I

117TH CONGRESS
1ST SESSION

# H. R. 3904

To increase the annual funding for the Chronic Disease Prevention and Health Promotion Fund, the National Institute on Minority Health and Health Disparities, and the Offices of Minority Health within the Office of the Secretary of Health and Human Services, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services, the Food and Drug Administration, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration to enable the United States and State departments of public health to better combat disparities that have emerged during the COVID–19 crisis and beyond, and for other purposes.

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IN THE HOUSE OF REPRESENTATIVES

JUNE 15, 2021

Mrs. HAYES (for herself and Mr. THOMPSON of Mississippi) introduced the following bill; which was referred to the Committee on Energy and Commerce

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# A BILL

To increase the annual funding for the Chronic Disease Prevention and Health Promotion Fund, the National Institute on Minority Health and Health Disparities, and the Offices of Minority Health within the Office of the Secretary of Health and Human Services, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services, the Food and Drug Administration, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Serv-

ices Administration to enable the United States and State departments of public health to better combat disparities that have emerged during the COVID–19 crisis and beyond, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Reducing COVID–19 Disparities by Investing in Public Health Act''.

**SEC. 2. FINDINGS.**

The Congress finds the following:

(1) Funding under this Act is essential to core efforts at the Department of Health and Human Services and in local and State health departments to prevent and control the spread of chronic disease and conditions. The National Center for Chronic Disease Prevention and Health Promotion works to raise awareness of health disparities faced by minority populations of the United States such as American Indians, Alaska Natives, Asian Americans, African Americans, Latino Americans, and Native Hawaiians or other Pacific Islanders. One of the primary functions of the Center is to reduce risk factors for groups affected by health disparities.

(2) Six in ten Americans live with at least one chronic disease, like heart disease and stroke, can-

cer, or diabetes. These and other chronic diseases are the leading causes of death and disability in America. Specifically, chronic diseases are responsible for 7 in 10 deaths each year. According to the Centers for Disease Control and Prevention (''CDC''), individuals who are at high risk for severe illness from COVID–19 are people with chronic lung disease or moderate to severe asthma, people with serious heart conditions, people who are immunocompromised—sometimes because of cancer or HIV/AIDS, people with diabetes, people with liver disease, people with severe obesity, and people with chronic kidney disease undergoing dialysis.

(3) According to the CDC, adults suffering from cancer, chronic kidney disease, chronic lung diseases, including chronic obstructive pulmonary disease (COPD), asthma, interstitial lung disease, cystic fibrosis, and pulmonary hypertension, dementia or other neurological conditions, diabetes, Down syndrome, heart conditions, including heart failure, coronary artery disease, cardiomyopathies or hypertension, HIV infection, liver disease, sickle cell disease, stroke, or cerebrovascular disease are more likely to get severely ill from COVID–19 and face in-

creased rates of hospitalization, intensive care, assisted ventilation, or even death.

(4) According to hospital data from the first month of the COVID–19 epidemic in the United States released by the CDC, roughly 1 in 3 people who required hospitalizations from COVID–19 were African American. While 33 percent of total hospitalized patients are Black, African Americans constitute just 13 percent of the entire American population. Early data released by States and municipalities show that African Americans suffered higher mortality rates from COVID–19.

(5) Racial and ethnic disparities in COVID–19 hospitalization were driven by both a higher risk of exposure to the disease, often from essential frontline work performed at disproportionate rates by Black and Latino workers, and social determinants of health. Social inequities and environmental injustices, such as differing access to healthy food, clean air, safe drinking water, safe neighborhoods, education, job security, and reliable transportation, affect health risks and outcomes, reinforcing disparities in health and access to care.

(6) Socioeconomic factors further contribute to racial disparities seen in both prevalence of chronic

conditions and exposure to COVID–19. Individuals in low-income communities and people of color are more likely to have many of the chronic health conditions that have been identified as risk factors for complications from COVID–19, yet suffer decreased access to care, compounded by a decreased likelihood of undergoing appropriate treatment.

(7) According to the American Diabetes Association, 12.5 percent of Hispanic Americans, 11.7 percent of African Americans, 9.2 percent of Asian Americans, and 14.7 percent of American Indians/Alaska Natives have been diagnosed with diabetes, compared to just 7.5 percent of White Americans. The CDC calculated that compared to non-Hispanic Whites, Hispanics are 40 percent more likely to die from diabetes, African Americans are twice as likely to die from diabetes, and American Indians/Alaska Natives are almost twice as likely to die from the disease.

(8) According to the National Institutes of Health, African Americans are more than 30 percent more likely to die from heart disease, are twice as likely to have a stroke—which tends to be more severe with a higher morbidity and results in higher mortality, are 40 percent more likely to have high

blood pressure, and have a higher rate of hypertension and heart failure than their White counterparts.

(9) Minority groups suffer from asthma at a disproportionate rate, have the highest number of emergency room visits and hospital stays due to asthma, and have higher mortality rates from asthma than their White counterparts. African Americans, American Indians, and Alaska Natives are 42 percent more likely than their White counterparts to have asthma. The prevalence of childhood asthma for African Americans is 11.7 percent higher than for White Americans, while mortality rates in children and adults are eightfold and threefold higher, respectively, for African Americans compared to White Americans.

(10) Vaccinations are key to disease prevention and overall health outcomes, especially in the case of COVID–19. However, a longstanding history and legacy of systemic racism, discrimination, and mistreatment has contributed to a larger distrust of the health care system and medical establishment within communities of color, which can further engender disparities and perpetuate rates of chronic disease. According to data from the CDC, despite higher

COVID–19 mortality, hospitalization, and infection rates amongst African Americans, the rate of COVID–19 vaccination amongst Black Americans still lags behind those of White individuals in almost every State. This necessitates increased funding for education, increased access to care, and targeted efforts to reach communities of color and address racial inequities.

(11) Cuts to, or even level funding for, the Chronic Disease Prevention and Health Promotion Fund and other public health prevention efforts undermine efforts to create an affordable and accessible health care system, and a better quality of life for Americans of all ethnic, racial, and socioeconomic backgrounds. Cuts to this Fund would also exacerbate existing disparities and underlying health conditions that have created seemingly vast disparities in hospitalization and mortality rates due to COVID–19.

(12) Prevention efforts have proven to be effective. Funding increases for community-based public health programs reduce preventable disease caused by diabetes, cancer, and cardiovascular disease. Improved access to intervention, treatment, and afford-

able care is also proven to mitigate the development of associated chronic diseases and mortality rates.

(13) Increasing the Chronic Disease Prevention and Health Promotion Fund funding to $2,400,000,000 annually will allow the Fund to invest in more innovative, evidence-based public health programs, maintain and expand investments in programs with demonstrated success, and help reduce racial health disparities and rates of chronic disease that can put persons of color at greater risk of hospitalization or death from COVID–19.

(14) Further, the Office of Minority Health in the Office of the Secretary of Health and Human Services (established by section 1707 of the Public Health Service Act (42 U.S.C. 300u–6)) was designed for the purpose of ''improving minority health and the quality of health care minorities receive, and eliminating racial and ethnic disparities''. The Office of Minority Health and Health Equity at the CDC serves to decrease health disparities, address social determinants of health, and promote access to high-quality preventative health care. The Office of Minority Health and Health Equity at the Food and Drug Administration promotes and protects the health of diverse populations through research and

communication of science that addresses health disparities. The National Institute on Minority Health and Health Disparities leads scientific research that advances understanding of minority health and health disparities.

(15) Increasing funding for these and other critical health programs will enable the United States and State departments of public health to better combat disparities that have emerged during the COVID–19 crisis and beyond.

**SEC. 3. REDUCING COVID–19 DISPARITIES BY INVESTING IN PUBLIC HEALTH.**

(a) CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION.—There is authorized to be appropriated, and there is hereby appropriated, out of any money in the Treasury not otherwise appropriated, for ''Centers for Disease Control and Prevention—Chronic Disease Prevention and Health Promotion'', for fiscal year 2021 and each subsequent fiscal year, $2,400,000,000.

(b) NATIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH DISPARITIES.—There is authorized to be appropriated, and there is hereby appropriated, out of any money in the Treasury not otherwise appropriated, to the National Institute on Minority Health and Health Dis-

parities, for fiscal year 2021 and each subsequent fiscal year, $782,000,000.

(c) OFFICE OF MINORITY HEALTH.—There is authorized to be appropriated, and there is hereby appropriated, out of any money in the Treasury not otherwise appropriated, to the Office of Minority Health in the Office of the Secretary of Health and Human Services (established by section 1707 of the Public Health Service Act (42 U.S.C. 300u–6)), for fiscal year 2021 and each subsequent fiscal year, the amount that is twice the amount of funds made available to such Office of Minority Health for fiscal year 2021.

(d) OTHER OFFICES OF MINORITY HEALTH WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—There is authorized to be appropriated, and there is hereby appropriated, out of any money in the Treasury not otherwise appropriated, to the Office of Minority Health of the Agency for Healthcare Research and Quality, the Office of Minority Health of the Centers for Disease Control and Prevention, the Office of Minority Health of the Centers for Medicare & Medicaid Services, the Office of Minority Health of the Food and Drug Administration, the Office of Minority Health of the Health Resources and Services Administration, and the Office of Minority Health of Substance Abuse and Mental Health

Services Administration (as established pursuant to section 1707A of the Public Health Service Act (42 U.S.C. 300u–6a)), for fiscal year 2021 and each subsequent fiscal year, the amount that is twice the amount of funds made available to the respective Office of Minority Health for fiscal year 2021.

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