

110TH CONGRESS
2D SESSION

S. 3674

To amend the Public Health Service Act to establish a Wellness Trust.

IN THE SENATE OF THE UNITED STATES

OCTOBER 1 (legislative day, SEPTEMBER 17), 2008

Mrs. CLINTON introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To amend the Public Health Service Act to establish a Wellness Trust.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “21st Century Wellness
5 Trust Act”.

6 **SEC. 2. FINDINGS AND PURPOSE.**

7 (a) FINDINGS.—Congress finds as follows:

8 (1) Preventable and chronic diseases are the
9 epidemic of the 21st century. The number of people
10 with chronic conditions is rapidly increasing and it
11 is estimated that, if there is no intervention now, by

1 2025 nearly half of the United States population will
2 suffer from at least 1 chronic disease. About 70 per-
3 cent of deaths and health costs in the United States
4 are attributable to chronic diseases (such as cardio-
5 vascular disease and cancer), some of which may be
6 preventable. Nearly 90 percent of Medicare bene-
7 ficiaries have some type of chronic illness.

8 (2) This affects Americans' health. The United
9 States has the highest rate of preventable deaths
10 among 19 industrialized nations and lags behind 28
11 other nations in life expectancy. For example, obe-
12 sity, which is rising rapidly, contributes to a wide
13 range of problems, from diabetes to stroke to cancer.
14 The life expectancy for a 20-year old man may be
15 reduced by 17 percent due to obesity. If trends con-
16 tinue, children's life spans may be shorter than
17 those of their parents for the first time in about a
18 century.

19 (3) The wellness gap also affects health care
20 costs. About 78 percent of all health spending in the
21 United States is attributable to chronic illness, much
22 of which is preventable. Chronic diseases cost the
23 United States an additional \$1,000,000,000,000
24 each year in lost productivity, and are a major con-
25 tributing factor to the overall poor health that is

1 placing the Nation's economic security and competi-
2 tiveness in jeopardy.

3 (4) Unlike some health care challenges, proven
4 preventive services and programs exist. If effective
5 risk reduction were implemented and sustained by
6 2015, the death rate due to cancer could drop by 29
7 percent. Improved blood sugar control for people
8 with diabetes could reduce the risk for eye disease,
9 kidney disease, and nerve disease by 40 percent.
10 Similarly, blood pressure control could reduce the
11 risk for heart disease and stroke by 33 to 50 per-
12 cent.

13 (5) Yet, only half of recommended clinical pre-
14 ventive services are provided to adults. About 20
15 percent of children do not receive all recommended
16 immunizations, with higher rates in certain areas.
17 Nearly 70 percent of people with high blood pressure
18 do not now control it. And racial disparities in use
19 of prevention exist.

20 (6) The United States faces low use of preven-
21 tive services because of the low value placed on pre-
22 vention, a delivery system bent toward fixing rather
23 than preventing problems, and financial disincentives
24 for prevention. Insurers have little incentive to invest
25 in preventive services today that will benefit other

1 insurers tomorrow. This is especially true for those
2 preventive services that reduce chronic diseases that
3 develop over a period of several years or decades.
4 The costs of prevention are incurred immediately
5 but most of its benefits are realized later, often by
6 Medicare.

7 (7) There is a low investment in prevention.
8 The United States spends only an estimated 1 to 3
9 percent of national health expenditures on preventive
10 health care services and health promotion. This has
11 not increased as much as one might expect since
12 1929, 1.4 percent, despite the development of expen-
13 sive screenings, early interventions, and the growth
14 of the preventable disease burden.

15 (8) The workforce to deliver prevention is also
16 insufficient. The supply of providers who are trained
17 to emphasize prevention is shrinking. Between 1997
18 and 2005, the number of medical school graduates
19 entering family practice residencies dropped by 50
20 percent. There is an acute shortage of community
21 health workers. Between 25 and 50 percent of the
22 existing Federal, State, and local public health work-
23 force is eligible for retirement in the next 5 years.
24 As of 2008, more than 75 percent of the existing
25 public health workforce has no formal public health

1 or prevention training. There is no national, uniform
2 credentialing system for public health or prevention
3 workers that would ensure that these workers are
4 trained in the basics of preventive care.

5 (9) A system that promoted full use of high-pri-
6 ority prevention could save lives. A recent com-
7 prehensive assessment found that 1,200,000 quality-
8 adjusted life years could be saved by achieving 90
9 percent use of just the following 3 services:

10 (A) Smoking cessation counseling.

11 (B) Use of aspirin to prevent heart at-
12 tacks.

13 (C) Screening for colorectal cancer.

14 (10) A system that promoted full use of high-
15 priority prevention could reduce costs. For example,
16 complete, routine childhood vaccination could save
17 up to \$40,000,000,000 in direct and societal costs
18 over time. Promoting screenings and behavioral
19 modifications in the workplace can lower absentee-
20 ism and, in most cases, health costs to firms. Pre-
21 ventive health care services could reduce government
22 spending on health care. If all elderly received a flu
23 vaccine, health costs could be reduced by nearly
24 \$1,000,000,000 per year. Over 25 years, Medicare
25 could save an estimated \$890,000,000,000 from ef-

1 fective control of hypertension, and
 2 \$1,000,000,000,000 from returning to levels of obe-
 3 sity observed in the 1980s.

4 (11) Investing in community-level interventions
 5 that promote and enable proper nutrition, increased
 6 access to physical activity, and smoking cessation
 7 programs can prevent and mitigate chronic diseases,
 8 improve quality of life, increase economic produc-
 9 tivity, and reduce healthcare costs.

10 (b) PURPOSE.—The purpose of this Act is to create
 11 a 21st century prevention system called the Wellness
 12 Trust that assures access to clinical and community-level
 13 prevention services that improve health, quality of life, and
 14 reduce healthcare costs.

15 **SEC. 3. WELLNESS TRUST.**

16 Title III of the Public Health Service Act (21 U.S.C.
 17 241 et seq.) is amended by adding at the end the fol-
 18 lowing:

19 **“PART S—WELLNESS TRUST**

20 **“SEC. 399KK. DEFINITIONS; ESTABLISHMENT OF WELLNESS**
 21 **TRUST.**

22 “(a) DEFINITIONS.—In this part:

23 “(1) CERTIFIED PREVENTION HEALTH WORK-
 24 ER.—The term ‘certified prevention health worker’

1 means a licensed health professional or other health
2 worker deemed certified by the Trustees.

3 “(2) TRUST.—The term ‘Trust’ means the
4 Wellness Trust established under subsection (b).

5 “(3) TRUSTEES.—The term ‘Trustees’ means
6 the members of the Trust Fund Board appointed
7 under section 399LL(b).

8 “(b) ESTABLISHMENT OF THE WELLNESS TRUST.—
9 There is established within the Centers for Disease Con-
10 trol and Prevention the Wellness Trust.

11 **“SEC. 399LL. STRUCTURE.**

12 “(a) TRUST FUND BOARD.—The Trust shall be
13 headed by the Trust Fund Board.

14 “(b) COMPOSITION.—The Trust Fund Board shall be
15 composed of 7 members appointed by the President by and
16 with the advice and consent of the Senate.

17 “(c) DATE OF APPOINTMENTS.—The initial 7 Trust-
18 ees shall be appointed not later than December 31, 2009.

19 “(d) STAGGERED TERMS.—Of the members first ap-
20 pointed under subsection (c)—

21 “(1) 4 shall be appointed for a period of 4
22 years; and

23 “(2) 3 shall be appointed for a period of 3
24 years.

1 “(e) VACANCIES.—A vacancy on the Trust Fund
2 Board—

3 “(1) shall not affect the powers of the Trust
4 Fund Board; and

5 “(2) shall be filled in the same manner as the
6 original appointment was made.

7 “(f) MEETINGS.—The Trust Fund Board shall meet
8 at the call of the Chairperson.

9 “(g) QUORUM; REQUIRED VOTES.—A majority of
10 Trustees shall constitute a quorum for purposes of voting,
11 but a lesser number of members may hold hearings. The
12 Chairperson shall require a vote of the Trustees on major
13 decisions regarding prevention priorities, resource alloca-
14 tion, delivery system structure, and other Trust functions.

15 “(h) CHAIRPERSON AND VICE CHAIRPERSON.—The
16 Trust Fund Board shall select a Chairperson and Vice
17 Chairperson from among the Trustees.

18 “(i) REMOVAL.—A Trustee may be removed by the
19 President only for cause.

20 “(j) RECOMMENDATIONS.—The Trustees may submit
21 recommendations directly to Congress, without oppor-
22 tunity for comment or change by the Secretary.

23 “(k) STAFF.—The Trustees may employ and fix the
24 compensation of personnel as necessary. Not more than
25 5 percent of the funds appropriated in a fiscal year to

1 the Trust Fund established under section 399NN may be
2 used to fund the staff, operations, and other purposes as
3 the Trustees determine appropriate of the Trust Fund
4 Board, subject to the oversight of the Secretary.

5 **“SEC. 399MM. REPORTS; PLAN FOR DELIVERING SYSTEMS.**

6 “(a) DEVELOPMENT OF KEY REPORTS.—Not later
7 than 1 year after the appointment of the Trustees under
8 section 399LL(c), the Trustees shall submit to Congress
9 and make publicly available the following reports:

10 “(1) REPORT ON BROADENING THE PREVEN-
11 TION WORKFORCE.—A report that develops and de-
12 scribes a system for certification and recertification
13 of ‘prevention health workers’ to complement the
14 health system as in existence at the time of such re-
15 port. Such system may expand certification efforts
16 in existence at the time of such report for the public
17 health workforce and community health workers.
18 Such report shall also examine the impact of State
19 licensing requirements and explore and describe op-
20 tions for health profession training and continuing
21 education, 1 or more registries of certified preven-
22 tion health workers, and an employment structure
23 that encourages flexible deployment but protects pre-
24 vention health workers’ benefits.

1 “(2) REPORT ON ALIGNING PAYMENTS WITH
2 PREVENTION GOALS.—A report that examines and
3 describes payment methodologies and presents op-
4 tions for paying certified prevention health workers
5 for clinical preventive care that aligns incentives
6 with goals, as well as payment methodologies for
7 community organizations involved in the provision of
8 prevention services. Such report shall address the
9 shortfalls of the payment systems in existence at the
10 time of such report that have not proven effective at
11 encouraging the provision of prevention services.

12 “(3) REPORT ON IDENTIFYING EXISTING FUND-
13 ING FOR PREVENTION.—A report that examines and
14 describes the amount of money spent on prevention
15 by public health, public and private health insurers,
16 and applicable self-insured health plans (as defined
17 in section 39900) during the most recent year for
18 which such data is available.

19 “(b) PLAN FOR DELIVERY SYSTEMS.—Not later than
20 1 year after the appointment of the Trustees under section
21 399LL(c), the Trustees shall establish a plan for deliv-
22 ering and financing prevention priorities and implement
23 pilot programs. Such plan shall include—

24 “(1) identifying effective delivery systems based
25 on evidence and expert judgment to determine how

1 best to deliver priority clinical and community-based
2 prevention activities;

3 “(2) assessing the current capacity of effective
4 delivery systems and actions necessary to ensure
5 adequate infrastructure and capacity to deliver pri-
6 ority clinical and community-based prevention activi-
7 ties as determined by the Trust; and

8 “(3) identifying cost-saving clinical and commu-
9 nity-based interventions to implement before Decem-
10 ber 31, 2011, which shall include evidence-based
11 interventions in obesity, diabetes, heart disease, or
12 cancer.

13 **“SEC. 399NN. INFRASTRUCTURE AND PRIORITIES.**

14 “(a) DESIGNATING NATIONAL PREVENTION PRIOR-
15 ITIES.—The Trustees shall issue a ranked list of des-
16 ignated ‘prevention priorities’. The inclusion of an activity
17 on such list shall be based on the potential of such activity
18 to improve health and the cost effectiveness of such activ-
19 ity. Such list shall—

20 “(1) include clinical preventive services and
21 community-based interventions; and

22 “(2) be used by the Trustees to—

23 “(A) determine what prevention services
24 shall be paid for through the Trust Fund under
25 section 39900;

1 “(B) allocate resources within the Trust;

2 “(C) educate the public on critical preven-
3 tion priorities; and

4 “(D) emphasize coverage and use within
5 existing authorities.

6 “(b) CREATION AND SUPPORT OF INFRASTRUC-
7 TURE.—The Trustees shall establish and otherwise sup-
8 port and sustain the infrastructure for an effective
9 wellness system, including the following components:

10 “(1) CENTRAL SOURCE OF PREVENTION INFOR-
11 MATION.—A centralized, national, easily accessible
12 information clearinghouse on prevention priorities.
13 Such information clearinghouse shall be made avail-
14 able in multiple media and updated regularly and
15 shall connect individuals, health care providers, and
16 others to national and local resources.

17 “(2) DEVELOPING, IMPLEMENTING, AND MAIN-
18 TAINING THE ELECTRONIC PREVENTION RECORD.—
19 If no nationwide interoperable electronic medical
20 record system exists, a privacy-protected electronic
21 prevention record or registry to—

22 “(A) track provision of prevention over the
23 course of individuals’ lifetimes;

24 “(B) facilitate reimbursement of certified
25 prevention health workers; and

1 “(C) assist in evaluations of the efficacy of
2 the policies of the Wellness Trust.

3 “(3) TRAINING AND CREDENTIALING PREVEN-
4 TION HEALTH WORKERS.—Training for prevention
5 health workers through agencies such as the Health
6 Resources and Services Administration and the Cen-
7 ters for Disease Control and Prevention. The Trust-
8 ees shall—

9 “(A) provide funding to such agencies
10 through the Trust Fund under section 3990O;

11 “(B) establish a central registry of cer-
12 tified prevention health workers; and

13 “(C) encourage such workers to access ad-
14 ditional training.

15 **“SEC. 3990O. FUNDING FOR WELLNESS TRUST.**

16 “(a) INITIAL FUNDING.—There is authorized to be
17 appropriated and there is appropriated to the Trust Fund
18 Board such sums as may be necessary to carry out sec-
19 tions 399MM and 399NN and other activities necessary
20 for the implementation of this part.

21 “(b) ESTABLISHMENT OF WELLNESS TRUST
22 FUND.—Not later than January 1, 2011, there shall be
23 established in the Treasury of the United States a trust
24 fund to be known as the ‘Wellness Trust Fund’ (referred
25 to in this section as the ‘Trust Fund’), consisting of such

1 amounts as are appropriated or credited to the Fund as
2 provided under this section.

3 “(c) APPROPRIATIONS TO THE FUND.—

4 “(1) FISCAL YEAR 2011.—There is hereby ap-
5 propriated to the Trust Fund for fiscal year 2011 an
6 amount equal to the amount spent by all Federal
7 health programs to pay for prevention services (as
8 defined by the U.S. Preventive Services Task Force)
9 in the most recent year for which complete data is
10 available, as estimated by the Trustees.

11 “(2) FISCAL YEAR 2012.—There is hereby ap-
12 propriated to the Trust Fund for fiscal year 2012
13 the amount appropriated to the Trust Fund for the
14 previous fiscal year, increased by the annual percent-
15 age increase in the medical care component of the
16 consumer price index (United States city average)
17 for the 12-month period ending with April of the
18 preceding fiscal year.

19 “(3) FISCAL YEAR 2013 AND SUBSEQUENT
20 YEARS.—There is hereby appropriated to the Trust
21 Fund for fiscal year 2013 and each subsequent fiscal
22 year an amount equal to the sum of—

23 “(A) the amount appropriated to the Trust
24 Fund for the previous fiscal year, increased by
25 the annual percentage increase in the medical

1 care component of the consumer price index
2 (United States city average) for the 12-month
3 period ending with April of the preceding fiscal
4 year.

5 “(B) the amount collected by the Secretary
6 from health insurance issuers and applicable
7 self-insured health plans under subsection (d)
8 for the fiscal year; and

9 “(C) the amount associated with preven-
10 tion priorities for State and local spending,
11 under-use, and the uninsured for the fiscal
12 year, as estimated by the Trustees (which shall
13 not exceed the amount equal to 10 percent of
14 the amount otherwise appropriated to the Trust
15 Fund for the fiscal year).

16 “(4) AVAILABILITY.—Amounts appropriated
17 pursuant to this subsection shall remain available
18 until expended.

19 “(d) ASSESSMENT OF HEALTH INSURANCE ISSUERS
20 AND APPLICABLE SELF-INSURED HEALTH PLANS.—

21 “(1) IN GENERAL.—Beginning in fiscal year
22 2013 and on an annual basis thereafter, the Sec-
23 retary shall, subject to paragraph (2), assess and
24 collect a fee from each health insurance issuer and
25 each applicable self-insured health plan in an

1 amount equal to the estimated amount spent by
2 such health insurance issuer and self-insured health
3 plan, respectively, for prevention services (as defined
4 by the U.S. Preventive Services Task Force).

5 “(2) COLLECTION AMOUNT ADJUSTMENT BE-
6 GINNING IN FISCAL YEAR 2013.—The amount deter-
7 mined under paragraph (1) shall, on an annual
8 basis, be increased by the annual percentage in-
9 crease in the medical care component of the con-
10 sumer price index (United States city average) for
11 the 12-month period ending with April of the pre-
12 ceding fiscal year.

13 “(e) DEFINITIONS.—In this section:

14 “(1) APPLICABLE SELF-INSURED HEALTH
15 PLAN.—The term ‘applicable self-insured health
16 plan’ means any plan for providing accident or
17 health coverage if—

18 “(A) any portion of such coverage is pro-
19 vided other than through an insurance policy;
20 and

21 “(B) such plan is established or main-
22 tained—

23 “(i) by 1 or more employers for the
24 benefit of their employees or former em-
25 ployees;

1 “(ii) by 1 or more employee organiza-
2 tions for the benefit of their members or
3 former members;

4 “(iii) jointly by 1 or more employers
5 and 1 or more employee organizations for
6 the benefit of employees or former employ-
7 ees;

8 “(iv) by a voluntary employees’ bene-
9 ficiary association described in section
10 501(c)(9) of the Internal Revenue Code of
11 1986;

12 “(v) by any organization described in
13 section 501(c)(6) of such Code; or

14 “(vi) in the case of a plan not de-
15 scribed in the preceding clauses, by a mul-
16 tiple employer welfare arrangement (as de-
17 fined in section 3(40) of the Employee Re-
18 tirement Income Security Act of 1974), a
19 rural electric cooperative (as defined in
20 section 3(40)(B)(iv) of such Act), or a
21 rural telephone cooperative association (as
22 defined in section 3(40)(B)(v) of such
23 Act).

24 “(2) HEALTH INSURANCE ISSUER.—The term
25 ‘health insurance issuer’ means an insurance com-

1 pany, insurance service, or insurance organization
 2 (including a health maintenance organization, as de-
 3 fined in paragraph (3)) which is licensed to engage
 4 in the business of insurance in a State and which is
 5 subject to State law which regulates insurance (with-
 6 in the meaning of section 514(b)(2) of the Employee
 7 Retirement Income Security Act of 1974).

8 “(3) HEALTH MAINTENANCE ORGANIZATION.—
 9 The term ‘health maintenance organization’
 10 means—

11 “(A) a federally qualified health mainte-
 12 nance organization (as defined in section
 13 1301(a));

14 “(B) an organization recognized under
 15 State law as a health maintenance organization;
 16 or

17 “(C) a similar organization regulated
 18 under State law for solvency in the same man-
 19 ner and to the same extent as such a health
 20 maintenance organization.

21 **“SEC. 399PP. INSURING PREVENTION PRIORITIES.**

22 “(a) WELLNESS TRUST AS PRIMARY PAYER FOR
 23 PREVENTION SERVICES.—The Trust shall enter into con-
 24 tracts with certified prevention health workers to reim-
 25 burse such workers for the prevention services designated

1 by the Trustees under section 399NN(b) as prevention
2 priorities.

3 “(b) PRIORITIES.—The Trustees shall develop annual
4 and 5-year targets for prevention priorities, budgets to
5 achieve these targets, and a list of what shall be included
6 for funding. Such targets shall include a set-aside for com-
7 munity-based services.

8 “(c) ELIGIBLE INDIVIDUALS.—Pursuant to the con-
9 tracts described under subsection (a), the Trust shall re-
10 imburse certified prevention health workers for the preven-
11 tion services described under such subsection provided to
12 all individuals who are United States citizens or legal im-
13 migrants, without regard to the insurance status of such
14 individuals.

15 “(d) DEVELOPMENT, REFINEMENT, AND CHANGE OF
16 PAYMENT SYSTEMS.—The Trustees shall determine pay-
17 ment methodologies for prevention priorities. Such pay-
18 ment methodologies shall correspond to the following tiers
19 of activity:

20 “(1) COMPETITIVE CONTRACTING AUTHOR-
21 ITY.—The Trustees shall have a competitive con-
22 tracting authority for the national delivery system
23 activities.

24 “(2) DIRECT PAYMENT SYSTEMS.—The Trust-
25 ees shall develop different payment methodologies

1 for the various designated prevention services. These
2 payment systems shall take into account existing
3 rates, rates for similar services, and whether geo-
4 graphic adjustment is needed. Such systems shall
5 link the priority of the service with payments.

6 “(3) USE OF STATE AND LOCAL GRANT SYS-
7 TEMS.—The Trustees shall utilize existing grant
8 programs where feasible to distribute funds from the
9 Trust Fund for prevention priorities.

10 “(4) REPORTS FROM FEDERAL PROGRAMS.—
11 Programs that receive funding for prevention prior-
12 ities through the Trust Fund shall report annually
13 to Congress on the extent to which this funding dis-
14 places existing spending on prevention priorities.

15 “(e) PARTNERSHIP WITH MEDICARE AND OTHER IN-
16 SURERS.—The Trustees shall determine the most efficient
17 way to transfer funds from the Trust Fund to certified
18 prevention health workers. In making such determination,
19 the Trustees shall carry out the following:

20 “(1) COORDINATION WITH MEDICARE.—The
21 Trustees shall examine the use of Medicare systems
22 for direct payments to certified prevention health
23 workers. Any additional administrative cost associ-
24 ated with the use of the payment systems, including

1 those of a broader set of providers, shall come from
2 the Trust Fund.

3 “(2) CONTRACT WITH OTHER INSURERS.—To
4 the extent that Medicare program, private insurers,
5 or States prove that such program, insurer, or State
6 has the capacity to deliver prevention priorities in a
7 cost effective manner, the Trustees may contract
8 with such entity for delivery of prevention services
9 covered under this Trust Fund.”.

○