Eduardo Sanchez
Testimony
House Education and Labor Committee Hearing
Improving Nutrition for America's Children Act (H.R. 5504)
July 1, 2010

Chairman Miller, Ranking Member Kline, Members of the committee, thank you for inviting me to testify today on children's health, childhood obesity, child nutrition, and the importance of passing H.R 5504 to strengthen child nutrition programs.

My name is Eduardo Sanchez, Vice President and Chief Medical Officer for Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, which operates three additional Blue Cross and Blue Shied Plans in Illinois, New Mexico, and Oklahoma. HCSC is the nation's largest non-investor-owned health insurance company serving 12.4 million members.

I am a physician trained in family medicine and in public health. I practiced medicine for ten years in Austin and served as Commissioner of the Texas Department of Health and then the Texas Department of State Health Services from 2001 to 2006. I have long been interested in childhood obesity and the incredible burden it places not only on individual children themselves, but on schools, their families, the workplace, governments, and, of course, our health care and economic systems. As Commissioner of Health in Texas, I worked closely with my agriculture and education state agency counterparts to address childhood obesity. And because the scope of my responsibilities in Texas included oversight of the Women, Infants, and Children program, WIC, I have a keen appreciation for the importance of the Improving Nutrition for America's Children Act. Although I will be speaking about childhood obesity, I want to make clear that childhood hunger and obesity are counter-intuitively linked. The access, availability, and affordability of healthy food for families are all critical factors for promoting health, preventing hunger, and combating obesity.

You are, no doubt, familiar with the alarming statistics on childhood obesity in all of our states and in all of our communities. The recently released *F as in Fat* report from Trust for America's Health highlights that we have a long way to go to comprehensively address and reverse this epidemic. And sadly, wide disparities remain among different racial and ethnic groups. There are roughly 10 million obese children and adolescents age 5 to 19 in the United States. That is more children than there are people in each of 40 states across the country.

In my home state of Texas, the incidence of obesity is higher than the national average – in fact, we rank seventh in obesity rate among 10 to 17 year olds – tipping the scales at over 20% compared to the national average of about 16%.[1] And, while all categories of children are impacted, the poor, African Americans, Hispanics, American Indians, and Pacific Islanders are disproportionately more overweight and obese than their white counterparts. In a state like Texas, with a dramatically shifting demographic

[1] F as in Fat: How Obesity Threatens America's Future, June 2010

profile and significant numbers of families and children in poverty, we feel this burden even more. This has tremendous relevance nationwide, as the demographic profile of our communities, our states, and indeed, our nation, shifts.

Obesity threatens the health of our young people, their future potential, and our nation's global competitiveness. Obese children miss more days of school than their healthy-weight peers.[2] They're at increased risk for a variety of serious health conditions, including asthma, heart disease and type 2 diabetes.[3] Some experts warn that if obesity rates continue to climb, today's young people may be the first generation in American history to live sicker and die younger than their parents' generation.[4] And as we have heard from Major General Monroe, childhood obesity is threatening our military readiness. The 27% who are too overweight to serve in our military did not become so overnight, and they represent our entry level workforce. Obese children become obese adults. If current trends continue, that 27% cohort of young people becomes more overweight with each passing decade. Childhood obesity challenges local, state, and national budgets and will put U.S. businesses at a competitive disadvantage by reducing worker productivity and increasing health care costs.[5]

The impact of obesity on public health and children's well-being is real and bears significant cost. From a national perspective, obesity-related medical costs are nearly 10 percent of all annual medical spending[6] and were estimated to be $147 million in 2009.[7] . Very conservatively speaking, the aggregated cost of obesity in the United States over the next ten years will approach, if not exceed, two trillion dollars. Put another way, in the state of Texas, we estimated the cost of obesity in 2005 at $10 billion (a cost of $500 per Texan per year) and projected that the cost would be approximately $40 billion in 2040 – a quadrupling of the cost but only a doubling of the population. The bill we are talking about today is estimated to cost about $8 billion dollars over 10 years – that is less than one tenth the cost of obesity in just the state Texas over the same ten years!

Our sister state, Arkansas has examined the cost of obesity among its own state employees—something every employer (including government agencies and large corporations) should consider. For the State of Arkansas, the yearly claims cost associated with obesity now exceeds that of tobacco, with obese employees costing

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[2] Geier, A, Foster G, Womble L, et al. "The Relationship Between Relative Weight and School Attendance Among Elementary Schoolchildren." *Obesity*, 15(8): 2157–2161, August 2007.
[3] *Overweight and Obesity, Health Consequences.* Centers for Disease Control and Prevention, 2009. *www.cdc.gov/obesity/causes/health.html* (accessed June 2009) (No authors given.)
[4] Olshansky S, Passaro D, Hershow R, et al. "A Potential Decline in Life Expectancy in the United States in the 21st Century." *New England Journal of Medicine*, 352(11): 1138–1145, March 2005.
[5] Christeson W, Taggart AD, Messner-Zidell S. *Ready, Willing, and Unable to Serve. Washington, DC: Mission: Readiness, 2009.*
[6] F as in Fat: How Obesity Threatens America's Future, June 2010
[7] Finkelstein E, Trogdon J, Cohen J, Dietz W. "Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates." Health Affairs, 28, July 2009.

over 50% more than their counterparts who don't smoke, have a normal BMI, and do some exercise.[8]

These costs start early in life. Arkansas has looked at the cost impact in its Medicaid and SCHIP programs and sees higher rates of illness, more physicians' visits, and increases in costs as early as 10 to 14 years of age.[9]

For the nation, childhood obesity is associated with annual prescription drug, emergency room, and outpatient costs of $14.1 billion, plus inpatient costs of $237.6 million.[10] Given that approximately 4000 children and adolescents are diagnosed with type 2 diabetes annually in the United States,as a consequence of childhood obesity, these costs will grow significantly.[11]

I realize that I have painted a bit of a bleak picture of the health of America's children, about child obesity, and the threat it poses not only to children, but to our nation's well being. But I am hopeful. With the nation's attention on health costs, the recent passage of health care reform legislation with an emphasis on prevention and wellness, First Lady Michelle Obama's focus on childhood obesity, the report from the White House Task Force on Childhood Obesity and the phenomenal efforts of the private sector such as the Robert Wood Johnson Foundation and advocates across the country, we have a unique opportunity to make a difference. And we are beginning to see the positive results of comprehensive efforts to improve the health of children with nutritious food and physical activity in communities and states across the country. Of particular interest is research from the Diabetes Prevention Project that shows that healthy eating and regular physical activity can reduce the likelihood of developing diabetes in adults by over 50%.

Healthy eating and physical activity promote heart health, bone health, and prevent diabetes in children, and schools provide a natural setting to promote healthy habits. Given that kids spend so much time there and eat 30-50% of their calories there on school days, we have a captive audience. The research shows that fit kids are smart kids – promoting health in children improves academic performance, behavior, and reverses childhood obesity. Having access to healthy food is an important aspect of promoting children's health.

Addressing the challenges of poor nutrition and obesity will take action from all levels of government, businesses, health care organizations, public health advocates, schools, families, and individuals – we all have a stake in making real changes, including hard

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[8] Unpublished data, Arkansas Center for Health Improvement.
[9] Card-Higginson P, Thompson JW, Shaw JL, Lein S. Cost and health impact of childhood obesity among Medicaid/SCHIP enrollees. 2008 AcademyHealth Annual Research Meeting, Washington, DC, June 9, 2008.
[10] Cawley J. "The Economics of Childhood Obesity." *Health Affairs,* Vol. 29 (No. 3): 364-371, 2010.
[11] Centers for Disease Control and Prevention. *National Diabetes Fact Sheet, 2007.* Atlanta, Ga: US Dept of Health and Human Services; 2007.

choices, to improve the health of this generation and generations of children to come. The child nutrition and WIC programs are critical tools for making this change.

Blue Cross and Blue Shield of Texas (BCBSTX) is pleased to be a part of the system response to childhood obesity in Texas. BCBSTX and HCSC take the long view when making commitments to programs such as those focused on childhood obesity. While addressing this problem today may not provide an immediate return on investment in the traditional sense, we fully understand the generational impact of action or inaction when it comes to childhood obesity.

In the school environment, we have supported OrganWise Guys, a program that brings science-based nutrition, physical activity, and other lifestyle behavior messages to children in school settings and effects healthy changes, and we are providing modest financial support to the school district in Seguin, Texas to provide the Coordinated Approach to Child Health (CATCH) program, another evidence-based coordinated school health program.

We provide financial support to MarathonKids, a program that encourages physical activity and healthy eating among elementary school children in Texas. It is one of the arrows in the quiver to promote health and prevent childhood obesity. More than 100,000 children participate in this four month program in Texas. We are supporting MEND, a community-based, family-centered childhood obesity treatment program in Dallas, Texas provided through a partnership with the YMCA. We are in the second phase of providing the Blue Cross and Blue Shield Association ***Pediatric Obesity and Diabetes Prevention*** **Toolkit** for physicians and their patients in Texas. As a health plan, we are addressing adult overweight and obesity in the workplace and at home. We understand that the key to better health overall is living healthy by eating smart and moving more.

So, here we sit today, debating and discussing one of the most important pieces of legislation that, if enacted – let me restate that – *when* enacted, has the potential to impact millions of our nation's children in a positive way. I applaud you, Mr. Chairman, your Committee, and your staff for your leadership. The "Improving Nutrition for America's Children Act" (H.R. 5504) is a strong bill that includes a number of important provisions to help shift the balance and make it easier for children to make healthy choices at school.

More than 50 years ago, our nation launched the National School Lunch Program. Interestingly, the language that characterized the rationale for the policy and program in 1946 is still quite relevant today:[12]

> *"The educational features of a properly chosen diet served at school should not be under-emphasized. Not only is the child taught what a good diet consists of, but his parents and family likewise are indirectly instructed."*

[12] http://www.fns.usda.gov/cnd/lunch/AboutLunch/ProgramHistory.htm

"It is hereby declared to be the policy of Congress, as a measure of national security, to safeguard the health and well-being of the Nation's children and to encourage the domestic consumption of nutritious agricultural commodities and other food…."

H.R. 5504 will improve meal quality, update nutrition standards for all foods and beverages at school, strengthen local wellness policies, and provide needed resources for training, technical assistance and nutrition education. The bill also includes a number of provisions to increase access and make it easier for kids to participate in child nutrition programs throughout the year – not just during the school day. And program access goes hand-in-hand with healthy food and beverages choices. For example, improving meal quality and reducing unhealthy options in vending machines often results in increased participation in school meal programs – a win-win situation. In Texas, Susan Combs, former Commissioner of Agriculture, understood that relationship and I know that Jim Weill will talk about important investments to improve access.

Meal Quality

While schools across the country are working hard to provide nutritious meals to children, inadequate reimbursement rates and limited training and technical assistance hamper their efforts. In fact, the majority of meals served in schools today fail to meet the 2005 *Dietary Guidelines for Americans*. For example, in the 2004-2005 school year, nearly one-third of schools served whole milk, one of the largest sources of saturated fat in children's diets. An analysis by USDA of school food service operations across the country found that French fries were one of the most frequently offered vegetables to students, regardless of grade. Only 5 percent of schools offered whole-grain breads, and a majority of schools offered only a limited variety of fruits and vegetables.[13] This bill goes a long way in improving meal quality. First and foremost, it calls for increasing the reimbursement rate for lunches by 6 cents. It also provides much needed training and technical assistance resources to food service operators, replaces high fat milk with healthier low fat options, strengthens accountability and program transparency, and continues efforts to improve commodities.

National School Nutrition Standards

This bill grants USDA the ability to update the nutrition standards for all foods served and sold – like those in vending machines, school stores, and a la carte in the cafeteria - to ensure they are health promoting and consistent with current dietary recommendations and nutrition guidance. The existing standards must be revised. While a number of states and districts have made strides in improving standards for competitive foods, many fall short of current recommendations.

According to a report by *Bridging the Gap*, in the 2007–08 school year (the latest year for which we have data), 62% of public elementary school students were able to

[13] Condon E, Crepinsek M, Fox M. School Meals: "Types of Foods Offered to and Consumed by Children at Lunch and Breakfast." *Journal of the American Dietetic Association*, 109(2): S67-S78, February 2009.

purchase competitive foods or beverages through school stores, vending machines and à la carte cafeteria lines. Such venues typically offered less healthy items. The picture is worse for middle and high schools.[14] [15]

Training, Technical Assistance and Nutrition Education

I cannot underscore the importance of training and technical assistance resources, as well as nutrition education and promotion priorities outlined in the bill. We all get that improving meal quality and providing only healthy options are key – what we sometimes forget is the work behind the scenes to make sure that food service operators have the skills and knowledge to make needed changes, and that kids are given opportunities to fully benefit from healthier options through education and promotion. The old saying "If you build it they will come" may work for baseball fields but we know it does not work for kids and food. How many times have we all tried to get our kids to eat the healthier options only to find it hidden under the table or thrown in the trash? It does no good to invest in improving meal quality without also investing in the necessary training, technical assistance and nutrition education and promotion that go hand-in-hand with increased reimbursement rates and meal standards.

Local Wellness Policies

H.R. 5504 builds on the local wellness policies introduced in the last reauthorization and calls on school districts to implement their policies in a transparent way that involves parents. The bill also ensures there is a wellness committee for each school district so that the success of the wellness policies are periodically reviewed and updated as necessary. This particular piece is important and consistent with our experience in Texas where every independent school system is required by law to have a School District Health Advisory Council (SHAC). SHAC's are often the entity tasked with developing and implementing local wellness policies and provide a permanent infrastructure to enhance the effectiveness and sustainability of the policies. This has worked well in Texas and it is important to carry this nation-wide as H.R. 5504 proposes.[16] The bill further dedicates funding to the USDA to provide technical assistance to districts to assist them in overcoming challenges to establishing and implementing effective policies.

I know you and your colleagues have many pressing issues these days but renewal of the child nutrition programs cannot wait any longer – this has already been delayed for

[14] Chriqui JF, Schneider L, Chaloupka FJ, Ide K and Pugach O. Local Wellness Policies: Assessing School District Strategies for Improving Children's Health. School Years 2006-07 and 2007-08. Chicago, IL: Bridging the Gap Program, Health Policy Center, Institute for Health Research and Policy, University of Illinois at Chicago, 2009.

[15] Turner L, Chaloupka FJ, Chriqui JF and Sandoval A. School Policies and Practices to Improve Health and Prevent Obesity: National Elementary School Survey Results: School Years 2006–07 and 2007–08. Chicago, IL: Bridging the Gap Program, Health Policy Center, Institute for Health Research and Policy, University of Illinois at Chicago, 2010.

[16] http://www.dshs.state.tx.us/schoolhealth/sdhac.shtm

more than a year and our children's health and well-being cannot be put on hold. This is a smart bill and I urge you to work with your colleagues in the House to secure funding and pass this bill soon – time is running out and our children deserve our attention. The health of America's children depends on a prescription for healthy food and more physical activity. This bill can play a significant role in improving the health of America's children, reversing the childhood obesity epidemic, reducing the burden of diabetes, heart and other chronic diseases and demand for expensive medical care, and finally, improving the readiness, willingness, and ability of our future civilian and military workforce – to compete and defend our nation.

I thank you for the time and your interest.