LATE TESTIMONY

NEIL ABERCROMBIE
GOVERNOR OF HAWAII

LORETTA J. FUDDY, A.C.S.W., M.P.H.
INTERIM DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. Box 3378
HONOLULU, HAWAII 96801-3378

In reply, please refer to:
File:

HOUSE COMMITTEE ON HEALTH

SB1506 SD2, RELATING TO HEALTH

Testimony of Loretta J. Fuddy, A.C.S.W., M.P.H.
Interim Director of Health

March 15, 2011; 8:30AM

Department's Position: The Department of Health (DOH) supports the intent of this bill, but has reservations on the fiscal implications due to the current budget deficits.

Fiscal Implications: Would designate general funds to DOH for the purpose of administering a childhood obesity pilot program. The Department respectfully requests visiting opportunities for other funding opportunities, such as taxing sugar sweetened beverages as a means of funding childhood obesity prevention programs.

Purpose and Justification: : The purpose of Senate Bill 1506 SD2 is to establish a childhood obesity pilot program to be administered by the DOH and requires insurers to cover childhood obesity as a billable provider visit for services rendered by participating health care providers. This bill would also appropriate funds for the administration of the childhood obesity pilot program and require the childhood obesity pilot program provider participants to submit a report to the DOH and the Legislature no later than twenty days prior to the convening of the 2015 regular session.

The DOH acknowledges the importance of addressing childhood and adolescent overweight and obesity prevention and intervention in the healthcare setting as a critical element to addressing the

obesity epidemic. While the DOH supports the intent of this bill, it has some comments and recommendations.

The DOH recommends that the design of the pilot program include the continuum of care by health professionals to support children and parents. A 1997 study from the New England Journal of Medicine recommended interventions for obese three through nine year old children with obese parents because of the opportunity available by parents to positively influence behavior (Whitaker, Wright, Pepe, Seidel, Dietz). The same study found that parental obesity more than doubled the risk of adult obesity among obese and non-obese children less than ten years of age.

A coordinated clinical and public health prevention approach is needed to address the issue of childhood obesity. The DOH is currently addressing childhood obesity through the efforts of the Healthy Hawaii Initiative (HHI) and the Family Health Services Division (FHSD). HHI is an evidence-based statewide effort to encourage healthy eating, physical activity, and tobacco free lifestyles so that people can experience many productive healthy years of life. HHI works with partners on policies, systems and environmental changes to reintegrate physical activity and healthy eating into daily living where Hawaii residents and families live, work, and play. The FHSD Maternal and Child Health Branch (MCHB) and Women, Infants and Children (WIC) Branch provide perinatal screening and anticipatory guidance for healthy behavior and breastfeeding support. WIC also provides healthy supplemental foods, nutrition education and counseling, and incentives for breastfeeding.

The DOH defers to the Department of Commerce and Consumer Affairs on Section 3 of the measure since Section 23-51 of the Hawaii Revised Statutes requires an auditor's report on the social and financial impact of any legislative measure that mandates health insurance coverage for specific health services.

The DOH defers to the Department of Human Services (DHS), on existing requirements under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) to cover medically necessary care for

children. If the treatment for childhood obesity is determined to be medically necessary, it is required to be provided, however interventions that have not been shown to be effective will not meet the criteria for medical necessity. Though the EPSDT requirements are in place, additional requirements, research, and guidelines for effective treatment of childhood obesity are potentially needed. The DOH encourages dialogue and additional research, like the pilot program suggested in SB1506SD2, to move Hawaii towards a solution on addressing reimbursement for the prevention and treatment of childhood obesity.

The DOH expresses concerns over the availability of monies to fund a pilot obesity prevention program. In the light of the council on state revenues and projected budgetary shortfalls we ask the committee to consider legislation for a sugar-sweetened beverage (SSB) tax to ensure that SB1506SD2 and other important children's health promotion programs are sufficiently funded. A SSB tax could help encourage Hawaii citizens to make healthy decisions relating to the consumption of sugar-sweetened beverages and funds collected from this tax could be utilized to create a children's health promotion special fund to be administered by DOH. Such a fund could be used for statewide childhood obesity prevention activities and programs; including those described in SB1506SD2, and community-based childhood obesity prevention programs; evidence-based prevention, early recognition, monitoring, and weight management intervention activities in the medical setting; promotion of nutrition and physical activity in secondary schools; and prenatal to early childhood development intervention programs. The fund could also be used for a thorough evaluation of the effects of a SSB tax if the legislation was passed.

In Hawaii, adult obesity has more than doubled between 1995 and 2009, and childhood obesity increased by 38 percent from 1999 and 2009. Obesity-related medical expenditures in Hawaii were calculated to be over $323 million in 2009, and are continuing to rise. Sugar-sweetened beverages have been identified by countless scientific studies as a major contributor to our costly obesity epidemic. A

2004 study found that sugared soft drinks are the single largest contributor of calorie intake in the United States.

A tax on sugar-sweetened beverages could have both fiscal and health impacts. Based on the best estimates to date of the responsiveness of demand for soft drinks to changes in price, a 10% tax could result in about an 8% reduction in consumption. The effects could be higher for heavy users of soft drinks. According to the Yale-Rudd Center for Childhood Obesity's Revenue Calculator for Sugar-sweetened Beverages, tax revenue could amount to over $65 million dollars in 2012 for Hawaii, if sugar-sweetened beverages were taxed a penny per ounce. Polling data has also demonstrated increased public support when the funds are earmarked for specific preventative programming, such as obesity prevention programs or nutrition programs, or to promote the health of key groups such as children. The tax is intended to increase a mindful consumption of SSB across the spectrum of price ranges and tastes; including fountain drinks, and high calorie sugary specialty items such as smoothies, chai teas and frappucinnos.

The DOH offers its support on any amendment consideration to add the definition of a SSB tax while deferring to the Department of Taxation on the tax structure and the estimate of revenues that will be generated as a result of a tax.

Thank you for the opportunity to provide testimony.

American Cancer Society®

LATE TESTIMONY

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March 14, 2011

Committee on Health
Representative Ryan Yamane, Chair
Representative Dee Morikawa, Vice Chair

Hearing:
March 15, 2011, 8:30 a.m.
Hawaii State Capitol, Room 329

RE: SB1506, SD2 – Relating to Health

Testimony in Strong Support

Chair Yamane, Vice Chair Morikawa, and members of the Committee on Health. Thank you for the opportunity to offer this testimony in strong support of SB1506, SD2 which establishes the childhood obesity pilot program and requires insurers to cover childhood obesity as a billable provider visit for services rendered by participating health care providers.

For over 60 years, the American Cancer Society in Hawaii has been leading the battle against cancer. We have made much progress in saving lives through early detection and new cutting edge treatments as a result of ongoing research. Research has shown that obesity increases the risk of multiple health conditions, including diabetes, hypertension and certain cancers including:

- Breast cancer (after menopause)
- Cervical cancer
- Colon or rectal cancer
- Esophageal cancer
- Gall bladder cancer
- Kidney cancer
- Liver cancer
- Multiple myeloma
- Non-Hodgkin lymphoma
- Ovarian cancer
- Pancreas cancer
- Stomach cancer (in men), and
- Uterine cancer

American Cancer Society Hawai'i Pacific, Inc., 2370 Nu`uanu Avenue, Honolulu, Hawaii 96817-1714
•Phone: (808) 595-7500 •Fax: (808) 595-7502 •24-Hour Cancer Info: (800) 227-2345 •http://www.cancer.org

SSBs consumed by children age 2-18 years increased, while the percentage of milk decreased. In the mid-1990s the intake of SSBs surpassed that of milk.

Experience from taxing tobacco and alcohol have proven to be highly effective in reducing consumption of these products. Thus, I strongly encourage the House members to also consider strategies like taxation on SSBs to help combat the obesity epidemic. Companies that produce SSBs have done little to promote responsible consumption of their products. A tax on SSBs could help to create programs and campaigns to educate the public about the impacts of SSBs and to help the public make healthier choices especially for children. Moreover, funding could be used to assist the Department of Health to implement the provisions of SB 1506.

The personal and monetary cost of creating a generation of obese kids is worth the initial discomfort to families as they adjust to lower consumption of SSBs and adopt healthier behaviors. Or as a society would we rather see increases in the early onset of diabetes among children, high blood pressure and cholesterol, heart disease, orthopedic problems, higher cancer rates, not to mention social ridicule and bullying obese children often endure and related poor self-esteem.

Lastly, a tax on SSBs sends a message to the food industry that consumers need healthier options. The overwhelming number of convenience food products with no nutritional value that flood our markets is unconscionable. It's time to level the playing field and give consumers an equal chance to select from an array of healthy, affordable, and appealing products. The tax can help encourage that industry trend.

Thank you for all your good work on behalf of the people of Hawai'i. As policymakers you are on the cusp of reversing a growing trend toward ill-health by holding our businesses, institutions and communities accountable to help our families and children make healthier choices. I look forward to hearing of your support for broader, evidence based public health strategies to address the trend of obesity.

Exactly how obesity causes cancer is open to debate, although evidence suggests that the cancer's location is just one of the many factors associated with obesity. For instance, obesity affects estrogen levels, perhaps explaining why obese women develop uterine cancer. Obesity also increases the risk of gastroesophageal reflux disease, a known risk factor for esophageal cancer.

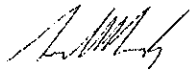
Obesity is a serious health concern for children and adolescents. Results from the 2007-2008 National Health and Nutrition Examination Survey, using measured heights and weights, indicate that an estimated 17% of children and adolescents ages 2-19 years are obese. Among pre-school age children 2-5 years of age, obesity increased from 5 to 10.4%; among 6-11 year olds from 6.5 to 19.6%; and among adolescents aged 12-19 from 5 to 18.1%.

Alarmingly, obese children and adolescents are more likely to become obese as adults. One study found that approximately 80% of children who were overweight at aged 10–15 years were obese adults at age 25 years. Another study found that 25% of obese adults were overweight as children. Clearly something has to be done.

We think that SB1506, SD2 is a very good first step in combating childhood obesity in Hawaii, and hopefully, data amassed from the pilot will result in expanded health insurance coverage for obesity services.

Thank you for the opportuntiy to offer testimony regarding this important health issue.

Respectfully,



George S. Massengale, JD
Director of Government Relations

LATE TESTIMONY

Testimony in Support of SB 1506 SD1 Relating to Childhood Obesity Pilot Program

SB 1506 provides an important initial step in beginning to reverse the epidemic of childhood obesity. Obesity is a major contributor to cardiovascular disease, diabetes and several types of cancer. Children now account for almost half of new cases of type 2 diabetes in some communities. Children who are obese after age 6 have a greater than 50 percent chance of being obese as adults, regardless of parental obesity status.

The purpose of this bill is to establish a childhood obesity pilot program and requires insurers to cover childhood obesity as a billable provider visit for services rendered by participating health care providers in the pilot study. In general, this bill is consistent with the US Preventive Services Task Force (USPSTF) Recommendation Statement on Screening for Obesity in Children and Adolescents and initiating interventions to promote improvements in weight status. However, unlike the USPSTF statement, it does not recognize evidence based data that already exists to justify all visits for childhood obesity screening as legitimate medical encounters between provider and patient that should be a covered benefit.

The Hawai'i Chapter of the American Academy of Pediatrics recommends an amendment to this proposal. In the current proposal, it would be difficult to build a valid demonstration project on childhood obesity intervention in Hawaii. We suggest a task force be convened of representatives of health plans, self-insured plans and mutual benefit societies who have enrolled members < 18 years of age with pediatricians, family practitioners and other health care providers as deemed necessary to review and report back to the legislature the following: 1. What is the extent of childhood overweight/obesity as measured by the health plans? 2. What are the current levels of health plan benefits available to the child and family when the child is overweight/obese, but does not yet have any associated co-morbidities? 3. What health plan benefits should overweight/obese children have access to? HAAP would be willing to be the lead organization in this task force.

The Hawai'i Chapter of the American Academy of Pediatrics supports the passage of SB 1506 SD1 relating to childhood obesity with amendments.

Respectfully submitted,
Kenneth T. Nakamura, M.D.
President, Hawai'i Chapter
American Academy of Pediatrics

TO: HLTestimony@Capitol.hawaii.gov

LATE TESTIMONY

To: Reps. Ryan Yamane, Chair & Dee Morikawa, Vice Chair
House Committee on Health

Hearing Info: **Senate Committee on Health**
Tuesday, March 15, 8:30 am
Conference Room 329

From: Annette Taeko Mente, private citizen

RE: Testimony **In Support** of **SB1506** Relating to Health

Aloha Chair Yamane and Members of the Committee,

I wish to commend the Chair and members for hearing this important bill and offer testify in support of SB1506. I work as a planner for the Department of Health, Family Health Services Division, but testify today as a private citizen concerned about the growing epidemic of obesity and related modern chronic diseases plaguing our society. We are all too familiar with that fact that chronic diseases related to poor diet and lack of physical activity cost the country billions of health care dollars each year.

Data on young children in our state show that obesity starts much earlier than imagined. We have been accustomed to seeing rates of 1 in 4 adolescents at-risk for obesity or obese. But, data for children as young as 2-4 years old in Hawai`i are showing similar rates of obesity. In 2009, the federal supplemental nutrition program, WIC, reported 22.1% (over 1 in 5 children) ages 2-4 years were either overweight or obese. Data from 2007-2008 of 4-5 years olds entering public schools, showed 30% (nearly 1 in 3) were overweight or obese.

While SB1506 addresses the need for medical intervention, obesity is really a problem of unhealthy lifestyles that are highly influenced by larger social and environmental factors. Today, it is so much easier to make unhealthy choices than healthy choices: the evolution of the modern food industry that produces and aggressively markets high caloric, cheap, sugar sweetened convenience foods, to our greater dependence on cars, lack of accessible fresh produce and safe/inviting facilities for physical activity.

Given the complexity of the epidemic, the Centers' for Disease Control has compiled a list of evidence-based strategies for preventing and reducing overweight and obesity that address these larger social/environmental factors including the over-consumption of sugar sweetened beverages (SSB).

More than any category of foods, rigorous scientific studies (that have not been funded by the beverage industry) have shown that consumption of SSBs is associated with poor diet, increasing rates of obesity, and risk for diabetes. These links are particularly strong for children. For children, an extra can or glass of SSB consumed per day increased their chance of becoming obese by 60%.

A substantial increase has occurred in the consumption of SSBs since the 1970s, now averaging 46 gallons per person per year. U.S. per capita consumption of calories from SSBs doubled between 1997-2002 across all age groups. The percentage of beverage calories from

HMSA

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LATE TESTIMONY

March 15, 2011

The Honorable Ryan Yamane, Chair
The Honorable Dee Morikawa, Vice Chair
House Committee on Health

Re: SB 1506 SD2 – Relating to Health

Dear Chair Yamane, Vice Chair Morikawa and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 1506 SD2 which would mandate health plans provide coverage for treatment for childhood obesity for members participating in a Department of Health administered pilot program. HMSA always opposes unfunded mandated benefits.

One of the goals of the Affordable Care Act (ACA) was to ensure that individuals with health care coverage were able to access preventive services with no co-payments. Under the ACA, if a plan did not provide one of the mandated preventive services, this benefit had to be included in all non-grandfathered plans. One of these benefits was screening and treatment for obesity, for children and adults.

As of September 2010, the majority of HMSA's members who are children 6 years of age and older can receive screening and assessments for obesity. Due to this change, we believe that the pilot program in SB 1506 SD2 is unnecessary at this time. This is especially true given the fact that this measure would only provide services for children while the ACA requires that these services be provided to both children and adults.

Additionally having to provide a certain set of services for use with specific providers in the community would likely prove difficult and almost impossible for health plans to administer. There are also certain providers which HMSA does not currently contract with directly who are listed as being able to provide services to pilot project participants. We object to mandatorily requiring plans to provide services from specific types of providers.

Finally, if there is interest in starting a childhood obesity demonstration project, we might recommend that the State look into applying for federal grant monies for such a program as outlined in the ACA. Under this grant, awards will be made to three recipients with an average award made to each recipient of $1.75 million for each of the first three years and $1.025 million for the fourth year. The grant application is due April 8, 2011. Under this grant, monies will be provided "to determine whether an integrated model of primary care and public health approaches in the community can improve underserved children's risk factors for obesity. These approaches may include policy, systems, and environmental supports that encourage nutrition and physical activity for underserved children and their families." These grant funds require no cost-sharing or in-kind donations. Additionally, the scientific structure under which the ACA funded program must be conducted will undoubtedly provide relevant information as all stakeholders continue to seek appropriate and effective obesity treatments.

We believe the language regarding obesity services is unnecessary due to ACA changes and that much of the language outlining the pilot program would be prove administratively difficult to administer.

LATE TESTIMONY

Therefore we would respectfully request the Committee see fit to hold SB 1506 SD2 at this time.

Thank you for the opportunity to testify today.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

Papa Ola Lokahi
Nana I Ka Pono Na Ma

LATE TESTIMONY

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Phone: 808.597.6550 ~ Facsimile: 808.597.6551

TESTIMONY: SB 1506, SD 2, Relating to Health

HOUSE COMMITTEE ON HEALTH
Rep. Ryan Yamane, Chair
Rep. Dee Morikawa, Vice Chair

Hardy Spoehr, Executive Director

Tuesday, March 15, 2011
8:30 am
Conference Room 329
State Capitol

Aloha Chair Yamane, Vice Chair morikawa and Members of the House Committees on Health. Papa Ola Lokahi (POL) strongly supports this measure.

Obesity is one of, if not, the most important health issue facing our young folks. Native Hawaiian and Pacific Islander youth are greatly impacted by this and we would strongly recommend that this pilot program include a Native Hawaiian cohort. Further, we would hope that the "provider participants" be culturally competent in their abilities to relate to those participating in this pilot program. The health professionals involved could well serve as models for youngsters in the program.

Thank you for the opportunity to provide testimony on this important measure.