

TO REPEAL THE PREVENTION AND PUBLIC HEALTH
FUND

APRIL 11, 2011.—Committed to the Committee of the Whole House on the State of
the Union and ordered to be printed

Mr. UPTON, from the Committee on Energy and Commerce,
submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 1217]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred
the bill (H.R. 1217) to repeal the Prevention and Public Health
Fund, having considered the same, report favorably thereon with-
out amendment and recommend that the bill do pass.

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PURPOSE AND SUMMARY

H.R. 1217, a bill to repeal the Prevention and Public Health Fund in the Patient Protection and Affordable Care Act (PPACA)(Public Law No. 111-148), was introduced on March 29, 2011, by Rep. Joseph Pitts (R-PA), and was referred to the Committee on Energy and Commerce.

The goal of H.R. 1217 is to reduce federal spending, deficits, and debt by repealing mandatory programs with limited Congressional oversight.

BACKGROUND AND NEED FOR LEGISLATION

The Prevention and Public Health Fund, Section 4002 of PPACA, is a \$17.75 billion account (FY12-FY21) administered by the Secretary of Health and Human Services (HHS) to provide for “expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.”

Section 4002 appropriates \$1 billion for FY 2012; \$1.25 billion for FY 2013; \$1.5 billion for FY 2014; \$2 billion for FY 2015 and each fiscal year thereafter in perpetuity. The proposed legislation would repeal Section 4002 and rescind any unobligated funds.

The Secretary has full authority to spend funds in this account on any program or activity under the Public Health Service Act (PHSA) the Department chooses without further Congressional action. Repealing this fund does not cut any specific program. The Prevention and Public Health Fund provides supplemental funding for PHSA programs above their FY 2008 level. The House-passed health care bill in the last Congress, H.R. 3962, did create a public health trust fund at a cost of \$34 billion over 10 years. However, this fund would have been subject to Congress providing a subsequent appropriation.

Providing an advanced appropriation limits Congressional oversight of spending under the PHSA. Rather than provide the Secretary a large appropriation with broad discretion, the Committee believes Congress should identify worthy public health service programs and authorize them at appropriate levels. Congress can then set fiscal priorities by subsequently providing funding through the appropriations process after weighing the relative value of different programs.

The large and permanent advanced appropriation made available under Section 4002 also comes at a time when the growth in federal spending, particularly health care spending, has fueled mounting deficits and debt. The President’s Budget calls for \$3.8 trillion in federal spending for FY 2011. These spending levels represent 25.3 percent of GDP and are well above the historical average of 20.3 percent.

Consequently, this record spending has lead to a FY 2011 deficit of \$1.6 trillion (10.9 percent of GDP). Deficits for 2011 represent an all-time record both in nominal terms and as a share of the economy post-World War II.

Record deficits have also induced record borrowing. The federal government is now borrowing 42 cents for every dollar it spends. By the end of the decade, the federal debt will nearly double from

\$14 trillion to \$26 trillion. Interest payments alone will increase to \$841 billion annually by 2021.

In light of these facts, reigning in government spending is the only responsible course if we are to avoid a debt crisis. H.R. 1217 helps achieve this goal by eliminating a mandatory appropriation that would not have been subject to Congressional oversight.

HEARINGS

The Subcommittee on Health held a hearing on a discussion draft identical to H.R. 1217 on March 9, 2011. The following witnesses testified at the hearing:

- The Honorable Ernest J. Istook, The Heritage Foundation
- Dr. John Goodman, President and CEO, National Center for Policy Analysis
- The Honorable Joseph F. Vitale, New Jersey State Senate

The Secretary of HHS also testified before the Health Subcommittee at a March 3, 2011 hearing regarding the President's FY 2012 Budget and implementation of PPACA.

COMMITTEE CONSIDERATION

H.R. 1217 was introduced by Mr. Joseph Pitts on March 29, 2011, and was referred to the Committee on Energy and Commerce.

On March 31, 2011, the Subcommittee on Health met in open markup session to consider H.R. 1217. Subsequently, the Subcommittee ordered H.R. 1217 favorably reported by a recorded vote of 14–11.

On April 5, 2011, the Energy and Commerce Committee met in open markup session to consider H.R. 1217. Subsequently, the Committee ordered H.R. 1217 favorably reported by a vote of 26–16.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto.

**COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 20**

BILL: H.R. 1217, to repeal the Prevention and Public Health Fund

AMENDMENT: A motion by Mr. Upton to order H.R. 1217 favorably reported to the House, without amendment. (Final Passage)

DISPOSITION: **AGREED TO**, by a roll call vote of 26 yeas to 16 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton	X			Mr. Waxman		X	
Mr. Barton	X			Mr. Dingell			
Mr. Stearns	X			Mr. Markey			
Mr. Whitfield				Mr. Towns			
Mr. Shimkus	X			Mr. Pallone		X	
Mr. Pitts	X			Mr. Rush			
Mrs. Bono Mack				Ms. Eshoo		X	
Mr. Walden	X			Mr. Engel			
Mr. Terry	X			Mr. Green		X	
Mr. Rogers	X			Ms. DeGette		X	
Mrs. Myrick				Mrs. Capps		X	
Mr. Sullivan	X			Mr. Doyle			
Mr. Murphy	X			Ms. Schakowsky		X	
Mr. Burgess	X			Mr. Gonzalez			
Mrs. Blackburn	X			Mr. Inslee		X	
Mr. Bilbray	X			Ms. Baldwin		X	
Mr. Bass	X			Mr. Ross		X	
Mr. Gingrey	X			Mr. Weiner		X	
Mr. Scalise	X			Mr. Matheson		X	
Mr. Latta	X			Mr. Butterfield		X	
Mrs. McMorris Rodgers				Mr. Barrow		X	
Mr. Harper	X			Ms. Matsui		X	
Mr. Lance	X			Ms. Christensen		X	
Mr. Cassidy	X						
Mr. Guthrie	X						
Mr. Olson	X						
Mr. McKinley							
Mr. Gardner	X						
Mr. Pompeo	X						
Mr. Kinzinger	X						
Mr. Griffith	X						

Current as of 03/14/2011

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the oversight findings and recommendations of the Committee are reflected in the descriptive portions of this report, including the finding that reigning in mandatory spending is necessary to avoid a debt crisis.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the performance goals and objectives of the Committee are reflected in the descriptive portions of this report, including the goal of avoiding a debt crisis by reigning in mandatory spending.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 1217 would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

EARMARK

In compliance with clause 9(e), 9(f), and 9(g) of rule XXI, the Committee finds that H.R. 1217 contains no earmarks, limited tax benefits, or limited trade benefits.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

H.R. 1217—A bill to repeal the Prevention and Public Health Fund

Summary: H.R. 1217 would repeal a fund established by the Patient Protection and Affordable Care Act (PPACA), the Prevention and Public Health Fund, which provides grant assistance to entities to carry out prevention, wellness, and public health activities. The bill also would rescind any unobligated balances appropriated to the fund.

CBO estimates that enacting the legislation would decrease direct spending by more than \$6 billion over the 2012–2016 period and by \$16 billion over the 2012–2021 period. Pay-as-you-go procedures apply because enacting the legislation would affect direct spending.

The bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 1217 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year, in billions of dollars—											
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2012–2016	2012–2021
CHANGES IN DIRECT SPENDING												
Budget Authority	-1.0	-1.3	-1.5	-2.0	-2.0	-2.0	-2.0	-2.0	-2.0	-2.0	-7.8	-17.8
Estimated Outlays	-0.4	-0.9	-1.3	-1.6	-1.9	-2.0	-2.0	-2.0	-2.0	-2.0	-6.1	-16.0

Note: Numbers may not sum to totals because of rounding.

Basis of estimate: For this estimate, CBO assumes that the legislation will be enacted by the end of September 2011.¹ As established by PPACA, the Prevention and Public Health Fund provides grant funds to federal agencies to award to public and private entities to carry out prevention, wellness, and public health activities. The Act provided annual funding of \$750 million in 2011 rising to \$2.0 billion per year by 2015. CBO estimates that H.R. 1217 would prevent the Department of Health and Human Services from obligating any unobligated funds appropriated to the Prevention and Public Health Fund. CBO expects that all of the appropriated funds for fiscal year 2011 will be obligated by the time H.R. 1217 would be enacted. As a result, CBO estimates that enacting H.R. 1217 would reduce direct spending by \$6.1 billion over the 2012–2016 period and by \$16 billion over the 2012–2021 period.

Pay-as-you-go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table. Enacting H.R. 1217 would have no impact on federal revenues.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 1217, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON ENERGY AND COMMERCE ON APRIL 5, 2011

	By fiscal year, in billions of dollars—												
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2011–2016	2011–2021
NET DECREASE (–) IN THE DEFICIT													
Statutory Pay-As-You-Go Impact	0	-0.4	-0.9	-1.3	-1.6	-1.9	-2.0	-2.0	-2.0	-2.0	-2.0	-6.1	-16.0

Note: Numbers may not sum to totals because of rounding.

Intergovernmental and private-sector impact: H.R. 1217 contains no intergovernmental or private-sector mandates as defined in UMR. By rescinding funding amounts made available by the Prevention and Public Health Fund, the bill would decrease the amount of resources that state, local, and tribal governments receive to conduct prevention, wellness, and public health activities.

¹ If the bill were to be enacted sooner than the end of fiscal year 2011, a larger unobligated balance may remain than is estimated here. In that case, the amount of budget authority that could be rescinded by this legislation would increase, resulting in a corresponding increase in savings.

Estimate prepared by: Federal Costs: Lisa Ramirez-Branum; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Jimmy Jin.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1 repeals Section 4002 of PPACA and rescinds unobligated funds made available by such Section 4002.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets and existing law in which no change is proposed is shown in roman):

PATIENT PROTECTION AND AFFORDABLE CARE ACT

* * * * *

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems

* * * * *

[SEC. 4002. PREVENTION AND PUBLIC HEALTH FUND.

[(a) PURPOSE.—It is the purpose of this section to establish a Prevention and Public Health Fund (referred to in this section as the “Fund”), to be administered through the Department of Health and Human Services, Office of the Secretary, to provide for expanded and sustained national investment in prevention and public

health programs to improve health and help restrain the rate of growth in private and public sector health care costs.

[(b) FUNDING.—There are hereby authorized to be appropriated, and appropriated, to the Fund, out of any monies in the Treasury not otherwise appropriated—

[(1) for fiscal year 2010, \$500,000,000;

[(2) for fiscal year 2011, \$750,000,000;

[(3) for fiscal year 2012, \$1,000,000,000;

[(4) for fiscal year 2013, \$1,250,000,000;

[(5) for fiscal year 2014, \$1,500,000,000; and

[(6) for fiscal year 2015, and each fiscal year thereafter, \$2,000,000,000.

[(c) USE OF FUND.—The Secretary shall transfer amounts in the Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal year 2008 level, for programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research, health screenings, and initiatives, such as the Community Transformation grant program, the Education and Outreach Campaign Regarding Preventive Benefits, and immunization programs.

[(d) TRANSFER AUTHORITY.—The Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives may provide for the transfer of funds in the Fund to eligible activities under this section, subject to subsection (c).]

* * * * *

DISSENTING VIEWS

We, the undersigned Members of the Committee on Energy and Commerce, oppose the passage of H.R. 1217, a bill to repeal Prevention and Public Health Fund (established in the *Patient Protection and Affordable Care Act*) and accordingly, submit the following comments to express our concerns about this highly regressive, extremely short-sighted, and deeply divisive legislation.

INTRODUCTION AND BACKGROUND

Enacted in 2010, the *Patient Protection and Affordable Care Act* (ACA)¹ expands access to health care for some 32 million Americans and improves health benefits for millions more who are already insured.²

But as valuable as it is, health insurance cannot do everything necessary to make our nation healthy. Even if other parts of the ACA make it possible for virtually everyone to be insured, there will still be a major role for public health. Moreover, there will be an ongoing need for funding for these public health activities.

“Public health” includes many different things:

- It is working with groups and whole communities to improve health, often more effectively than could be done between a provider and a patient. Fluoridation of water for a town is, for instance, vastly better than simply filling every citizen’s cavities. Exercise programs to prevent obesity are better than having to treat diabetes among people who become obese.

- It is tailoring health insurance and health care to prevent and diagnose disease early rather than simply treating it in its later stages. Immunizations are always better than outbreaks. Screening for hypertension is better than simply waiting for strokes.

- It is providing for safety-net services where the insurance market alone fails to do so. Community health centers, HIV-service providers, and family planning clinics provide care to people who might not otherwise be able to find a provider. Health professions education programs can add to the primary care workforce when the market might produce only specialists. (Such programs will be even more necessary once the insurance expansion provisions of the ACA are implemented.)

- And, least glamorous but crucial, it is the infrastructure of daily disease control and health promotion. Closing down unsanitary restaurants is better than treating food poisoning. Compiling and studying epidemic trends can prevent major waves of disease.

The case might be made clearer by analogy: No community would be well-served if all its homeowners had fire insurance but

¹ACA is comprised of two public laws, P.L. 111–148 and P.L. 111–152.

²Letter from Douglas W. Elmendorf, Director, CEO to Speaker Nancy Pelosi (Mar. 20, 2010) (on line at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>).

there were no fire departments, firefighters, fire hydrants, smoke detectors, or indoor sprinklers. That very well-insured town would still burn to the ground. Insurance is necessary, but it is nowhere near sufficient.

The ACA addresses both approaches, with insurance and with public health. This required going beyond the investments in the law to provide health insurance to also include provisions to make significant public health investments.

It would be insufficient simply to authorize future appropriations for these activities while providing mandatory spending for coverage initiatives. While the Committee on Appropriations of both the House and the Senate has shown ongoing and great leadership in these public health programs, the budget allocations for them have been too tight to allow significant new initiatives of these sorts. Consequently, the ACA provides as firm a funding and organizational base for these services as possible—mandatory spending—because they are essential in making insurance efficient and productive and in making the nation healthier.

Among those programs designated for mandatory spending in the ACA is the Prevention and Public Health Fund (Fund). Its purpose is “to provide for expanded and sustained national investment in prevention and public health programs.”³ It is the first and only federal program with dedicated, ongoing resources specifically designed to improve the public’s health, and in turn, to make the United States a healthier nation.

The Fund is administered by the Secretary of the Department of Health and Human Services (HHS) and may be used to support “programs authorized under the Public Health Service Act.”⁴ It provides \$5 billion in mandatory spending for these activities over the period FY 2010 through FY 2014 and \$2 billion in mandatory spending each fiscal year thereafter. This significant and ongoing level of support is necessary to address the chronic underfunding of prevention activities which by some estimates, account for only 2% to 4% of national health expenditures.⁵

Support for prevention has long been a bipartisan perspective. Members of this Committee from both sides of the aisle and across the political spectrum have spoken strongly in favor of this public health function.⁶ Beyond the halls of Congress, this support is also widespread. A public opinion survey by Trust for America’s Health and the Robert Wood Johnson Foundation found that 71% of Americans favored an increased investment in disease prevention.⁷ And

³ACA, Section 4002.

⁴*Id.*

⁵J. M. Lambrew, *A Wellness Trust to Prioritize Disease Prevention*, Brookings Institution (Apr. 2007) (on line at http://www.brookings.edu/papers/2007/-/media/Files/rc/papers/2007/04useconomics_lambrew/04us).

⁶See, e.g., comments made by Reps. Pitts, Murphy, Matsui, and Cassidy in support of prevention efforts during the full Committee mark up of H.R. 1217, House Committee on Energy and Commerce, *Business Meeting to Mark Up H.R. 1217, To Repeal the Prevention and Public Health Fund*, 112th Cong., p. 242 (Apr. 5, 2011) (transcript of the proceeding):

- Rep. Pitts: “I am not against prevention and wellness”;
- Rep. Murphy: “I believe all of us are pretty strongly in favor of anything that has to do with prevention”;
- Rep. Matsui: “We are talking about having healthier Americans. . . . “[M]ost people here truly believe that prevention is probably the best way to do this”;
- Rep. Cassidy: “I strongly believe in many aspects of preventative medicine. . . .”;

⁷See <http://healthyamericans.org/newsroom/releases/?releaseid=198> for a description of the poll’s complete findings.

nearly 600 national, state, and local organizations support the Fund as a primary vehicle for making public health investments that would not only help to improve the public's health, but also to create jobs and lower long-term health care costs.⁸

PREVENTION FUND DOLLARS AT WORK

The Prevention and Public Health Fund is one of a number of ACA initiatives that is already in place. Currently, all 50 states and the District of Columbia are receiving Fund support.⁹ Among other activities, Fund dollars are being used for community-based projects to reduce tobacco use and obesity, prevent HIV infection, build epidemiology and laboratory capacity to track and respond to disease outbreaks, and train the public health workforce.

In general, the Fund is intended to provide support for programs generated at the local or community-based level. This is as it should be—communities know best what public health challenges they face and what interventions are most likely to work. Specific examples of this type of initiative include the following from the Centers for Disease Control and Prevention website:¹⁰

MOBILE COUNTY, ALABAMA, *HTTP://WWW.MOBILECOUNTYHEALTH.ORG*
\$3 MILLION FOR TOBACCO PREVENTION

The Alabama Communities Putting Prevention to Work project will address tobacco prevention efforts in Mobile County. Working with the Mobile Children's Policy Council, the Coalition for a Tobacco Free Mobile, and the Mobile Leadership Team, the program will implement a media campaign to educate Mobile citizens about the health benefits of clean, smoke-free indoor air and promote existing cessation services. The project will also educate decision makers about the public health impact of comprehensive smoke free policies. Mobile County will work with tobacco retailers to restrict point of purchase tobacco advertising and will support systems change in worksites and schools by increasing the availability of cessation services and tobacco-free environments. The intent of these systems and policy approaches is to reduce exposure to secondhand smoke, reduce social acceptability of tobacco use, and increase cessation attempts by tobacco users.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL *HTTP://WWW.SCDHEC.GOV/* \$1.6 MILLION FOR OBESITY PREVENTION

The South Carolina Department Health and Environmental Control received \$1.6 million for a statewide obesity, physical activity, and nutrition program. South Carolina will pilot a statewide Farm to School program. Key objectives include developing and maintaining an infrastructure to support local implementation of farm to

⁸Letter from Jeffrey Levi, PhD, Executive Director, Trust for America's Health (on behalf of 600 health-related organizations) to Chairman Fred Upton, Ranking Member Henry Waxman, Chairman Joe Pitts, and Ranking Member Frank Pallone, Jr. (Mar. 30, 2011) (on line at <http://healthyamericans.org/assets/files/Groups%20Supporting%20PreventionFund%20state%20by%20state-04-05-11.pdf>).

⁹For a description of these activities, see <http://www.healthcare.gov/news/factsheets/prevention02092011a.html>

¹⁰*Id.*

school programs. With approximately 1100 public schools in South Carolina, school meals are a lifeline for many children, especially low-income children. Each day the state's schools serve approximately 733,000 meals and provide opportunities for those students to learn about healthy nutrition and the importance of agriculture to South Carolina. Systems leveling approaches, like Farm to School programs, have the potential to impact not only the student population and school staff, but also the surrounding communities. Increased consumption of fruits and vegetables can build healthy children, schools, farms and communities and in the long term will reduce obesity and obesity-related chronic diseases.

DEKALB COUNTY BOARD OF HEALTH, GEORGIA [HTTP://WWW.DEKALBHEALTH.NET/](http://WWW.DEKALBHEALTH.NET/) \$2.35 MILLION FOR OBESITY PREVENTION

The DeKalb County Putting Prevention to Work initiative will work with community partners and local government officials to create a Master Active Living Plan (Plan). The Plan will include a policy that will allow neighborhood residents access to school recreational facilities affording them easy access to places for physical activity, and establishing community vegetable gardens in local parks. These changes will make it easier for children and adults to eat healthier and be more physically active. The goals of these CPPW initiatives include achieving (1) increased physical activity, (2) improving nutrition; and (3) decreasing overweight/obesity prevalence. The interventions will strive to reduce the burden of chronic disease, reduce health disparities and improve public health across the lifespan of DeKalb residents and will be adapted as necessary to meet the diverse cultural and linguistic needs of our community.

PITT COUNTY, NORTH CAROLINA [HTTP://WWW.PITTCOUNTYNC.GOV/DEPTS/HEALTH/](http://WWW.PITTCOUNTYNC.GOV/DEPTS/HEALTH/)

The Pitt County Health Department (PCHD) will strive to improve access to nutritious food through *The Corner Store Initiative*, which is centered on increasing access and availability of healthy food/drink/, improving product placement and attractiveness, and changing the relative prices of healthy versus unhealthy items in convenience stores. PCHD also plans to collaborate with three cities to develop point of decision making signage to encourage physical activity. PCHD also proposes to partner with state and local entities to develop the necessary infrastructure to support Safe Routes to Schools. In addition, the community will build upon established partnerships with local planning agencies and transportation officials to develop and place signage within communities to point out public parks, other recreational opportunities, and the availability of bike lanes and alternate forms of travel.

PREVENTION DOLLARS PRODUCE HIGH VALUE OUTCOMES

Preventable diseases cost the United States significant resources—in terms of unnecessary deaths, lost productivity, and enormous amounts of money. Indeed, over half of the deaths in this country are due to preventable causes such as tobacco use, diet and

activity patterns, and alcohol use.”¹¹ Chronic diseases consume an estimated 75% of the nation’s \$2 trillion health care spending each year¹² and cost employers \$1,685 for each employee each year, or \$225.8 billion annually in lost productivity.¹³ Obesity alone costs \$147 billion each year.¹⁴ A stable, ongoing investment in prevention can help alleviate each of these burdens.

It is true that some life-saving prevention interventions actually involve expenditures. But so do most life-saving drugs and devices. We provide mandatory funding for drugs and devices through programs such as Medicare and Medicaid because steady and secure funding for these programs ensures that more Americans can live longer and healthier lives. Prevention efforts can also reduce the number of deaths and promote the health of Americans and should, therefore, also be supported through the mandatory spending mechanism.

Some forms of prevention do, of course, save money—immunizations, for example, are among our most cost-effective public health investments. Community-based interventions can be cost-effective as well. According to the researchers at the New York Academy of Medicine, an investment of \$10 per person per year in proven community-based interventions to increase physical activity, improve nutrition, and prevent smoking can save the country more than \$16 billion each year—a return of \$5.60 for every \$1 invested.¹⁵ The Urban Institute estimates that certain proven community-based diabetes prevention programs can save as much as \$191 billion over 10 years.¹⁶

MANDATORY SPENDING

Despite the good and important work being done through the Fund, the health care savings it may help to produce, and the chronic underfunding of prevention activities in the past, Republicans are determined to bring the Fund to an end. They assert two principal arguments for their opposition to it: (1) the Fund’s funding mechanism—mandatory spending; and (2) the Secretary’s authority to determine how the Fund’s monies will be allocated. The two arguments are interrelated; taken together, they present a misleading analysis of how the Fund is intended to operate.

ACA Section 4002(b) provides for mandatory funding for the Fund. It authorizes to be appropriated and appropriates specified funding levels for FY 2010 and beyond. ACA Section 4002(d) addresses the role of the congressional appropriations committees in specifying how the appropriated funds are to be used. That section clearly states that these committees have explicit authority to allo-

¹¹ McGinnis JM and Foege WH, *Actual Causes of Death in the United States*, JAMA, 270(18): 2207–2212 (Nov. 10, 1993).

¹² Centers for Disease Control and Prevention, *Chronic Disease: The Power to Prevent, the Call to Control, At-A-Glance* (2009).

¹³ Centers for Disease Control and Prevention, *Workplace Health Promotion* (on line at <http://www.cdc.gov/workplacehealthpromotion/businesscase/reasons/productivity.html>).

¹⁴ Finkelstein EA, Trogdon JG, Cohen JW, et al., *Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates*, Health Affairs, 28(5): w822–w831 (2009).

¹⁵ Levi, J. et al., *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*, Trust for America’s Health (Feb. 2009) (on line at: <http://healthyamericans.org/reports/prevention08/Prevention08.pdf>).

¹⁶ Berenson, R. et al., *How We Can Pay for Health Reform*, Urban Institute and Robert Wood Johnson Foundation (July 2009) (on line at: http://urban.org/uploadedpdf/411932_howwecanpay.pdf).

cate monies from the Fund (in accordance with the Fund's purpose to support prevention and other public health activities). Senator Harkin (author of ACA Section 4002) addressed this very issue in a letter to the Committee, making it clear that it is the job of congressional appropriators to make the resource allocation decisions.¹⁷

It is only when Congress fails to pass an HHS appropriations bill that the HHS Secretary would have the authority to designate which public health programs or activities would receive Fund support. While it is true that the Secretary has already exercised this authority, it is also true that she has deferred spending these monies when requested to do so by Congress.¹⁸ Contrary to what Republicans have suggested, monies from the Fund have been allocated and are being used in accordance with both the Fund's purpose and the public health needs of the country.

AN ANTI-HEALTH REFORM IDEOLOGICAL AGENDA

In light of both the Fund's purpose and track record to date, it comes as a great disappointment that Republicans have targeted this program for elimination. Surely, this is not because of Republican assertions—made in this report and elsewhere—about the merits of discretionary spending versus mandatory spending or the need to protect Congress's prerogative to fund or not to fund health programs. Congress, Republicans and Democrats alike, makes those kinds of choices—often difficult choices—all of the time.¹⁹ And given traditional bi-partisan support for prevention activities, Republican opposition cannot be based on the substance of the program.

Pure and simple, H.R. 1217 represents the Republicans' new line of attack to disrupt, dismantle, and ultimately destroy the ACA—even those programs that have been funded and are up and running, and even those that make good health policy sense, in or out of the health reform law. What they have not been able to achieve whole cloth,²⁰ Republicans are now attempting to do piece by piece.

¹⁷Testimony of Senator Tom Harkin (submitted for the record), Subcommittee on Health, Committee on Energy and Commerce, *Hearing on Setting Fiscal Priorities in Health Care Funding*, 112th Cong. (Mar. 9, 2011) (stating, "Contrary to misperceptions that it evades the appropriations process, the Fund was established . . . in such a way that appropriators direct how monies from the Funds are spent").

¹⁸See the letter from Senator Tom Harkin, Chairman, Senate Committee on Health, Education, Labor, and Pensions and Chairman, Senate Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations to HHS Secretary Kathleen Sebelius (Jan. 4, 2011) in which he requested that the Secretary allocate monies in accordance with the prevention and public health priorities set forth in the proposed FY 2011 omnibus, year-long continuing resolution, including the Community Transformation Grants Program and tobacco prevention and control. The Secretary subsequently announced a spending plan for FY 2011 which closely tracked Chairman Harkin's request. (see HHS press release on line at <http://www.hhs.gov/news/press/2011pres/02/20110209b.html>). However, at the request of Reps. Denny Rehberg and Harold Rogers, the Secretary has not yet allocated any resources from the Fund for FY 2011. (Letter from Chairman Denny Rehberg, Chair, House Committee on Appropriations and Chairman Harold Rogers, Chair, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, House Committee on Appropriations to HHS Secretary Kathleen Sebelius (Mar. 2, 2011)).

¹⁹For examples of various federal programs that are supported through mandatory spending, see Committee on Energy and Commerce, Democratic Staff, *The Pitts Proposal to Block Mandatory Funding in the Affordable Care Act* (Mar. 9, 2011) (on line at: http://democrats.energycommerce.house.gov/sites/default/files/image_uploads/Fact%20Sheet_03.09.11.pdf).

²⁰Although the House of Representatives has passed legislation to repeal the ACA, that legislation will not become law since the Senate has defeated the proposal. (H.R. 2 passed the House of Representatives in January 2011 (Congressional Record, H322-323 (Jan. 11, 2011)). The Senate defeated a similar proposal a month later. (Congressional Record S475 (Feb. 2, 2011)).

H.R. 1217 puts the Prevention and Public Health Fund in the frontline of this ongoing assault.

In our view, this is not where the Prevention and Public Health Fund should be. Rather, it should remain exactly where it is—at the forefront of helping to realign the nation’s approach to health and health care, making us a healthier and more productive people.

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