

September 21, 2021

The Honorable Cheri Bustos
1233 Longworth House Office Building
Washington, DC 20515

The Honorable Tom Cole
2207 Rayburn House Office Building
Washington, DC 20515

The Honorable G.K. Butterfield
2080 Rayburn House Office Building
Washington, DC 20515

The Honorable Markwayne Mullin
2421 Rayburn House Office Building
Washington, DC 20515

Dear Honorable Representatives Bustos, Butterfield, Cole, and Mullin,

On behalf of the Endocrine Society, thank you for your attention to the issue of social determinants of health. Founded in 1916, the Endocrine society is the world's oldest, largest, and most active organization devoted to research on hormones and the clinical practice of endocrinology. The Society's membership of over 18,000 includes experts in all research and clinical aspects of hormone health, including diabetes, obesity, and endocrine disrupting chemicals (EDCs). Our members deal with the consequences of social determinants of health daily in the patients they see and in the research questions they study. Our Society is committed to and has prioritized health equity and, therefore, we are interested in the development of the Social Determinants of Health Caucus and hope to work together to improve health outcomes and maximize existing and future federal investments in health, food, housing, transportation, and other important social drivers of health outcomes.

We hope you will consider the comments we have provided below to address some of the key questions the Caucus has posed:

**What specific SDOH challenges have you seen to have the most impact on health?
What areas have changed most during the COVID-19 pandemic?**

In endocrinology, some of our areas of research and practice are affected by multiple social determinants of health that all contribute individually and in combination to poor outcomes, so it will be important for the caucus to consider these complex interactions as a defining challenge. For example, social determinants of health like food security may influence COVID outcomes and also the development of diabetes, which itself contributes to poor COVID outcomes. The cumulative effect of such determinants may have greater overall public health impact when considered holistically.



During the COVID-19 pandemic, we have seen cracks in the public health system grow to craters. For instance, for people with diabetes who rely on public transportation to get to physician visits, the pandemic has introduced another life-threatening barrier to access to care. Routes that were unreliable in the past, often became even more unreliable because of staffing shortages and reduced schedules. Together, these challenges make it even harder for patients to see their physician to stay in control of their diabetes. These challenges are magnified for people with diabetes who live in food deserts where it is difficult to maintain appropriate diets to keep their sugars under control. However, during the pandemic, we also were able to provide increased access to telehealth and audio-only visits through Medicare and private insurance waivers that opened the virtual doors to greater opportunities for some to see their endocrinologist and comply with visit schedules.

Is there a unique role technology can play to alleviate specific challenges (e.g. referrals to community resources, telehealth consultations with community resource partners, etc.)? What are the barriers to using technology in this way?

Technology provides a unique opportunity that if utilized correctly, can help close health care gaps for many Americans. Telehealth and audio-only visits have been particularly valuable. Studies show that more than 1 in 4 Medicare beneficiaries had a telehealth visit between the summer and fall of 2020.¹

The use of telehealth during the pandemic has created numerous benefits, particularly for patients considered “high-risk” for serious complications if they contract COVID-19. However, when engaging with communities of all sizes and varied demographic characteristics, it is important to keep in mind their different needs. For instance, our members encountered challenges treating many of their patients, especially elderly patients, who had difficulty adjusting to online platforms and video telehealth visits. Technological literacy is not uniform across all communities and some populations may feel more comfortable using audio-only services rather than online, video platforms. Furthermore, research has indicated that telehealth use is lower in communities with higher rates of poverty and among patients with limited English proficiency, potentially undermining goals of expanding access to underserved communities and exacerbating health inequities.²

Affordable and robust broadband infrastructure is vital to connecting physicians and patients to provide adequate telehealth services. This is especially important for patients

¹ Watt Koma, Juliette Cubanski, Tricia Neuman. “[Medicare and Telehealth: Coverage and Use During the COVID-19 Pandemic and Options for the Future](#)”, *Kaiser Family Foundation* (May 19, 2021).

² Jorge A. Rodriguez et al., “[Disparities in Telehealth Use Among California Patients with Limited English Proficiency](#),” *Health Affairs* 40, no. 3 (Mar. 2021): 487–95; and Sadiq Y. Patel et al., “[Variation in Telemedicine Use and Outpatient Care During the COVID-19 Pandemic in the United States](#),” *Health Affairs* 40, no. 2 (Feb. 2021): 349–58.



who live in rural areas and do not have easily accessible Wi-Fi hot spots or the infrastructure that would allow for Wi-Fi. This also includes Americans that live in major internet markets like Dallas and Chicago but may not be able to afford broadband internet. One recently published study estimates that 42 million Americans are without access to high-speed internet.³ Congress can help address broadband issues through funding to improve basic infrastructure and ensuring an accurate census count that will help determine Federal Communications Commission dollars to address the digital divide.

It is also important for Medicare and private health plans to work with physicians to provide incentives to further minimize inequities related to access to healthcare. This may be in the form of compensation strategies for telehealth visits that receive high satisfaction ratings or parity for video, telephone, and in-person visits when appropriate for patients who meet certain requirements (e.g., elderly, living in a rural setting, without access to reliable transportation). Doing so could not only help reach more vulnerable communities, but also create informative data to better understand how some socio-economic factors affect a community's health over time. Congress can help lead this effort by working with the Centers for Medicare and Medicaid Services to address payment parity issues and encouraging states to expand telehealth coverage. During the pandemic, 22 states changed laws or policies to promote access to telemedicine and 30 states have weighed legislation to revise their telehealth coverage standards.⁴

We encourage the SDOH Caucus to support:

- **The continuation of telehealth expansion in order to increase access to health care;**
- **Robust broadband and basic infrastructure funding to better connect physicians and patients to telehealth services;**
- **Research, development, and coverage of new technologies that will improve health outcomes and access to care;**
- **An accurate census count to help determine Federal Communications Commission dollars to address the digital divide in all communities; and**
- **Incentives for physicians and insurance companies to cover telehealth services by helping address payment parity issues.**

How can Congress best address the factors related to SDOH that influence overall health outcomes in rural, tribal and/or underserved areas to improve health outcomes in these communities?

³ John Busby, Julia Tanberk, BroadbandNow Team. "[FCC Reports Broadband Unavailable to 21.3 Million Americans, BroadbandNow Study Indicates 42 Million Do Not Have Access](#)", *BroadbandNow Research* (May 2021).

⁴ JoAnn Volk, Dania Palanker, Madeline O'Brien, Christina L. Goe. "[States' Actions to Expand Telemedicine Access During COVID-19 and Future Policy Considerations](#)", *The Commonwealth Fund* (June 23, 2021).



Endocrine disrupting chemicals (EDCs) have been demonstrated by abundant scientific evidence and confirmed by international consensus to cause significant adverse health effects in humans. Strong evidence exists for a causative role for EDCs in metabolic disorders such as obesity and diabetes, female and male reproductive health disorders, hormone-sensitive cancers including breast cancer and prostate cancer, thyroid disease, and developmental neurological and neuroendocrine effects.⁵

While acknowledging that all demographic sectors bear risks due to EDC exposure, such risks are not distributed uniformly. There exist numerous examples where here pollution has been concentrated in specific regions where land is inexpensive. This has resulted in disparate impacts on specific communities, such as “Cancer Alley” in Louisiana⁶; and Parkersburg, West Virginia by per- and polyfluoroalkyl substances (PFAS)^{7,8}; and air pollution along the Houston Texas ship channel community⁹. The health effects of EDC exposures include cancer, fertility loss, and neurodevelopmental issues across generations. These chronic health effects also play a role in exacerbating disparities in mortality due to public health crises such as COVID-19¹⁰. Impacts are further magnified when industry creates an economic dependence to gain support from impacted communities at both the grassroots and political level. As an example, EDCs can cause declining sperm counts and increased incidence of endometriosis and other reproductive health disorders; consequently, increased use of reproductive health technologies will be necessary to achieve pregnancy¹¹. Because these procedures are expensive, the health and economic inequalities experienced by impacted communities are further exacerbated, with profound impacts on the right to benefit from scientific progress.

Traditionally, companies and governments have paid closer attention to short term economic effects and immediate toxic effects. The concept of endocrine disruption requires us to think about longer timeframes where exposures during development, or cumulative exposures, may cause the development of disease later in life. Such timeframes raise important questions about the rights of health, body integrity, and autonomy for pregnant

⁵ A.C. Gore et al., EDC-2: The Endocrine Society's Second Scientific Statement on Endocrine-Disrupting Chemicals, *Endocrine Reviews*, Volume 36, Issue 6, 1 December 2015, Pages E1–E150, <https://doi.org/10.1210/er.2015-1010>.

⁶ Tristan Baurick, Lylla Younes, Joan Meiners. [Welcome to “Cancer Alley,” Where Toxic Air Is About to Get Worse](#), *The Times-Picayune and The Advocate*, Oct. 30, 2019.

⁷ Sharon Lerner. [The Teflon Toxin: How DuPont Slipped Past the EPA](#), *The Intercept*, August 20, 2015.

⁸ John Henderson, [GenX in water supply causing stress for residents who live near Chemours plant](#), *The Fayetteville Observer*, August 14, 2020.

⁹ Lauren Elliott. [These Houston residents dream of moving to where the air is clear](#), *Reuters*, January 3, 2020.

¹⁰ Kimberly A. Terrell and Wesley James. Racial Disparities in Air Pollution Burden and COVID-19 Deaths in Louisiana, USA, in the Context of Long-Term Changes in Fine Particulate Pollution. *Environmental Justice*, September 2, 2020. <http://doi.org/10.1089/env.2020.0021>.

¹¹ Shanna H. Swan and Stacey Colino. *Count Down: How Our Modern World Is Threatening Sperm Counts, Altering Male and Female Reproductive Development, and Imperiling the Future of the Human Race*, Simon & Schuster, 2021.



women, children, and future generations in the context of chemical exposures. Regulatory agencies have taken steps to address vulnerability or susceptibility of subpopulations to chemical exposures; however, there are opportunities to improve upon these processes. For example, the SDOH Caucus can work with Congress to encourage agencies to prioritize chemical reviews and regulation based in part on different exposure profiles for environmental justice communities. Additionally, it is imperative that biological sex be recognized as an important variable that contributes to social determinants of health. In the context of pollution, agencies must acknowledge that different responses to toxicants may occur for men and women. We note with concern that the US Food and Drug Administration (FDA) has required that for an observed effect to be toxicologically relevant, it must occur in both sexes. This requirement is not supported by abundant scientific evidence demonstrating that males and females often have different responses to biological perturbations or stressors. In general, assessments involving vulnerable populations or different exposure profiles should be used as a floor to set a fundamental standard that can be applied generally, to ensure widespread protection consistent with the precautionary principle.

Separately, Congress should also consider a long-term extension of programs like the Special Diabetes Program (SDP) to further advance health outcomes. SDP is made up of two programs – the Special Diabetes Program for Type 1 Diabetes and the Special Diabetes Program for Indians (SDPI). Congress created these programs in 1997 to advance research for type 1 diabetes at the National Institute of Diabetes and Digestive and Kidney Disorders (NIDDK) and to provide treatment and education programs for type 2 diabetes among American Indians and Alaska Natives (AI/AN).

Through the SDPI, more than 400 treatment and education programs on type 2 diabetes have been implemented in AI/AN communities. AI/ANs have the highest prevalence of diabetes, with more than 50% of adults who have been diagnosed with the disease. The SDPI has successfully reduced A1c levels, cardiovascular disease, and promoted healthy lifestyle behaviors. Together, these programs have proven to be a critical pathway to preventing and treating diabetes and its complications for millions of Americans.

However, despite strong bipartisan support and long-term success, the SDP was subjected to six short term extensions before being reauthorized for a three-year extension in December 2020. A longer-term, or even a permanent extension of SDP is important to maintaining the program's success and would greatly benefit the 122 million Americans with diabetes or pre-diabetes. Previous short-term funding has jeopardized the viability of SDP resulting in interruptions of important research and cuts to SDP services.

We therefore urge the Caucus to consider:

- **The impact of endocrine disrupting chemicals on the health of disproportionately affected communities;**



- **Encouraging agencies to prioritize chemical reviews and regulations based in part on different exposure profiles for environmental justice communities;**
- **Requiring the FDA recognize that observed chemical effects do not need to occur in both sexes to be toxicologically relevant;**
- **Longer term reauthorization of the Special Diabetes Program.**

What are the main barriers to programs addressing SDOH and promoting in the communities you serve? What should Congress consider when developing legislative solutions to address these challenges?

The COVID-19 pandemic has illustrated the importance of investing in our public health systems. This includes sustained increases for programs that not only monitor emerging health threats, but programs that help prevent chronic diseases. Today, nearly half of all Americans 55 and older have two or more chronic conditions.¹² The Centers for Disease Control and Prevention's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) funds science-based programs that prevent chronic diseases and reduce unhealthy behaviors in communities across the nation. These efforts improve health-related quality of life and save money in medical costs and lost productivity. However, NCCDPHP has been flat funded by Congress for several years¹³. Investments in prevention programs save money by preventing injuries and illnesses that disproportionately affect our health care system and minority populations.

However, even before the pandemic, chronic diseases and under-funded public health systems affected all communities and populations. Some minority groups suffer a disproportionate burden to these issues due to factors such as historic disinvestment, poverty, structural racism, and discrimination. Community engagement is a key element to addressing SDOH and advancing health equity within these underserved communities. Federal agencies are especially primed to work with local governments and community organizers that have the infrastructure necessary to engage with communities that trust them. The National Institutes of Health (NIH) and CDC's Diabetes Prevention Program (DPP) is a prime example of this. DPP, and the ongoing DPP Outcomes Study, is a partnership with the NIH's National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) and CDC, that studies how people who are at a higher risk of type 2 diabetes can prevent or delay the disease through lifestyle changes. Through public-private partnerships with organizations already established within communities like the YMCA, state and local health departments, universities, and public and private insurers, the

¹² Percentage of U.S. Adults 55 and over with Chronic Conditions. Centers for Disease Control and Prevention, National Center for Health Statistics, 2015.

https://www.cdc.gov/nchs/health_policy/adult_chronic_conditions.htm

¹³ Department of Health and Human Services FY 2022 Centers for Disease Control and Prevention Justification of Estimates for Appropriation Committees, p. 143 <https://www.cdc.gov/budget/documents/fy2022/FY-2022-CDC-congressional-justification.pdf>



program has successfully reached many underserved communities across the country.¹⁴ Further prioritizing funding for underserved communities through programs like DPP is critical if we are to improve the health and well-being of the nation and address long-standing inequities.

Additionally, Congress should consider economic disparities and prescription drug costs when addressing health outcomes. For example, as of 2020, 34.2 million Americans (1 in 10) have diabetes, and 88 million Adults (1 in 3) have prediabetes.¹⁵ Diabetes disproportionately affects non-Hispanic blacks, people of Hispanic origin, and American Indian/Alaska Natives.¹⁶ Insulin is a life-saving medication for people with diabetes. However, its cost has nearly tripled in the past 15 years.¹⁷ Diabetes is also the most expensive chronic condition in the United States,¹⁸ with average medical expenses costing 2.3 times higher for people with diabetes.¹⁹ As the cost of insulin continues to rise for all Americans, this burden of cost is especially felt in populations that have received a lower quality of health care, including preventative health services, than their white counterparts.²⁰ Congress can help reduce these burdens and improve health outcomes for people with diabetes by developing policies that can help expand access to affordable insulin by:²¹

- Encouraging greater transparency across the supply chain to understand rising insulin costs
- Limiting future list price increases to the rate of inflation
- Allowing government negotiation of drug prices
- Limiting out-of-pocket costs through 1, or more, of the following policies without increasing premiums or deductibles:
 - Limiting cost-sharing to a co-pay of no more than \$35
 - Providing first-dollar coverage
 - Capping costs at no more than \$100 per month

¹⁴ Centers for Disease Control and Prevention, National Diabetes Prevention Program <https://www.cdc.gov/diabetes/prevention/about.htm>

¹⁵ National Diabetes Statistics Report, 2020. Centers for Disease Control and Prevention <https://www.cdc.gov/diabetes/library/features/diabetes-stat-report.html>

¹⁶ Ibid

¹⁷ Xinyang Hua, Natalie Carvalho, Michelle Tew. [Expenditures and prices of antihyperglycemic medications in the United States: 2002-2013](#). *JAMA*. 2016;315(13):1400-1402.

¹⁸ Matthew Petersen. Economic costs of diabetes in the U.S. in 2017, *Diabetes Care*. American Diabetes Association. ProMED-mail website. <http://care.diabetesjournals.org/content/41/5/917>. (August 27, 2021)

¹⁹ National Diabetes Prevention Program. Centers for disease control and prevention. ProMED-mail website. <https://www.cdc.gov/diabetes/prevention/prediabetes-type2/index.html>.

²⁰ Juan R Canedo, Stephania T Miller, David Schlundt, Mary K Fadden, Maureen Sanderson. “[Racial/Ethnic Disparities in Diabetes Quality of Care: the Role of Healthcare Access and Socioeconomic Status](#)”, *Journal Racial Ethnic Health Disparities*. 2018;5:7–14

²¹ Increasing Insulin Affordability: An Endocrine Society Position Statement, Endocrine Society. <https://www.endocrine.org/advocacy/position-statements/increasing-insulin-affordability#4>



- Eliminating rebates, or passing savings from rebates along to consumers without increasing premiums or deductibles
- Expediting the approval of insulin biosimilars to create competition in the marketplace
- Include real-time benefit information in electronic medical records
- Developing a payment model for Medicare Part B beneficiaries in addition to Part D that lowers their out-of-pocket copays.

We therefore urge the SDOH Caucus to:

- **Work with Congressional leaders to prioritize funding for prevention and chronic disease programs including those run by NCCDPHP;**
- **Prioritize funding for underserved minority populations;**
- **Increase funding for state and local health departments to address SDOH; and**
- **Help address health care cost barriers like rising insulin costs that disproportionately burden minority populations.**

Conclusion

Thank you for your attention to the impact of social determinants of health on the public's health. The Endocrine Society has a deep commitment to these issues and hopes to work with the SDOH Caucus to help advance the Caucus' goals of addressing and improving health for all Americans. Thank you for considering our comments. If we can be of further assistance and provide additional information, please contact the Endocrine Society's Chief Policy Officer, Mila Becker at mbecker@endocrine.org.

Sincerely,

Carol Wysham, MD
President, Endocrine Society