FIM framework include partnerships among public health, healthcare, and other sectors.¹⁴ Examples of these interventions include consumer education, nutrition standards for food procurement, or tax credits for healthy food options in stores. These population-level approaches are critical to the success of individual-level programs, such as medically tailored meals. These patient-level programs are more intensive interventions by a healthcare team for individuals with existing diet-related diseases and limitations on activities of daily living. By pairing individual interventions with broader population level changes to increase access to healthy food, Congress can multiply the positive impacts of FIM interventions. For example, by ensuring coordination with Medicaid and Medicare Advantage FIM programs, synergies across public health, healthcare, and agriculture, can advance food security and regional food production while also supporting the nutrition security, health and economic resilience of low-income patients.¹⁵ As the Committee considers efforts to expand access to FIM programs, we encourage you to also support complementary efforts at CDC to multiply the impact of such innovations.

Addressing Adverse Childhood Experiences

Prevention efforts can also help address the link between adverse childhood experiences (ACEs) and a variety of chronic physical and mental health conditions. ACEs are potentially traumatic events that occur in childhood such as neglect, experiencing or witnessing violence, or having a family member attempt or die by suicide. ACEs also include aspects of a child's environment that can undermine their sense of safety, stability, and bonding, such as living in a household

¹² Centers for Disease Control and Prevention. "State Physical Activity and Nutrition."

<https://www.cdc.gov/span/php/about/index.html>

¹³ Ibid.

¹⁴ Mozaffarian, D., Blanck, H.M., Garfield, K.M. *et al.* A Food is Medicine approach to achieve nutrition security and improve health. *Nat Med* 28, 2238–2240 (2022). <https://doi.org/10.1038/s41591-022-02027-3>

¹⁵ Ibid.

where a parent or caregiver struggles with substance use or an ongoing mental health condition. ACEs can have long-lasting effects on an individual's lifelong health and opportunity. For example, a 2023 Centers for Disease Control and Prevention (CDC) study of 2011-2020 survey data from across the United States found that around two thirds of adults reported at least one ACE, and one in six reported four or more ACEs.¹⁶ As the number of ACEs an individual experiences increases, the risk for negative health outcomes like asthma, diabetes, cancer, and poor mental and behavioral health (like anxiety, depression, substance misuse, and suicide) across the lifespan also increases. In fact, CDC estimates that ACEs prevention could avoid 21 million cases of depression and 1.9 million cases of heart disease among adults.¹⁷ Importantly, a 2021 review also found an association between ACEs and the development and severity of substance use disorder.¹⁸

A reduction in ACEs could also lead to significant economic benefits. According to a 2023 study, the national economic burden of ACEs-related health conditions for adults is \$14.1 trillion annually, including \$183 billion in direct medical spending and \$13.9 trillion in lost healthy life-years.¹⁹ The study notes that all U.S. states “face a substantial economic burden of both direct medical spending and economic loss from reduced healthy life-years for ACE-associated adult health conditions.”²⁰ A 2018 study also found that the economic burden of child maltreatment alone—a major contributor to ACEs—was at least \$428 billion annually as of 2015.²¹

Robust funding for CDC programs would strengthen federal efforts to prevent ACEs and their negative impacts by building the evidence base through supporting innovative research and evaluation, promoting data innovation, and identifying strategies and building capacity to prevent ACEs across the country.²² Through the Essentials for Childhood: Preventing Adverse Childhood Experiences through Data to Action initiative, CDC builds state-wide capacity to collect and learn from ACEs data, implement strategies to prevent ACEs from occurring, and use data to inform prevention and intervention actions. Passage of the Preventing Adverse Childhood Experiences Act (H.R. 7536), sponsored by Rep. Danny Davis (D-IL) and Rep. Michael Lawler (R-NY), would authorize sustained funding for the CDC ACEs program and enable new studies, evaluation, and research to support ACEs prevention. In addition, the RISE from Trauma Act (H.R. 4541), sponsored by Rep. Davis and Rep. Mike Gallagher (R-WI), would increase funding

¹⁶ Swedo E, et al., “Prevalence of Adverse Childhood Experiences Among U.S. Adults — Behavioral Risk Factor Surveillance System, 2011–2020,” *Morbidity and Mortality Weekly Report*, 72(26):707-715, June 30, 2023.

¹⁷ About Adverse Childhood Experiences. In Centers for Disease Control and Prevention, *Adverse Childhood Experiences*, <https://www.cdc.gov/aces/about/index.html> (accessed September 19, 2024).

¹⁸ Leire L, et al., “Adverse Childhood Experiences (ACEs) and Substance Use Disorder (SUD): A Scoping Review,” *Drug and Alcohol Dependence*, 221:1-10, April 1, 2021.

¹⁹ Peterson C, et al., “Economic Burden of Health Conditions Associated With Adverse Childhood Experiences Among US Adults,” *JAMA Network Open*, 6(12):e2346323, December 6, 2023.

²⁰ *Id.*

²¹ Peterson C, et al., “The economic burden of child maltreatment in the United States, 2015,” *Child Abuse & Neglect*, 86:178-183, December 2018.

²² *Adverse Childhood Experiences Prevention Strategy FY2021-FY2024*. Atlanta: Centers for Disease Control and Prevention, September 2020. https://www.cdc.gov/injury/pdfs/priority/ACEs-Strategic-Plan_Final_508.pdf (accessed September 19, 2024).

for community-level efforts to prevent trauma and expand trauma-informed workforces in schools and healthcare settings.

Supporting the Health of Older Adults

Chronic disease prevention is a critical consideration for the nation's older adults. Eighty percent of Medicare beneficiaries have one chronic condition and nearly 70 percent have two or more (such as diabetes, hearing loss and heart disease).²³ Chronic diseases are costly -- Medicare enrollees with chronic conditions account for an estimated 96 percent of Medicare spending.²⁴ Isolation and loneliness, financial struggles, and limited access to transportation, healthy food, and affordable housing are challenges many older people face. Social isolation alone increases the risk of heart disease, infections, depression, cognitive decline, and death among older people and accounts for \$6.7 billion in additional Medicare spending annually.²⁵ Yet, historically, there have been limited collaborations across the public health and aging services sectors and little funding to ensure public health capacity and capability to address the unique needs of older adults.

Addressing the social determinants of health that impact older adults, while addressing inequities that significantly impact the health and well-being of older adults in communities that are under-resourced and marginalized, requires a multisector approach involving public health departments, aging services agencies, and the whole network of social service providers that work with and for older adults.

Public health interventions can optimize the health and well-being of the aging population, prolong their independence, reduce their use of expensive healthcare services, and promote health equity. These could include improving community access to clinical services, expanding age- and ability-friendly physical activity opportunities, and supporting informal caregivers with resources for their own health and well-being. In order to play a meaningful role in promoting the health of older adults, public health departments need dedicated resources. To accomplish this, a grant program should be established at the CDC to expand its healthy aging work to include coordinating healthy aging efforts across CDC, collecting and disseminating data for public health decision-making, funding applied research and translation for implementation into public health practice, and awarding cooperative agreements to build capacity in state, local, tribal, and territorial public health departments to promote the health of older adults within an Age-Friendly Public Health System. Age-Friendly Public Health Systems are part of the broader age-friendly ecosystem, which involves wholistically addressing older adult health across

²³ Centers for Disease Control and Prevention. *Healthy aging at a glance, 2011: Helping people to live long and productive lives and enjoy a good quality of life*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services, 2011. <http://stacks.cdc.gov/view/cdc/22022>.

²⁴ ²⁴ Centers for Medicare & Medicaid Services. Chronic Conditions Charts, 2017. Accessed August 2019 at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts.html.

²⁵ Flowers, Lynda, et al. Medicare Spends More on Socially Isolated Older Adults. AARP, 2017, Medicare Spends More on Socially Isolated Older Adults, www.aarp.org/content/dam/aarp/ppi/2017/10/medicare-spends-more-on-socially-isolated-older-adults.pdf.

sectors. Congress can accomplish this by passing the Protecting the Health of America's Older Adults Act, as introduced in the 117th Congress.²⁶

Conclusion

TFAH appreciates the opportunity to comment on strategies to prevent chronic diseases. We look forward to further discussions about how to best advance policies that protect the health and security of our country. Please contact Madison West, Government Relations Manager, at mwest@tfah.org with any questions or for additional information.

Sincerely,



J. Nadine Gracia, MD, MSCE
President and CEO
Trust for America's Health

²⁶ Congress.gov. Protecting the Health of America's Older Adults Act, 117th Congress.
<https://www.congress.gov/bill/117th-congress/house-bill/6302/text?s=1&r=47>



House Committee on Ways and Means Health Subcommittee
Investing in a Healthier America: Chronic Disease Prevention and Treatment

ACPM Testimony

Mirza I. Rahman, MD, MPH, FAAFP, FACP
President, American College of Preventive Medicine

October 2, 2024

Dear Chair Buchanan, Ranking Member Doggett and the Health Subcommittee,

I am submitting testimony on behalf of the American College of Preventive Medicine (ACPM), a professional medical society representing approximately 2,000 physicians, dedicated to the practice of preventive medicine. Members of ACPM are board-certified in preventive medicine and dedicate their careers to the practice of population health, chronic disease prevention and health promotion.

Preventive medicine physicians are at the forefront of the effort to integrate clinical care with public health, shifting our curative health system to one that prioritizes wellness. It is also the specialty at the forefront of preventing chronic disease, epidemics and pandemics. However, it is difficult to accomplish this when only 3% of U.S. health funding is dedicated toward prevention and public health.¹

Significant investment in preventive and lifestyle medicine – including appropriate funding and reimbursement – through the support of federal legislation would greatly help address these shortcomings. ACPM fully supports the Subcommittee’s efforts to explore ways to leverage health programs – such as Medicare – to prioritize prevention, and we are prepared to serve as a resource to the Committee if requested.

There is substantial need for reforming the nutrition available to the American public, including through government programs. Americans need better access to and more information about nutritious and healthy foods, and the government should embrace policies that increase independent decision making – such as better menu and nutrition labeling. Initiatives such as matching dollar-for-dollar programs to purchase fresh fruit and vegetables and increasing

¹ Trust for America’s Health (2020). The Impact of Chronic Underfunding on America’s Public Health System: Trends, Risks, and Recommendations, 2020. <https://www.tfah.org/wp-content/uploads/2020/04/TFAH2020PublicHealthFunding.pdf>

funding for programs that support fruit and vegetable farmers could help alleviate some of the economic drivers that factor into consumer decision making and promoting healthy eating.

However, while the U.S. faces a crisis in population health – with chronic diseases like diabetes, hypertension, heart disease and obesity – there exists an equally substantial crisis in the delivery of health care services. More than 100 million Americans currently live in designated Health Professional Shortage Areas (HPSA)² and government agencies and physician associations have estimated the U.S. will face a substantial physician shortage by 2030.^{3,4} ACPM recognizes how severely underprepared the health professional workforce is with regard to taking care of this country's aging and increasingly sick population, as well as being unprepared for natural disasters and other health-related crises – like the obesity epidemic in this country – along with global disasters like the COVID-19 pandemic, and asks the Committee to consider addressing this topic in the near future.

Preventive medicine physicians have unique training and skillsets to care for individuals and populations; however, the specialty receives little federal support. The primary funding source for graduate medical education (GME) in preventive medicine is allocated within the Health Resources and Services Administration (HRSA) Bureau of Health Workforce. Preventive medicine as a specialty is one of the only specialties whose GME costs are not fully supported by Medicare (CMS) GME funding. Preventive Medicine Residency Programs experience significant reductions in CMS reimbursement due to the percentage of time spent not directly caring for Medicare patients; however, this is typically because a critical component of preventive medicine training is conducted in settings such as health departments or Federally Qualified Health Centers (FQHCs), thus still indirectly serving these populations.

Preventive medicine physicians are particularly qualified to serve in crucial leadership positions in local, state, and federal health agencies, private industry, military health, and more, due to dedicated clinical and administrative training and focused education related to public and population health. With approximately 3,000 board-certified public health and general preventive medicine physicians nationwide,⁵ the specialty accounts for only 0.3% of physicians in the U.S.⁶

² Health Resources and Services Administration (2024). State of the U.S. Health Care Workforce, 2023.

<https://bhwrhsa.gov/sites/default/files/bureau-health-workforce/data-research/state-of-the-health-workforce-report-2023.pdf>

³ Association of American Medical Colleges (2024). The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. <https://www.aamc.org/media/75236/download?attachment>

⁴ Health Resources and Services Administration (2023). Physician Workforce: Projections, 2021-2036.

<https://bhwrhsa.gov/sites/default/files/bureau-health-workforce/physicians-projections-factsheet-10-23.pdf>

⁵ Ondrula, CJ (2024). American Board of Preventive Medicine 2024 Program Director Summit, <https://www.theabpm.org/wp-content/uploads/2024/05/2024-PD-Summit-FINAL.pdf>

⁶ American Board of Medical Specialties (2023). 2022-2023 ABMS Board Certification Report, <https://www.abms.org/wp-content/uploads/2023/11/abms-board-certification-report-2022-2023.pdf>

Preventive medicine certification has continuously declined⁵ and the average age of preventive medicine physicians is around 60 years. More than 70% of preventive medicine physicians are over the age of 55, the highest relative percentage of all medical specialties.⁷ Without targeted and definitive intervention, the preventive medicine workforce will continue to decline. This hinders the delivery of preventive and health care services that aid in combating chronic diseases across communities nationally, including but not limited to veterans, rural and underserved communities.

ACPM asks the Subcommittee to explore avenues to sustain preventive medicine training and address shortages in the field. This could be done by directing Medicare GME to fully fund all Preventive Medicine Residency Programs. Modernizing physician training to include advancements in lifestyle medicine, prevention, population health and technology-driven care would assist those on the frontlines of healthcare to be better prepared to promote wellness and address chronic conditions before the onset of disease, saving millions of lives and billions of dollars over time.

Fully funding preventive medicine training programs is an investment in the health professional workforce, in our communities and in our country. This step has the potential to address shortages in the healthcare and public health workforces, and it will ensure the resilience and preparedness of the underserved and at-risk areas that need it most.

Thank you for this opportunity to provide input on the needs of our nation and steps we can take together to prevent chronic diseases and promote health and wellbeing. Please contact ACPM's Communication and Advocacy Specialist, Noah Isenstein, at nisenstein@acpm.org or 202-601-0130 with any questions or requests for additional information or support.

⁷ American Association of Medical Colleges (2022). 2022 Physician Specialty Report Data Highlights, <https://www.aamc.org/data-reports/workforce/data/2022-physician-specialty-report-data-highlights>



FOR YOUTH DEVELOPMENT®
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**House Ways and Means Subcommittee on Health
Written Testimony for "Investing in a Healthier America: Chronic Disease Prevention
and Treatment"**

**by Katie Adamson, Vice President Health Partnerships and Policy
and Heather Hodge, Vice President of Emerging Opportunities
YMCA of the USA**

October 2, 2024

The YMCA of the USA wants to thank the Subcommittee for holding a hearing focused on chronic disease prevention and treatment. As one of the oldest and largest community-based nonprofits dedicated to strengthening communities through youth development, healthy living, and social responsibility, the Y has a unique lens on community and individual health as we work to ensure all Americans reach their full health and human potential. We appreciate the opportunity to share our perspective on how the nation can "Invest in a Healthier America: Chronic Disease Prevention and Treatment." Our vantage point is the result of over 20 years of partnership with the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), philanthropy, academia, voluntary health organizations and the private health sector.

As background, today 2,600 Ys in 10,000 communities make a difference in the lives and health outcomes of almost 17 million Americans each year, including millions of children and youth, adults and older adults. We are the largest nonprofit provider of child care, afterschool programs, camp, swim instruction, youth sports and in-person evidence-based chronic disease programs. We are also one of the leading providers of healthy meals and snacks to children and youth-- serving more than 111 million meals since 2022 in partnership with USDA and community partners. We very much appreciate and understand the importance and Committee focus on Food as Medicine in the hearing as we know that food helps nourish the lives of the millions of children we serve and helping children, youth and adults adopt healthy eating and physical activity practices as part of their daily lives is critical to all the evidence-based programs we offer.

At the Y we strive to strengthen the bond—and bridge the gap—between academic research, traditional healthcare and community-based prevention strategies. We also work to increase the physical health of community environments (walkability of communities, access to fresh affordable food) to improve health outcomes by creating communities we all want to live in. The Y has worked with CDC to translate clinical trials and evidence-based research into community-based programs that prevent or control the leading causes of death and disability (heart disease, diabetes, cancer, arthritis, and obesity). These diseases are also the greatest drivers of our nation's health care budget. With more investment in efforts to scale and pay for these programs, we could save countless lives and billions of dollars.

YMCA OF THE USA
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Alarming, 6 in 10 Americans live with a chronic disease and 4 in 10 live with more than one chronic condition. Today 90% of our \$4.3 trillion annual health care budget goes to treat people with one or more chronic diseases, and we invest far too little in the prevention and control of these diseases. CDC's National Center for Chronic Disease Prevention and Health Promotion was launched 35 years ago, but the research and data behind the need for these programs is over 60 years old. CDC launched the Center to build the infrastructure and capacity to address the epidemic of chronic disease we see today. The chronic disease prevention and control work of the Agency responds to state and community needs for programs, strategies and best practices that will improve health outcomes and reduce health care costs.

The Y works closely with the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). CDC supports states health departments to address chronic diseases and disabilities associated with them. To a lesser extent, CDC has worked with national organizations that can utilize their networks (like the Y) to scale evidence-based programs that prevent and control disease. We have prioritized the translation of evidence-based interventions into communities with the CDC to build the nationwide and community-wide capacity to scale and deliver on what works and then ensure public and private payers cover the costs of these life changing programs. There are insufficient dollars invested in these programs today, even though these programs have the greatest potential to save millions of lives and billions of dollars in health expenditures.

NCCDPHP has never had the financial resources necessary to support staff, systems, and programs in states and communities to address the enormity of the challenge. The Y has joined with other patient advocacy organizations and health groups to ask Congress to increase funding for the National Center for Chronic Disease Prevention and Health Promotion. It is hard to imagine how states could truly respond to the public health needs of chronic diseases like heart disease, hypertension, stroke, cancer, diabetes, arthritis, and Alzheimer's when receiving \$1 million a year at most (and often far less or in some case no money) for each of these conditions and risk factors. How can a state health department build the local capacity necessary to address each of these diseases when you consider how many Americans suffer from them, including:

- 1 in 3 adults, or 96 million Americans live with prediabetes.
- Half of all adults have hypertension – or 116 million Americans.
- One in four adults, or more than 50 million people, have arthritis.
- There are 18 million cancer survivors and that is expected to grow to 22 million by 2030.
- 1 in 5 children and youth, approximately 16 million, live with obesity. And this number has grown since the pandemic began.

Recommendation #1: Congress should increase investments in CDC chronic disease prevention and control programs at the state and community level. Helping Americans understand how to manage their risk and undertake their needed prevention and management strategies for chronic conditions that impact tens of millions of Americans will take more funding, by disease and risk factor, than we have invested to date. As a community-based organization, that also works at the state level, we work closely with

our state and local health departments to help scale evidence-based programs. *But they have so few resources to regrant to community, we are only able to work at the margins of the crisis. And these programs are proven to work.*

Programs that work and recommendations for the Committee:

The Y was instrumental in translating the NIH's Diabetes Prevention Program in community, with our first effort in 2005 with the Indiana School of Medicine and the YMCA of Greater Indianapolis. We helped advance legislative efforts to establish the lifestyle change program to a national program at CDC-now the [National Diabetes Prevention Program](#). (NDPP). Through the program, individuals with prediabetes can lower the risk of developing type 2 diabetes by as much as 58% (71% reduction if over age 60). CDC and public and private dollars have helped the Y build capacity throughout the US to scale the program. To date we have scaled the program in 41 states at more than 1,150 sites, have served more than 81,000 individuals living with prediabetes and have achieved the average weight loss goal of 5.7% weight loss. We could not have done this without the important Congressional investment in this program.

Recommendation #2: The nation needs to continue to invest in CDC, state health departments and organizations like the Y to offer the NDPP program where people live, work, and provide virtual options for this group-based program to reach the greatest number of individuals at risk.

Recommendation #3: Congress needs to find more efficient and effective ways for both Medicare and Medicaid to contract directly with trusted, community-based providers of evidence-based chronic disease prevention and control programs in federally supported programs, like Medicaid, and supplemental benefits for the chronically ill in Medicare.

Building on our success with the CDC's National Diabetes Prevention Program, in 2012, Y-USA received a Health Care Innovation Award (HCIA) from the CMS Innovation Center, the impetus of the Medicare Diabetes Prevention Program (MDPP), to test expansion of the Diabetes Prevention Program ("DPP") to Medicare beneficiaries at high risk for developing type 2 diabetes. In collaboration with multiple partners, Y-USA and 17 local YMCAs worked over a three-year period to engage nearly 8,000 Medicare beneficiaries in the YMCA's Diabetes Prevention Program ("YMCA's DPP"). **The Y not only achieved the attendance and weight loss goals, but the CMS Office of the Actuary certified, based on results and associated data provided by the participating Ys, that expansion of the DPP to Medicare beneficiaries would reduce Medicare spending by \$2,650 per senior over 15 months** and improve the quality of care without limiting coverage or benefits. The achievement of program benchmarks and the CMS Actuary's certification led to former HHS Secretary Burwell's decision to expand program coverage to Medicare beneficiaries.

Recommendation #4: Ensure House and Senate passage of the Prevent Diabetes Act. This legislation could make substantial improvements to the MDPP by allowing virtual providers to participate in the MDPP program and removing the "once-in-a-lifetime"

benefit for beneficiaries. We are so pleased this bill has already passed the Energy and Commerce Committee Subcommittee on Health and hope that the Ways and Means Committee will also support passage. The MDPP expansion program also still needs to be made permanent, and we hope Congress will do that before it expires in 2027.

Recommendation #5: Ensure House and Senate passage of the Treat and Reduce Obesity Act, which would require CMS to advance a National Coverage Decision on which providers can deliver Intensive Behavior Therapy for individuals living with Obesity and cover anti-obesity medications. The National Diabetes Prevention Program and the Medicare Diabetes Prevention Program are both evidence-based examples of Intensive Behavior Therapy delivered by community-based organizations. We offer our sincere thanks to the Ways and Means Committee for advancing this legislation and hope the Energy and Commerce Committee and the Senate will do the same.

The Y has worked with CDC’s Heart Disease and Stroke Program to scale Blood Pressure Self-Monitoring Programs at the community-level to manage hypertension.

High blood pressure is often referred to as “The Silent Killer” because there are typically no warning signs or symptoms. High blood pressure is a key, modifiable, risk factor for both heart disease and stroke, which are two of the leading causes of death in the United States. As long-term adherence to lifestyle modifications and medication treatment can be challenging, many studies have focused on the potential of self-monitoring as a tool for blood pressure management. To address these issues, the Y designed an evidence-based, self-monitoring program aimed to help participants better manage their blood pressure. The program emphasizes self-monitoring and tracking of individuals’ blood pressure plays a significant role in reducing one’s blood pressure and improving quality of life. CDC has supported the **YMCA’s Blood Pressure Self-Monitoring Program**, which is now offered at Ys in 41 states, but more resources would help it reach 50 states and many more communities.

Recommendation #6: Congress needs to increase investments in CDC Heart Disease and Stroke programs and national partnerships with organizations like the Y that help individuals monitor and control their blood pressure. CDC and state health departments have been able to support the Y in scaling the program to some communities in 41 states, but CDC and state health departments have nowhere near the resources to do so in all communities.

The Y has worked with CDC and state health departments to scale evidence-based arthritis control programs like Enhance@Fitness - a proven community-based senior fitness, arthritis management and falls prevention program. The Y has scaled the Enhance@Fitness program in 45 states and served more than 42,500 participants. The program helps older adults become more active, energized, and empowered for independent living. Enhance@Fitness has been nationally recognized by the Centers for Disease Control and Prevention, US Department of Health and Human Services, Administration for Community Living, and the National Council on Aging.

Studies show:

- **90%** participant **retention rate**
- **35%** improvement in **physical functioning**

- **53%** improvement in **depression**
- **26%** decreased risk of a **medical fall**
- **Fewer hospitalizations** and **\$945 less in health care costs** per year than non-participants

Recommendation #7: Congress needs to increase investment in arthritis programs so all 50 states have programs and can help scale programs like EnhanceFitness – a program that can control arthritis and prevent falls – diseases which both cause enormous societal costs and are key drivers of healthcare spending.

The Y has worked with philanthropic partners to scale LIVESTRONG® at the YMCA - an evidence-based physical activity program that helps adult cancer survivors reclaim their health and well-being following a cancer diagnosis. Ys in more than 42 states are offering the program and have served over 85,000 survivors. The Y has invested in clinical trials with Yale University and Dana Farber Cancer Institute to prove the programs benefits, including:

- Help survivors **MEET OR EXCEED** the recommended amount of physical activity.
- Help survivors **SIGNIFICANTLY INCREASE** their cardiovascular endurance.
- **IMPROVE** cancer survivors' overall quality of life and **DECREASE** their cancer-related fatigue.

Recommendation #8: Help CDC and state health departments scale this evidence-based cancer survivorship program with increased resources and direction from Congress to invest in the program through the CDC comprehensive cancer program.

The CDC has supported the Y in scaling Healthy Weight and Your Child Program, an evidence-based program that empowers 7-to-13-year-olds and their families to live a healthier lifestyle. Since its launch thanks to philanthropic funding, the program has been delivered in nearly 100 Ys in 31 states across the country. The program's curriculum is adapted from the most widely disseminated and evaluated child weight management program in the world, MEND, where research showed a statistically significant reduction in body mass index, waist circumference, sedentary activities and improvements in physical activity and self-esteem at 6 and 12 months. The family-centered program emphasizes three elements: healthy eating, regular physical activity and behavior change to elicit a positive life-long lifestyle transformation. 71% of program participants have reduced BMI or slowed their weight gain.

Recommendation #9: Congress needs to support the scaling of evidence-based family weight management programs like Healthy Weight and Your Child at CDC. CMS could also support coverage for evidence-based family weight management programs for children living with obesity.

The Y has participated in the EXERT (Exercise in Adults with Mild Memory Problems) trial, funded by the NIA (publish results expected soon). Researchers partnered with Ys at 13 sites around the United States to deliver an exercise program over a period of 12 months. Previously sedentary participants with Mild Cognitive Impairment (MCI) exercised under supervision four times a week at either high or low intensity and were compared with those who did not exercise. The treatment group showed no cognitive decline over 12 months, while the control group did decline. There was no difference in cognitive outcomes among the high-intensity

versus low-intensity exercise groups. The finding is that any regular exercise of 120-150 minutes per week may increase resistance or resilience to cognitive decline for people with MCI.

Recommendation #10: CDC needs funding to invest in all 50 states to address multiple strategies at the individual, organization, community, and societal level to increase physical activity among children, adults and older adults. Funding the Nutrition, Physical Activity and Obesity Division at CDC so it reaches beyond 16 states is critical. Additionally, Congress should enable CDC to have the resources to scale new innovative physical activity programs like those in the EXERT trial to prevent further cognitive decline and other programs the Y has underway with those living with Parkinsons Disease. Physical Activity is medicine as we have seen in our work.

The Y is extremely proud of our work to date to take the best available chronic disease prevention and control program models from clinical trials and academic settings and work with CDC, CMS, and key public and private health care partners to deliver these program model in our communities. We have been able to document improved health outcomes and cost-savings from our work, saving lives and health care dollars. Now we need to take what we know and scale these programs with the Ys and other health and community-based organizations and work with our health systems to pay for programs. We look forward to working with your Committee and Congress to advance these recommendations.



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