

110TH CONGRESS
1ST SESSION

H. R. 3373

To catalyze change in the care and treatment of diabetes in the United States.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 3, 2007

Mr. SPACE (for himself, Ms. DEGETTE, Mr. GENE GREEN of Texas, and Mr. CASTLE) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To catalyze change in the care and treatment of diabetes in the United States.

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; TABLE OF CONTENTS; FINDINGS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Catalyst to Better Diabetes Care Act of 2007”.

6 (b) **TABLE OF CONTENTS.**—The table of contents of
7 this Act is as follows:

Sec. 1. Short title; table of contents; findings.

Sec. 2. Medicare diabetes screening collaboration and outreach program.

Sec. 3. Advisory group regarding diabetes and chronic employee wellness
incentivization and disease management best practices.

Sec. 4. National diabetes report card.

Sec. 5. Improvement of diabetes mortality data collection.

Sec. 6. Study on appropriate level of diabetes medical education.

1 (c) FINDINGS.—The Congress finds as follows:

2 (1) Diabetes is a chronic public health problem
3 in the United States that is getting worse.

4 (2) According to the Centers for Disease Con-
5 trol and Prevention:

6 (A) One in three Americans born in 2005
7 will get diabetes.

8 (B) One in two American minorities born
9 in 2005 will get diabetes.

10 (C) 1,500,000 new cases of diabetes were
11 diagnosed in adults in 2005.

12 (D) In 2005, 20,800,000 Americans had
13 diabetes, which is 7 percent of the population of
14 the United States.

15 (E) 6,200,000 Americans are currently
16 undiagnosed.

17 (F) About one in every 500 children and
18 adolescents have type 1 diabetes.

19 (G) African-Americans are nearly twice as
20 likely as whites to have diabetes.

21 (H) Nearly 13 percent of American Indi-
22 ans and Alaska Natives over 20 years old have
23 diagnosed diabetes.

1 (I) In States with significant Asian popu-
2 lations, Asians were 1.5 to 2 times as likely as
3 whites to have diagnosed diabetes.

4 (3) Diabetes carries staggering costs:

5 (A) In 2002, the total amount of the direct
6 and indirect costs of diabetes was estimated at
7 \$132,000,000,000 according to the American
8 Diabetes Association.

9 (B) 18 percent of the Medicare population
10 has diabetes but spending on this group of peo-
11 ple consumes 32 percent of the Medicare budg-
12 et according to the Center for Medicare & Med-
13 icaid Services.

14 (4) Diabetes is deadly. According to the Centers
15 for Disease Control and Prevention:

16 (A) In 2002, according to death certificate
17 reports, diabetes contributed to an official num-
18 ber of 224,092 deaths.

19 (B) Diabetes is likely to be seriously
20 underreported as studies have found that only
21 35 percent to 40 percent of decedents with dia-
22 betes had it listed anywhere on the death cer-
23 tificate and only about 10 percent to 15 percent
24 had it listed as the underlying cause of death.

1 (5) Diabetes complications carry staggering eco-
2 nomic and human costs for our country and health
3 system:

4 (A) According to death certificate reports,
5 diabetes contributes to over 224,000 deaths a
6 year, although this number is likely vastly
7 underreported.

8 (B) The risk for stroke is 2 to 4 times
9 higher among people with diabetes.

10 (C) Diabetes is the leading cause of new
11 blindness in America, causing approximately
12 18,000 new cases of blindness each year.

13 (D) Diabetes is the leading cause of kidney
14 failure in America, accounting for 44 percent of
15 new cases in 2002.

16 (E) In 2002, 44,400 Americans with dia-
17 betes began treatment for end-stage kidney dis-
18 ease and a total of 153,730 were living on
19 chronic dialysis or with a kidney transplant as
20 a result of their diabetes.

21 (F) In 2002, approximately 82,000 ampu-
22 tations were performed on Americans with dia-
23 betes.

24 (G) Poorly controlled diabetes before con-
25 ception and during the first trimester of preg-

1 nancy can cause major birth defects in 5 per-
2 cent to 10 percent of pregnancies and sponta-
3 neous abortions in 15 percent to 20 percent of
4 pregnancies.

5 (6) Diabetes is unique because its complications
6 and tremendous costs are preventable with currently
7 available medical treatment:

8 (A) According to the Agency for
9 Healthcare Research and Quality, appropriate
10 primary care for diabetes complications could
11 have saved the Medicare and Medicaid pro-
12 grams \$2,500,000,000 in hospital costs in 2001
13 alone.

14 (B) According to the Diabetes Prevention
15 Project sponsored by the National Institutes of
16 Health, lifestyle interventions such as diet and
17 moderate physical activity for those with
18 prediabetes reduced the development of diabetes
19 by 58 percent; among Americans aged 60 and
20 over, lifestyle interventions reduced diabetes by
21 71 percent.

22 (C) Research shows detecting and treating
23 diabetic eye disease can reduce the development
24 of severe vision loss by 50 percent to 60 per-
25 cent.

1 (D) Research shows comprehensive foot
2 care programs can reduce amputation rates by
3 45 percent to 85 percent.

4 (E) Research shows detecting and treating
5 early diabetic kidney disease by lowering blood
6 pressure can reduce the decline in kidney func-
7 tion by 30 percent to 70 percent.

8 **SEC. 2. MEDICARE DIABETES SCREENING COLLABORATION**
9 **AND OUTREACH PROGRAM.**

10 (a) ESTABLISHMENT.—With respect to diabetes
11 screening tests provided for under the Medicare Prescrip-
12 tion Drug, Improvement, and Modernization Act of 2003
13 (Public Law 108–173) and for the purposes of reducing
14 the number of undiagnosed beneficiaries with diabetes or
15 prediabetes in the Medicare program, the Secretary of
16 Health and Human Services (in this section referred to
17 as the “Secretary”), in collaboration with the Director of
18 the Centers for Disease Control and Prevention (in this
19 section referred to as the “Director”), shall establish an
20 outreach program—

21 (1) to identify existing efforts to increase
22 awareness among Medicare beneficiaries and pro-
23 viders of the diabetes screening benefit;

24 (2) to maximize economies of scale, cost effec-
25 tiveness, and resource allocation in increasing utili-

1 zation of the Medicare diabetes screening program;
2 and

3 (3) to build upon ongoing efforts of the private
4 and nonprofit sector.

5 (b) CONSULTATION.—In carrying out this section,
6 the Secretary and the Director shall consult with—

7 (1) various units of the Federal Government,
8 including the Centers for Medicare & Medicaid Serv-
9 ices, the Surgeon General of the Public Health Serv-
10 ice, the Agency for Health Research and Quality, the
11 Health Resources and Services Administration, and
12 the National Institutes of Health; and

13 (2) entities with an interest in diabetes, includ-
14 ing industry, voluntary health organization, trade as-
15 sociations, and professional societies.

16 **SEC. 3. ADVISORY GROUP REGARDING DIABETES AND**
17 **CHRONIC EMPLOYEE WELLNESS**
18 **INCENTIVIZATION AND DISEASE MANAGE-**
19 **MENT BEST PRACTICES.**

20 (a) ESTABLISHMENT.—The Secretary of Commerce
21 shall establish an advisory group consisting of representa-
22 tives of the public and private sector. The advisory group
23 shall include representatives from the Department of
24 Commerce, the Department of Health and Human Serv-
25 ices, the Small Business Administration, and public and

1 private sector entities with experience in administering
2 and operating employee wellness and disease management
3 programs.

4 (b) DUTIES.—The advisory group established under
5 subsection (a) shall examine and make recommendations
6 of best practices of chronic illness employee wellness
7 incentivization and disease management programs in
8 order to—

9 (1) provide public and private sector entities
10 with improved information in assessing the role of
11 employee wellness incentivization and disease man-
12 agement programs in saving money and improving
13 quality of life for patients with chronic illnesses; and

14 (2) encourage the adoption of effective chronic
15 illness employee wellness and disease management
16 programs.

17 (c) REPORT.—Not later than 1 year after the date
18 of the enactment of this Act, the advisory group estab-
19 lished under subsection (a) shall submit to the Secretary
20 of Health and Human Services, the Speaker and Minority
21 Leader of the House of Representatives, and the Majority
22 Leader and Minority Leader of the Senate, the results of
23 the examination under subsection (b)(1).

1 **SEC. 4. NATIONAL DIABETES REPORT CARD.**

2 (a) IN GENERAL.—The Secretary of Health and
3 Human Services (referred to in this section as the “Sec-
4 retary”), in collaboration with the Director of the Centers
5 for Disease Control and Prevention (referred to in this
6 section as the “Director”), shall prepare a national diabe-
7 tes report card (referred to in this section as a “Report
8 Card”) for the Nation and, to the extent possible, for each
9 State on a biennial basis, that includes the statistically
10 valid aggregate health outcomes related to individuals di-
11 agnosed with diabetes including—

- 12 (1) HbA1c level;
13 (2) LDL;
14 (3) blood pressure; and
15 (4) complications and comorbidities.

16 (b) REPORT.—The Secretary, in collaboration with
17 the Director, shall—

- 18 (1) submit each Report Card to Congress; and
19 (2) make each Report Card readily available in
20 print and electronically to each State and to the
21 public.

22 (c) ADAPTABLE.—Each Report Card shall be able to
23 be adapted by State and, where possible, local agencies
24 in order to rate or report local diabetes care, costs, and
25 prevalence.

1 (d) UPDATED REPORT.—Each Report Card that is
2 prepared after the initial Report Card shall include trend
3 analysis for the Nation, and, to the extent possible, for
4 each State, in order to track progress in meeting estab-
5 lished national goals and objectives for improving diabetes
6 care, costs, and prevalence (including Healthy People
7 2010), and to inform policy and program development.

8 **SEC. 5. IMPROVEMENT OF DIABETES MORTALITY DATA**
9 **COLLECTION.**

10 (a) IN GENERAL.—The Secretary of Health and
11 Human Services (in this section referred to as the “Sec-
12 retary”), acting through the Director of the Centers for
13 Disease Control and Prevention (in this section referred
14 to as the “Director”), and in collaboration with appro-
15 priate agencies, shall conduct, support, and promote the
16 collection, analysis, and publication of biennial data on the
17 prevalence and incidence of type 1 and 2 diabetes and of
18 prediabetes.

19 (b) IMPROVEMENT OF MORTALITY DATA COLLEC-
20 TION.—

21 (1) ASSESSMENT.—The activities described in
22 subsection (a) shall include an assessment of diabe-
23 tes as a primary or underlying cause of death and
24 analysis of any under-reporting of diabetes as a pri-
25 mary or underlying cause of death in order to pro-

1 vide an accurate estimate of yearly deaths related to
2 diabetes.

3 (2) DEATH CERTIFICATE ADDITIONAL LAN-
4 GUAGE.—In carrying out the activities described in
5 paragraph (1), the Secretary may promote the addi-
6 tion of language to death certificates to improve col-
7 lection of diabetes mortality data, including adding
8 questions for the individual certifying to the cause of
9 death regarding whether the deceased had diabetes
10 and whether diabetes was an immediate, underlying,
11 or contributing cause of or condition leading to
12 death.

13 (c) REPORT.—

14 (1) IN GENERAL.—The Secretary and the Di-
15 rector shall submit to the Committee on Health,
16 Education, Labor, and Pensions of the Senate and
17 the Committee on Energy and Commerce of the
18 House of Representatives annual reports describing
19 the activities undertaken under this section.

20 (2) CONTENT.—The reports shall include an—

21 (A) analysis of any under-reporting of dia-
22 betes as a primary or underlying cause of death
23 in order to provide an accurate estimate of
24 yearly deaths related to diabetes; and

1 (B) projections regarding trends in each of
2 the areas described in subparagraph (A).

3 (3) AVAILABILITY.—The Secretary and the Di-
4 rector shall make such reports publicly available in
5 print and on the Internet site of the Centers for Dis-
6 ease Control and Prevention.

7 **SEC. 6. STUDY ON APPROPRIATE LEVEL OF DIABETES MED-**
8 **ICAL EDUCATION.**

9 (a) IN GENERAL.—The Secretary of Health and
10 Human Services (in this section referred to as the “Sec-
11 retary”) shall, in collaboration with the Institute of Medi-
12 cine and appropriate associations and councils, conduct a
13 study of the impact of diabetes on the practice of medicine
14 in the United States and the appropriateness of the level
15 of diabetes medical education that should be required prior
16 to licensure, board certification, and board recertification.

17 (b) REPORT.—Not later than 2 years after the date
18 of the enactment of this Act, the Secretary shall submit
19 a report on the study under subsection (a) to the Commit-
20 tees on Ways and Means and Energy and Commerce of
21 the House of Representatives and the Committees on Fi-
22 nance and Health, Education, Labor, and Pensions of the
23 Senate.

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