

111TH CONGRESS
1ST SESSION

H. R. 1402

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

IN THE HOUSE OF REPRESENTATIVES

MARCH 9, 2009

Mr. SPACE (for himself, Ms. DEGETTE, Mr. TERRY, Mr. CASTLE, Mr. MANZULLO, and Mr. BRALEY of Iowa) 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 2009”.

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. Diabetes screening collaboration and outreach program.

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

Sec. 4. National Diabetes Report Card.

Sec. 5. Improvement of vital statistics 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 3 Americans born in 2000 will
7 get diabetes.

8 (B) One in 2 Hispanic females born in
9 2000 will get diabetes.

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

12 (D) In 2007, 23,600,000 Americans had
13 diabetes, which is 7.8 percent of the population
14 of the United States.

15 (E) 5,700,000 Americans are currently
16 undiagnosed.

17 (F) African-Americans are nearly twice as
18 likely as whites to have diabetes.

19 (G) Nearly 13 percent of American Indians
20 and Alaska Natives over 20 years old have diag-
21 nosed diabetes.

22 (H) In States with significant Asian popu-
23 lations, Asians were 1.5 to 2 times as likely as
24 whites to have diagnosed diabetes.

1 (3) Diabetes carries staggering costs:

2 (A) In 2007, the total amount of the direct
3 and indirect costs of diabetes was estimated at
4 \$174,000,000,000.

5 (B) 18 percent of the Medicare population
6 has diabetes but spending on this group con-
7 sumes 32 percent of the Medicare budget.

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

10 (A) In 2007, according to death certificate
11 numbers, diabetes contributed to 284,000
12 deaths.

13 (B) Diabetes is likely to be seriously
14 underreported as studies have found that only
15 35 percent to 40 percent of decedents with dia-
16 betes had it listed anywhere on the death cer-
17 tificate and only about 10 percent to 15 percent
18 had it listed as the underlying cause of death.

19 (5) Diabetes complications carry staggering eco-
20 nomic and human costs for our country and health
21 system:

22 (A) Diabetes contributes to over 224,000
23 deaths a year.

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

1 (C) Diabetes is the leading cause of new
2 blindness in America, causing approximately
3 12,000 to 24,000 new cases of blindness each
4 year.

5 (D) Diabetes is the leading cause of kidney
6 failure in America, accounting for 44 percent of
7 new cases in 2005.

8 (E) In 2002, 44,400 Americans with dia-
9 betes began treatment for end-stage kidney dis-
10 ease and a total of 153,730 were living on
11 chronic dialysis or with a kidney transplant as
12 a result of their diabetes.

13 (F) In 2004, approximately 71,000 ampu-
14 tations were performed on Americans with dia-
15 betes.

16 (G) Poorly controlled diabetes before con-
17 ception and during the first trimester of preg-
18 nancy can cause major birth defects in 5 per-
19 cent to 10 percent of pregnancies and sponta-
20 neous abortions in 15 percent to 20 percent of
21 pregnancies.

22 (6) Diabetes is unique because many of its com-
23 plications and tremendous costs are largely prevent-
24 able through early detection, better education on di-

1 abetes self-management, and improved delivery of
2 available medical treatment:

3 (A) According to the Agency for
4 Healthcare Research and Quality, appropriate
5 primary care for diabetes complications could
6 have saved the Medicare and Medicaid pro-
7 grams \$2,500,000,000 in hospital costs in 2001
8 alone.

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

17 (C) Research shows detecting and treating
18 diabetic eye disease can reduce the development
19 of severe vision loss by 50 percent to 60 per-
20 cent.

21 (D) Research shows comprehensive foot
22 care programs can reduce amputation rates by
23 45 percent to 85 percent.

24 (E) Detecting and treating early diabetic
25 kidney disease by lowering blood pressure can

1 reduce the decline in kidney function by 30 per-
2 cent.

3 (7) Research shows that diabetes self manage-
4 ment training (DSMT) programs, involving a health
5 team approach that includes certified diabetes edu-
6 cators (CDEs), not only significantly reduces overall
7 health costs but also improves health outcomes.

8 **SEC. 2. DIABETES SCREENING COLLABORATION AND OUT-**
9 **REACH PROGRAM.**

10 (a) ESTABLISHMENT.—With respect to diabetes
11 screening tests and for the purposes of reducing the num-
12 ber of undiagnosed seniors with diabetes or prediabetes,
13 the Secretary of Health and Human Services (referred to
14 in this Act as the “Secretary”), in collaboration with the
15 Director of the Centers for Disease Control and Preven-
16 tion (referred to in this section as the “Director”), shall—

17 (1) review uptake and utilization of diabetes
18 screening benefits to identify and address any exist-
19 ing problems with regard to utilization and data col-
20 lection mechanisms;

21 (2) establish an outreach program to identify
22 existing efforts by agencies and by the private and
23 nonprofit sectors to increase awareness among sen-
24 iors and providers of diabetes screening benefits; and

1 (3) maximize cost effectiveness in increasing
2 utilization of diabetes screening benefits.

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

5 (1) various units of the Federal Government,
6 including the Centers for Medicare & Medicaid Serv-
7 ices, the Surgeon General of the Public Health Serv-
8 ice, the Agency for Healthcare Research and Qual-
9 ity, the Health Resources and Services Administra-
10 tion, and the National Institutes of Health; and

11 (2) entities with an interest in diabetes, includ-
12 ing industry, voluntary health organizations, trade
13 associations, and professional societies.

14 **SEC. 3. ADVISORY GROUP REGARDING EMPLOYEE**
15 **WELLNESS AND DISEASE MANAGEMENT BEST**
16 **PRACTICES.**

17 (a) ESTABLISHMENT.—The Secretary shall establish
18 an advisory group consisting of representatives of the pub-
19 lic and private sector. The advisory group shall include—

20 (1) representatives of the Department of Health
21 and Human Services;

22 (2) representatives of the Department of Com-
23 merce; and

24 (3) members of the public, representatives of
25 the private sector, and representatives of the small

1 business community, who have experience in diabetes
2 or administering and operating employee wellness
3 and disease management programs.

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

8 (1) provide public and private sector entities
9 with improved information in assessing the role of
10 employee wellness and disease management pro-
11 grams in saving money and improving quality of life
12 for patients with chronic illnesses; and

13 (2) encourage the adoption of effective employee
14 wellness and disease management programs.

15 (c) REPORT.—Not later than 1 year after the date
16 of the enactment of this Act, the advisory group estab-
17 lished under subsection (a) shall submit to the Secretary
18 the results of the examination under subsection (b)(1).

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

20 (a) IN GENERAL.—The Secretary, in collaboration
21 with the Director of the Centers for Disease Control and
22 Prevention (referred to in this section as the “Director”),
23 shall prepare on a biennial basis a national diabetes report
24 card (referred to in this section as a “Report Card”) and,
25 to the extent possible, for each State.

1 (b) CONTENTS.—

2 (1) IN GENERAL.—Each Report Card shall in-
3 clude aggregate health outcomes related to individ-
4 uals diagnosed with diabetes and prediabetes includ-
5 ing—

6 (A) preventative care practices and quality
7 of care;

8 (B) risk factors; and

9 (C) outcomes.

10 (2) UPDATED REPORTS.—Each Report Card
11 that is prepared after the initial Report Card shall
12 include trend analysis for the Nation and, to the ex-
13 tent possible, for each State, for the purpose of—

14 (A) tracking progress in meeting estab-
15 lished national goals and objectives for improv-
16 ing diabetes care, costs, and prevalence (includ-
17 ing Healthy People 2010); and

18 (B) informing policy and program develop-
19 ment.

20 (c) AVAILABILITY.—The Secretary, in collaboration
21 with the Director, shall make each Report Card publicly
22 available, including by posting the Report Card on the
23 Internet.

1 **SEC. 5. IMPROVEMENT OF VITAL STATISTICS COLLECTION.**

2 (a) IN GENERAL.—The Secretary, acting through the
3 Director of the Centers for Disease Control and Preven-
4 tion and in collaboration with appropriate agencies and
5 States, shall—

6 (1) promote the education and training of phy-
7 sicians on the importance of birth and death certifi-
8 cate data and how to properly complete these docu-
9 ments, including the collection of such data for dia-
10 betes and other chronic diseases;

11 (2) encourage State adoption of the latest
12 standard revisions of birth and death certificates;
13 and

14 (3) work with States to re-engineer their vital
15 statistics systems in order to provide cost-effective,
16 timely, and accurate vital systems data.

17 (b) DEATH CERTIFICATE ADDITIONAL LANGUAGE.—

18 In carrying out this section, the Secretary may promote
19 improvements to the collection of diabetes mortality data,
20 including the addition of a question for the individual cer-
21 tifying the cause of death regarding whether the deceased
22 had diabetes.

23 **SEC. 6. STUDY ON APPROPRIATE LEVEL OF DIABETES MED-**
24 **ICAL EDUCATION.**

25 (a) IN GENERAL.—The Secretary shall, in collabora-
26 tion with the Institute of Medicine and appropriate asso-

1 ciations and councils, conduct a study of the impact of
2 diabetes on the practice of medicine in the United States
3 and the appropriateness of the level of diabetes medical
4 education that should be required prior to licensure, board
5 certification, and board recertification.

6 (b) REPORT.—Not later than 2 years after the date
7 of the enactment of this Act, the Secretary shall submit
8 a report on the study under subsection (a) to the Commit-
9 tees on Ways and Means and Energy and Commerce of
10 the House of Representatives and the Committees on Fi-
11 nance and Health, Education, Labor, and Pensions of the
12 Senate.

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