ENDOCRINE SOCIETY
Hormone Science to Health

February 25, 2019

The Honorable Lamar Alexander
Chair, HELP Committee
US Senate
Washington, DC

The Honorable Patty Murray
Ranking Member, HELP Committee
US Senate
Washington, DC

Re: Opportunities to reduce health care costs

Dear Senators Alexander and Murray:

On behalf of the Endocrine Society, I am responding to the Health, Education, Labor, and Pensions (HELP) Committee's request to identify ways to reduce health care costs. The Endocrine Society is the world's largest professional organization of endocrinologists, representing the interests of over 18,000 physicians and scientists engaged in the treatment and research of endocrine disorders. Endocrine researchers have discovered many effective treatments for costly diseases and endocrinologists use their expertise in treating endocrine conditions to avoid costly complications and unnecessary tests. Our recommendations focus on the following areas:

Diabetes Prevention, Treatment, and Access

More than 30 million Americans have diabetes and an additional 84 million are at risk for developing the disease.[1] Having diabetes increases one's risk for serious health problems including heart attack, stroke, blindness, kidney failure, amputations, and death. In fact, diabetes is the seventh leading cause of death in America and the most costly chronic disease.[2] The annual cost of diagnosed diabetes has skyrocketed to $327 billion, and one-in-three Medicare dollars are spend treating the disease and its complications.[3] Effective prevention, treatment and access is critical in reducing the cost of diabetes as healthcare spending is 2.3 times greater for individuals with the disease.[4] A few ways this can be achieved is by reducing drug costs, funding and expanding diabetes prevention programs, and improving access to education programs.

Over the past fifteen years, the cost of insulin has tripled[5] making it difficult for many patients to afford this medication and effectively manage their disease. This has put patient safety in jeopardy

[1] Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2017. https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf
[2] Centers for Disease Control and Prevention. Leading Causes of Death. https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm
[3] American Diabetes Association. Economic Costs of Diabetes in the U.S. in 2017. http://care.diabetesjournals.org/content/early/2018/03/20/dci18-0007
[4] Ibid.
[5] Hua X, Carvalho N, Tew M, Huang ES, Herman WH, Clarke P. Expenditures and prices of antihyperglycemic medications in the United States: 2002-2013. JAMA 2016;315:1400–1402.

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as patients are forced to ration their insulin or forgo other medical care. Because the inventors of this drug sold their patent over 100 years ago for $1 to make it accessible for all, the current high prices are unexplainable and unacceptable. Of the 7.4 million Americans who use insulin to treat their diabetes, many are low-income, have high-deductible plans, experience the Part D donut hole, or are uninsured. As noted in recent Congressional hearings, patients have died as a result of not being able to afford their insulin. The Endocrine Society urges Congress to evaluate ways to reduce insulin costs and prevent unnecessary complications, hospitalizations, and death. Increasing transparency across the supply chain, limiting future list price increases, reducing cost-sharing, and passing along rebates to consumers without increasing premiums are several ways this issue could be addressed. The Society also believes that regulatory barriers should be addressed to create a more favorable environment for testing incentive programs that reduce cost and improve care (e.g. value-based purchasing agreements). Finally, incorporating formulary and price information into electronic health record systems would enable physicians and patients to more easily discuss affordable treatment options and whether there are patient assistance programs available to them.

Diabetes prevention is also critical in addressing the ongoing epidemic and reigning in healthcare costs. The National Diabetes Prevention Program, an evidence-based lifestyle intervention program funded through the NIH, has demonstrated that a 5-7 percent weight loss could reduce the risk of developing diabetes by 58 percent.[6] Among seniors, the program was even more successful, reducing the risk by 71 percent.[7] In 2018, Medicare began covering the benefit but more needs to be done to address barriers to expanding the program and ensuring access. The Medicare Diabetes Prevention Program (MDPP) should be aligned with the Centers for Disease Control and Prevention's (CDC) Diabetes Prevention Recognition Program guidelines to ensure that DPP suppliers do not need to meet two different sets of standards. We are also concerned that there is a once-per-lifetime limit for MDPP as some beneficiaries may require multiple attempts to achieve successful weight loss. Virtual programs should also be covered under MDPP for individuals who may not be able to attend in person.

Increasing diabetes self-management training (DSMT), an evidence-based service that teaches people with diabetes to effectively manage their disease, is important in reducing unnecessary complications and poor outcomes that can drive up costs. The service is covered by Medicare; however, it is significantly underutilized. A recent study found that only 5 percent of Medicare beneficiaries with newly diagnosed diabetes used diabetes services.[8] In order to increase utilization of DSMT, the "Expanding Access to DSMT Act" was introduced in the last Congress to:

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[6] National Institute of Diabetes and Digestive and Kidney Diseases. Diabetes Prevention Program. https://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp

[7] Ibid.

[8] Strawbridge LM, Lloyd JT, Meadow A, et al. Use of medicare's diabetes self-management training benefit. Health Education Behavior 2015;42:530-8.

- Extend the initial 10 hours of DSMT covered by Medicare beyond the first year until fully utilized and cover additional hours based on individual need;
- Allow medical nutrition therapy (MNT) and DSMT to be provided on the same day;
- Remove patient cost-sharing;
- Broaden which providers can refer to DSMT beyond the provider managing the beneficiary's diabetes to include other providers caring for the patient; and
- Clarify agency policy that hospital outpatient department based DSMT programs can expand to community-based locations, including alternate non-hospital locations.

We urge Congress to take action to remove these barriers and increase access to DSMT services for Medicare beneficiaries, including the reintroduction and passage of the "Expanding Access to DSMT Act."

Detecting and effectively treating gestational diabetes is also important in positively impacting the pregnancy outcome, proactively monitoring the mother to detect later diabetes, and taking steps to prevent it. The Society believes that there are opportunities through telehealth to better detect and treat gestational diabetes, which should be considered by the Committee. These opportunities are detailed below.

Telehealth

The Society has identified several ways telehealth could be utilized to reduce costs and improve outcomes. One example is gestational diabetes. The Society believes there is an opportunity to address diabetes in pregnancy through telehealth in the Medicaid population. Patients with diabetes who become pregnant are at a significantly greater maternal and fetal risk, particularly if their diabetes is uncontrolled. As a result, these individuals often require insulin therapy and frequent visits to an endocrinologist or high-risk obstetrician (every 1-2 weeks in addition to routine OBGYN appointments, which are typically monthly). During these visits, the physician will review blood glucose logs and adjust insulin doses as needed. Members of the care team and/or the physician may also provide diabetes education to the patient.

Telemedicine could be utilized for a significant proportion of these visits as blood glucose log review and therapy adjustment can be conducted remotely. Patients who require visits weekly could see their endocrinologists or high-risk obstetrician every other week and utilize telemedicine (telephone or video visit) for the remaining visits from their home. Patients who require bi-weekly visits can utilize telemedicine visits once per month. The Society believes that the use of telehealth in this population would ease the burden on patients who would find it difficult to be absent from work each week. Easing this burden would help ensure that patients receive more consistent care and avoid costly complications, unnecessary hospitalizations and c-sections.

In addition to expanding access to telehealth services for gestational diabetes, the Society believes there are opportunities to reduce costs and improve outcomes for patients with osteoporosis. Fifty-four million adults aged 50 and older have osteoporosis and low bone mass in the United States.[9] It is an important risk factor for fragility fractures in older adults, which costs the U.S. more than $19 billion to treat.[10] Each year, more than 300,000 people 65 and older are hospitalized for hip fractures, but only 20 percent of these patients are treated to reduce the risk of future fractures and these individuals do not often receive appropriate follow-up care.[11]

The use of telehealth provides an opportunity to increase the number of individuals with post-osteoporotic fractures who receive standard-of-care treatment. Following surgery, many patients receive post-acute care in a Skilled Nursing Facility. Existing models of care have failed to appropriately screen or treat individuals for osteoporosis following a fracture. A pilot could be implemented to evaluate whether a telehealth visit with an endocrinologist would improve outcomes in this patient population and care setting (e.g. reducing subsequent fractures, hospital readmissions, and mortality). During the visit, the endocrinologist would diagnose the patient with osteoporosis and potentially prescribe a bisphosphonate, which is used to treat the disease and reduces a patient's long-term risk for hip fracture by up to 50 percent and vertebral fracture by up to 70 percent.[12] These medications are generic and have minimal cost to the patient or Medicare.

Congress should explore the implementation of pilots for patients with osteoporosis and diabetes in pregnancy to reduce costs. This would require waiving the originating site requirements, which have been a barrier in accessing care for effective disease management.

Women's Preventive Health Care and Screening

Studies have demonstrated that many preventive health care services result in cost savings due to avoidance of disease or complications. Use of hormonal contraception (oral contraceptives, depo-provera injections, progestin implants, and levonorgestrel intrauterine devices) has demonstrated significant cost savings. The majority of women of reproductive age in the United States currently use at least one contraceptive method, with more than 99 percent having used contraception

[9] Wright NC, Looker AC, Saag KG, et al. The recent prevalence of osteoporosis and low bone mass in the United States based on bone mineral density at the femoral neck or lumbar spine. *J Bone Miner Res*. 2014;29(11):2520-6.

[10] National Osteoporosis Foundation. Osteoporosis Fast Facts. https://cdn.nof.org/wp-content/uploads/2015/12/Osteoporosis-Fast-Facts.pdf

[11] Lewiecki, E Michael et al. "Bone Health ECHO: telementoring to improve osteoporosis care" *Women's health (London, England)* vol. 12,1 (2016): 79-81.

[12] Villa, Jordan C et al. "Bisphosphonate Treatment in Osteoporosis: Optimal Duration of Therapy and the Incorporation of a Drug Holiday" *HSS journal : the musculoskeletal journal of Hospital for Special Surgery* vol. 12,1 (2015): 66-73.

during their lifetime.[13] Hormonal contraception provides a myriad of benefits beyond the expected reproductive planning by decreasing the number of unintended pregnancies and pregnancy-related health risks such as preeclampsia, gestational diabetes, and complications of childbirth.

Although the majority of women use contraception to prevent pregnancy, fourteen percent of oral contraceptive users—1.5 million women—rely on this method exclusively for non-contraceptive purposes.[14] The benefits of contraceptives beyond the use for reproductive planning include prevention of endometrial cancer and anemia, (menorrhagia) prevention of ovarian cancer and management of pelvic pain (endometriosis and ovarian cysts), Polycystic Ovary Syndrome (PCOS), mental health (premenstrual mood disorder), acne, and premenstrual migraines. When left untreated, these conditions result in higher medical costs and lost productivity. The economic burden of PCOS among those aged 14–44 years of age is approximately $4.37 billion annually.[15] Approximately 40 percent of these costs are due to the increased prevalence of diabetes associated with PCOS; 31 percent from the treatment of the associated menstrual dysfunction, 14 percent from the treatment of hirsutism, and 12 percent for the provision of infertility services.[16] Only two percent of the costs are associated with diagnosis of PCOS, which illustrates that a relatively small investment ($740 per patient) can lead to earlier intervention and fewer complications.[17]

The CDC estimates that unintended pregnancies cost American taxpayers at least $21 billion each year.[18] Nationally, 68 percent of these unintended pregnancies were paid for by public insurance programs including Medicaid, Children's Health Insurance Program, and the Indian Health Service.[19] Offering affordable access to hormonal contraception can have a measurable impact on these costs. For every public dollar invested in contraception, short-term Medicaid expenditures are reduced by $7.09 for the pregnancy, delivery, and early childhood care related to births from unintended pregnancies.[20] Critics of expanding access to free contraception argue that the benefit increases insurance costs. Estimates show that the cost to provide contraception per year ranges

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[13] Guttmacher Institute. Contraceptive Use in the United States. https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states. September 2016. Accessed April 28, 2017.
[14] Jones RK, Beyond Birth Control: The Overlooked Benefits of Oral Contraceptive Pills, New York: Guttmacher Institute, 2011.
[15] Health Care-Related Economic Burden of the Polycystic Ovary Syndrome during the Reproductive Life Span*, The Journal of Clinical Endocrinology & Metabolism*, Volume 90, Issue 8, 1 August 2005, Pages 4650–4658.
[16] *ibid.*
[17] *ibid.*
[18] Centers for Disease Control and Prevention. *Women's Reproductive Health*; 2016. https://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2016/aag-reproductive-health.pdf. Accessed April 28, 2017.
[19] Guttmacher Institute. Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care. February 2015. https://www.guttmacher.org/sites/default/files/report_pdf/public-costs-of-up-2010.pdf.
[20] Guttmacher Institute. Contraceptive Use in the United States. https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states. September 2016. Accessed April 28, 2017.

from $100-$600[21] while the cost for prenatal care, delivery, and newborn care averages $18,000-28,000 under private insurance.[22] As 45 percent of pregnancies are unintended, access to contraception has significant potential to improve women's health, reduce the number of elective pregnancy terminations, and lower health care costs.[23,24]

Title X is an important source of funding for both contraceptive and preventive services for women. In 2015, a study found that Title X-funded health centers prevented 822,000 unintended pregnancies, resulting in savings of $7 billion to federal and state governments.[25] Women and adolescent girls must not be restricted from receiving care from physicians and other qualified providers based on site-of-service. A Proposed Rule released by the Trump Administration proposes to alter eligibility criteria for Title X Family Planning Program funds that would result in many current Title X grantees being ineligible. These clinics provide vital health care services to women who are uninsured or unable to afford care at hospitals or physicians' offices. 97 percent of the services provided are for basic health care, preventive services, cancer screening, and sexually transmitted disease screening[26], largely to low-income and under-served populations. Texas provides a real-world example of the impact of defunding health care providers like Planned Parenthood. Analysis shows that there was a 25 percent average decrease in number of women served by clinics within the Texas Women's Health Program[27], an increase in the rate of childbirth covered by Medicaid[28], and a significant increase in maternal mortality rates[29] in the years after the defunding of Planned Parenthood.

We urge the Committee to ensure that women and adolescent girls continue to have access to preventive health care services, including contraception, in their communities and can receive care

[21] Guttmacher Institute. Good for Business: Covering Contraceptive Care Without Cost-Sharing is Cost-Neutral or Even Saves Money. July 16, 2014. https://www.guttmacher.org/article/2014/07/good-business-covering-contraceptive-care-without-cost-sharing-cost-neutral-or-even

[22] Truven Health Analytics MarketScan Study. The Cost of Having a Baby in the United States. January 2013. http://transform.childbirthconnection.org/reports/cost/

[23] Gutmacher Institute. New Clarity for the U.S. Abortion Debate. A Steep Drop in Unintended Pregnancy Is Driving Recent Abortion Declines. https://www.guttmacher.org/gpr/2016/03/new-clarity-us-abortion-debate-steep-drop-unintended-pregnancy-driving-recent-abortion. March 2016. Accessed June 22, 2017.

[24] Guttmacher Institute. Unintended Pregnancy in the United States. https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states. September 2016.

[25] Guttmacher Institute. Federally Qualified Health Centers: Vital Sources of Care, No Substitute for the Family Planning Safety Net. Guttmacher Policy Review. Volume 20: 2017. https://www.guttmacher.org/gpr/2017/05/federally-qualified-health-centers-vital-sources-care-no-substitute-family-planning.

[26] Analysis of Planned Parenthood Services Provided. https://www.plannedparenthood.org/files/3814/5756/0903/PP_Services.pdf

[27] Weinberg, A. Planned Parenthood was Defunded by Texas: Here's What Congress Can Learn. *ABC News Online.* August 3, 2015

[28] Stevenson, A. et al. Effects of Removal of Planned Parenthood from the Texas Women's Health Program. *N Engl J Med* 2016; 374:853-860.

[29] MacDorman MF, et al. Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues. *Obstet Gynecol* 2016;128:447-52

from any qualified provider, regardless of site-of-service. Furthermore, women who have been denied access to hormonal contraception at no-cost through their employer health plan due to their employer's religious or moral beliefs must be able to receive this benefit through a government sponsored program such as Title X. However, Title X funds must be increased to reduce the financial burden of caring for this increased population.

Reducing Costly Complications through Access to Specialty Care

Care by endocrinologists is associated with shorter length of stay (LOS), lower morbidity rates, fewer readmissions, and lower healthcare costs. For example, diabetes care is time- and personnel-intensive requiring an endocrinologist-led team to prevent both acute and long-term complications, which are costly for the patient and the health care system. A retrospective analysis of patients with diabetes who were admitted to the short-stay unit found that the LOS decreased from 5.49 to 4.90 days when an endocrinology team oversaw diabetes care.[30] Another study examined the impact of care by an endocrinologist versus a generalist for patients with a primary diagnosis of diabetic ketoacidosis (DKA). Findings showed that the LOS for patients of generalists was 4.9 days versus 3.3 days for patients of endocrinologists and mean hospital charges for these patients were $10,109 and $5,463 respectively. The generalists incurred additional charges in part because they ordered more procedures.[31] Approximately 40 percent of the total US population has at least one chronic disease and 30 percent of Medicare beneficiaries with diabetes have 5 or more chronic conditions, including osteoporosis and thyroid disease. Endocrinologists are often the primary care provider for these patients, as these conditions and associated complications are often too complex for a general practitioner to treat.

Despite the vital role of endocrinologists in the care of patients with these chronic diseases, there are currently fewer than 4,000 clinical endocrinologists in the United States to care for the 100 million potential patients that suffer from diabetes and prediabetes alone.[32] These workforce shortages can be partially attributed to the low compensation for endocrine care and the administrative burden associated with practice. Without action, we are concerned that these workforce shortages will intensify. Compensation is similar to that of primary care physicians, as over 90 percent of endocrinologists' charges are evaluation and management (E/M) codes. Currently, these codes do not account for the complex work delivered before, during and after a face-to-face encounter that endocrinologists and other cognitive specialists provide to patients with chronic conditions.

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[30] Puig, J, et al. Diabetes team consultation: Impact of length of stay of diabetic patients admitted to a short-stay unit. *Diabetes Research and Clinical Practice 78(2007)211-216.*

[31] Levetan CS, et al. Effect of physician specialty on outcomes in diabetic ketoacidosis. *Diabetes Care.* 1999 Nov;22(11):1790-5.

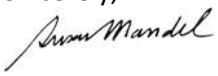
[32] Vigersky, RA. The clinical endocrinology workforce: current status and future projections of supply and demand. *J Clin Endocrinol Metab.* 2014 Sep:99(9):3112-21.

We appreciate CMS' interest in reducing the administrative burden associated with E/M services, as well as reassessing their payment, to ensure that they capture the true level of resource use associated with these services. However, the policy offered by CMS in the 2019 Physician Fee Schedule Final Rule does not adequately compensate specialists who typically provide higher level E/M services despite the agency's intention to retain a separate Level 5 payment**.** In fact, the CMS estimate found that endocrinology would experience a 2 percent reduction in payments under the revised E/M payment policy. The American Medical Association Resource-based Relative Value Scale Update Committee (RUC) will be surveying the E/M codes this year and will provide a recommendation to CMS for the appropriate value of these codes. However, we remain concerned that even after this RUC review that E/M services will not equitably reimburse for the services provided by our members since they do accurately describe the complex cognitive work performed during office visits. We continue to urge CMS to study the cognitive work associated with office visits and work with stakeholders to develop new codes that capture this work.

In the meantime, we encourage the Committee to identify opportunities to boost those specialties that are undercompensated, such as endocrinology, by providing loan forgiveness programs that will allow residents to choose a specialty based on factors other than whether they will earn enough to repay high medical school loans after graduation. With the increasing number of people with chronic conditions, investment in building the workforce in specialties facing a shortage will ensure patients have access to care when needed, thereby reducing unnecessary complications and hospitalizations.

Thank you for considering our comments. We appreciate that the Committee is looking at ways to reduce health care costs. This is important work and will have an impact on individuals and the country. We look forward to following the work of the HELP committee and working with you as you pursue legislative solutions to the rising health care costs. If we can provide any additional information, please contact Mila Becker, Chief Policy Officer, at mbecker@endocrine.org.

Sincerely,



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