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(Original Signature of Member)

117TH CONGRESS
1ST SESSION

H. R. ______

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.

IN THE HOUSE OF REPRESENTATIVES

Mrs. HAYES introduced the following bill; which was referred to the Committee on ______________________________

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 Adminis-

tration, 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.

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 ''Reducing COVID–19
5 Disparities by Investing in Public Health Act''.

6 **SEC. 2. FINDINGS.**

7 The Congress finds the following:

8 (1) Funding under this Act is essential to core
9 efforts at the Department of Health and Human
10 Services and in local and State health departments
11 to prevent and control the spread of chronic disease
12 and conditions. The National Center for Chronic
13 Disease Prevention and Health Promotion works to
14 raise awareness of health disparities faced by minor-
15 ity populations of the United States such as Amer-
16 ican Indians, Alaska Natives, Asian Americans, Afri-
17 can Americans, Latino Americans, and Native Ha-
18 waiians or other Pacific Islanders. One of the pri-
19 mary functions of the Center is to reduce risk fac-
20 tors for groups affected by health disparities.

1 (2) Six in ten Americans live with at least one
2 chronic disease, like heart disease and stroke, can-
3 cer, or diabetes. These and other chronic diseases
4 are the leading causes of death and disability in
5 America. Specifically, chronic diseases are respon-
6 sible for 7 in 10 deaths each year. According to the
7 Centers for Disease Control and Prevention
8 (''CDC''), individuals who are at high risk for severe
9 illness from COVID–19 are people with chronic lung
10 disease or moderate to severe asthma, people with
11 serious heart conditions, people who are
12 immunocompromised—sometimes because of cancer
13 or HIV/AIDS, people with diabetes, people with liver
14 disease, people with severe obesity, and people with
15 chronic kidney disease undergoing dialysis.
16 (3) According to the CDC, adults suffering
17 from cancer, chronic kidney disease, chronic lung
18 diseases, including chronic obstructive pulmonary
19 disease (COPD), asthma, interstitial lung disease,
20 cystic fibrosis, and pulmonary hypertension, demen-
21 tia or other neurological conditions, diabetes, Down
22 syndrome, heart conditions, including heart failure,
23 coronary artery disease, cardiomyopathies or hyper-
24 tension, HIV infection, liver disease, sickle cell dis-
25 ease, stroke, or cerebrovascular disease are more

1 likely to get severely ill from COVID–19 and face in-
2 creased rates of hospitalization, intensive care, as-
3 sisted ventilation, or even death.
4 (4) According to hospital data from the first
5 month of the COVID–19 epidemic in the United
6 States released by the CDC, roughly 1 in 3 people
7 who required hospitalizations from COVID–19 were
8 African American. While 33 percent of total hos-
9 pitalized patients are Black, African Americans con-
10 stitute just 13 percent of the entire American popu-
11 lation. Early data released by States and municipali-
12 ties show that African Americans suffered higher
13 mortality rates from COVID–19.
14 (5) Racial and ethnic disparities in COVID–19
15 hospitalization were driven by both a higher risk of
16 exposure to the disease, often from essential front-
17 line work performed at disproportionate rates by
18 Black and Latino workers, and social determinants
19 of health. Social inequities and environmental injus-
20 tices, such as differing access to healthy food, clean
21 air, safe drinking water, safe neighborhoods, edu-
22 cation, job security, and reliable transportation, af-
23 fect health risks and outcomes, reinforcing dispari-
24 ties in health and access to care.

1 (6) Socioeconomic factors further contribute to
2 racial disparities seen in both prevalence of chronic
3 conditions and exposure to COVID–19. Individuals
4 in low-income communities and people of color are
5 more likely to have many of the chronic health con-
6 ditions that have been identified as risk factors for
7 complications from COVID–19, yet suffer decreased
8 access to care, compounded by a decreased likelihood
9 of undergoing appropriate treatment.
10 (7) According to the American Diabetes Asso-
11 ciation, 12.5 percent of Hispanic Americans, 11.7
12 percent of African Americans, 9.2 percent of Asian
13 Americans, and 14.7 percent of American Indians/
14 Alaska Natives have been diagnosed with diabetes,
15 compared to just 7.5 percent of White Americans.
16 The CDC calculated that compared to non-Hispanic
17 Whites, Hispanics are 40 percent more likely to die
18 from diabetes, African Americans are twice as likely
19 to die from diabetes, and American Indians/Alaska
20 Natives are almost twice as likely to die from the
21 disease.
22 (8) According to the National Institutes of
23 Health, African Americans are more than 30 percent
24 more likely to die from heart disease, are twice as
25 likely to have a stroke—which tends to be more se-

1 vere with a higher morbidity and results in higher
2 mortality, are 40 percent more likely to have high
3 blood pressure, and have a higher rate of hyper-
4 tension and heart failure than their White counter-
5 parts.

6 (9) Minority groups suffer from asthma at a
7 disproportionate rate, have the highest number of
8 emergency room visits and hospital stays due to
9 asthma, and have higher mortality rates from asth-
10 ma than their White counterparts. African Ameri-
11 cans, American Indians, and Alaska Natives are 42
12 percent more likely than their White counterparts to
13 have asthma. The prevalence of childhood asthma
14 for African Americans is 11.7 percent higher than
15 for White Americans, while mortality rates in chil-
16 dren and adults are eightfold and threefold higher,
17 respectively, for African Americans compared to
18 White Americans.

19 (10) Vaccinations are key to disease prevention
20 and overall health outcomes, especially in the case of
21 COVID–19. However, a longstanding history and
22 legacy of systemic racism, discrimination, and mis-
23 treatment has contributed to a larger distrust of the
24 health care system and medical establishment within
25 communities of color, which can further engender

1 disparities and perpetuate rates of chronic disease.
2 According to data from the CDC, despite higher
3 COVID–19 mortality, hospitalization, and infection
4 rates amongst African Americans, the rate of
5 COVID–19 vaccination amongst Black Americans
6 still lags behind those of White individuals in almost
7 every State. This necessitates increased funding for
8 education, increased access to care, and targeted ef-
9 forts to reach communities of color and address ra-
10 cial inequities.

11 (11) Cuts to, or even level funding for, the
12 Chronic Disease Prevention and Health Promotion
13 Fund and other public health prevention efforts un-
14 dermine efforts to create an affordable and acces-
15 sible health care system, and a better quality of life
16 for Americans of all ethnic, racial, and socio-
17 economic backgrounds. Cuts to this Fund would also
18 exacerbate existing disparities and underlying health
19 conditions that have created seemingly vast dispari-
20 ties in hospitalization and mortality rates due to
21 COVID–19.

22 (12) Prevention efforts have proven to be effec-
23 tive. Funding increases for community-based public
24 health programs reduce preventable disease caused
25 by diabetes, cancer, and cardiovascular disease. Im-

1 proved access to intervention, treatment, and afford-
2 able care is also proven to mitigate the development
3 of associated chronic diseases and mortality rates.
4 (13) Increasing the Chronic Disease Prevention
5 and Health Promotion Fund funding to
6 $2,400,000,000 annually will allow the Fund to in-
7 vest in more innovative, evidence-based public health
8 programs, maintain and expand investments in pro-
9 grams with demonstrated success, and help reduce
10 racial health disparities and rates of chronic disease
11 that can put persons of color at greater risk of hos-
12 pitalization or death from COVID–19.
13 (14) Further, the Office of Minority Health in
14 the Office of the Secretary of Health and Human
15 Services (established by section 1707 of the Public
16 Health Service Act (42 U.S.C. 300u–6)) was de-
17 signed for the purpose of ‘‘improving minority health
18 and the quality of health care minorities receive, and
19 eliminating racial and ethnic disparities’’. The Office
20 of Minority Health and Health Equity at the CDC
21 serves to decrease health disparities, address social
22 determinants of health, and promote access to high-
23 quality preventative health care. The Office of Mi-
24 nority Health and Health Equity at the Food and
25 Drug Administration promotes and protects the

1 health of diverse populations through research and
2 communication of science that addresses health dis-
3 parities. The National Institute on Minority Health
4 and Health Disparities leads scientific research that
5 advances understanding of minority health and
6 health disparities.

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

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

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

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

1 parities, for fiscal year 2021 and each subsequent fiscal
2 year, $782,000,000.
3 (c) OFFICE OF MINORITY HEALTH.—There is au-
4 thorized to be appropriated, and there is hereby appro-
5 priated, out of any money in the Treasury not otherwise
6 appropriated, to the Office of Minority Health in the Of-
7 fice of the Secretary of Health and Human Services (es-
8 tablished by section 1707 of the Public Health Service Act
9 (42 U.S.C. 300u–6)), for fiscal year 2021 and each subse-
10 quent fiscal year, the amount that is twice the amount
11 of funds made available to such Office of Minority Health
12 for fiscal year 2021.
13 (d) OTHER OFFICES OF MINORITY HEALTH WITHIN
14 THE DEPARTMENT OF HEALTH AND HUMAN SERV-
15 ICES.—There is authorized to be appropriated, and there
16 is hereby appropriated, out of any money in the Treasury
17 not otherwise appropriated, to the Office of Minority
18 Health of the Agency for Healthcare Research and Qual-
19 ity, the Office of Minority Health of the Centers for Dis-
20 ease Control and Prevention, the Office of Minority
21 Health of the Centers for Medicare & Medicaid Services,
22 the Office of Minority Health of the Food and Drug Ad-
23 ministration, the Office of Minority Health of the Health
24 Resources and Services Administration, and the Office of
25 Minority Health of Substance Abuse and Mental Health

1 Services Administration (as established pursuant to sec-
2 tion 1707A of the Public Health Service Act (42 U.S.C.
3 300u–6a)), for fiscal year 2021 and each subsequent fiscal
4 year, the amount that is twice the amount of funds made
5 available to the respective Office of Minority Health for
6 fiscal year 2021.