

Testimony of Anne L. Peters, M.D.

Professor of Clinical Medicine
Keck School of Medicine of USC
Senior Scholar

Leonard D. Schaeffer Institute for Public Policy & Government Service
University of Southern California

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Key Points:

- **Chronic diseases are a growing health and economic burden:** Conditions like obesity, diabetes, heart disease, cancer, and Alzheimer's are becoming increasingly prevalent, driving up healthcare costs. By 2030, cumulative chronic disease costs could reach \$42 trillion.
- **Obesity is at the core of the chronic disease crisis:** New obesity treatments show promise, with potential for significant health improvements and cost savings. Medicare coverage of obesity treatments could generate \$4 trillion in social value to Americans over three decades.
- **Prevention and early intervention are critical:** Comprehensive treatment of chronic conditions like obesity and diabetes, especially when initiated at younger ages, can yield substantial long-term health and economic benefits. The social return on investment from treating adults with moderate obesity is estimated at more than 15% per year.
- **Delaying aging could have enormous benefits:** Scientific advances suggest it may be possible to slow the aging process and delay the onset of multiple age-related chronic diseases simultaneously. Even modest success in delaying aging could yield enormous health and economic benefits.
- **Policy changes are needed to incentivize prevention and health:** Recommendations include reimbursing physicians for patient outcomes, encouraging multi-year insurance contracts, ensuring innovators are paid socially desirable returns, creating regulatory and reimbursement incentives for preventive interventions, and implementing value-based reimbursement models.



Chairman Buchanan, Ranking Member Doggett, and Honorable Members of the Subcommittee, thank you for the opportunity to testify today about how we can create incentives to better prevent and treat chronic disease. My name is Dr. Anne Peters, and I am a Professor of Clinical Medicine at the Keck School of Medicine of the University of Southern California (USC). I am also a Senior Scholar at the USC Leonard D. Schaeffer Institute for Public Policy & Government Service. The views I express today are my own and do not represent those of the University of Southern California or the USC Schaeffer Institute.

My colleagues at USC Schaeffer and I have conducted research on the value and economics of prevention for well over a decade. I also speak today as a recipient of the American Diabetes Association Outstanding Physician-Clinician Award and the Laureate Award for Public Service from the Endocrine Society, having helped pioneer efforts to diagnose, prevent and treat diabetes in a variety of socioeconomic settings.

Chronic Disease in America

For decades, our medical system has been set up to fight disease, and we've largely succeeded in developing effective treatments and cures.(1) Americans now enjoy both longer and healthier lives as result of both medical advances and public health measures. However, we now face a new challenge - the rising tide of chronic diseases threaten to overwhelm our health system and erode quality of life for millions of Americans. Conditions like obesity, diabetes, heart disease, cancer, and Alzheimer's disease are becoming increasingly prevalent as our population ages.(2)

Not only are the health consequence of chronic disease large; so are the costs of treating them. Chronic disease is the leading driver of the nation's \$4.5 trillion in annual health care costs.(3) Without changes to our approach, these costs are projected to continue rising. One study estimated that by 2030, cumulative chronic disease costs could reach \$42 trillion.(4)

Treating the Obesity Epidemic

At the heart of this chronic disease crisis in the United States is the growing obesity epidemic. Obesity is associated with increased risk of more than 200 other diseases, including heart disease, diabetes, cancer and dementia.(5) Tackling the high and rising rates of obesity is a pressing public health issue: According to modeling by the USC Schaeffer Center, the average American adult will soon have obesity, despite decades of public health efforts.(6)

Minority populations have been particularly hard hit. Black and Hispanic individuals experience higher rates of severe obesity compared to white individuals, translating into higher rates of chronic diseases among Black and Hispanic populations.

Fortunately, new obesity treatments are proving to be increasingly effective, which has substantial value for the individual patient and society.

Much of the debate has focused on the price of these medications. Less attention has been placed on the savings derived from improved health and reduced complications. My USC Schaeffer Center colleagues estimate that if Medicare covered obesity treatments, the program would see \$700 billion in offsetting medical savings over the following three decades.

And this calculation, while useful for budget scoring purposes, misses the key point. There would be enormous benefits in terms of population health. Valuing that health appropriately, they find that Medicare coverage of obesity treatment would generate \$4 trillion in social value to Americans.⁽⁶⁾ And, if private insurers followed Medicare's lead, the value would be even greater: \$1.5 trillion in Medicare cost offsets and \$6.7 trillion in cumulative social benefits.⁽⁶⁾

Treating the Diabetes Epidemic

Much of these savings come from preventing diabetes. Almost 15% of U.S. adults have diabetes, making it one of the most prevalent chronic conditions and inseparable from the obesity epidemic. Among Medicare beneficiaries, the rate increases to more than one-in-four.^(7,8)

As a diabetes specialist my life has been devoted to preventing disease and its complications. As a professor of medicine, I have given lectures around the world and written papers, books and guidelines to help others understand the need for preventive healthcare.

There are proven ways to prevent and substantially reduce the risk of diabetes: diet, exercise, stress and other lifestyle factors can be modified. New wearable technologies like continuous glucose monitors can provide physicians with substantial data. But access is disparate and dependent largely on socioeconomic factors.

But most primary care doctors don't have the time to speak with their patients about prevention or possess the tools to help people achieve sustained lifestyle change. Our healthcare system pays surgeons a premium for performing heart surgery or amputating a leg. But doctors like me get paid very little for preventing cardiovascular disease or the development of a foot ulcer.

I know from experience that spending time with patients works. I personally have treated thousands of patients, some in affluent Beverly Hills and some in underserved East Los Angeles. My Beverly Hills patients live to become healthy 80- and 90-year-olds. I can't remember when my last patient lost their vision, had an amputation or started dialysis, the most common complications of diabetes. Almost none have heart attacks or strokes.

But in East LA I see people every week in their 20's and 30's who have waited too long and have now developed life altering, preventable complications from their diabetes—blindness, kidney failure, the loss of a limb. These patients rarely live to grow old, and if they do they suffer many complications of their disease. What is especially heartbreaking is it is preventable. My research has shown that if we provide these patients the resources they need, teach them about nutrition and exercise, and provide appropriate technology we can improve their outcomes. Everyone benefits from preventive healthcare.

The data support the premise that prevention is worth our investment. Schaeffer researchers have also modeled the value of preventing diabetes, finding there is significant long-term health and economic benefits from comprehensive treatment of chronic conditions like obesity and diabetes, particularly when initiated at younger ages and for those with moderate forms of the disease. Schaeffer modeling predicts that the social return on investment from treating adults with moderate obesity is more than 15% per year.(9) I am not an economist, but I am told that is more than double the real rate of return of the S&P 500 since 2000.(10) And, just like the S&P is a good investment, so too is incentivizing early intervention and prevention strategies is critical.

Delaying Aging in Sickness

Investments in prevention go beyond metabolic health. Increasing rates of chronic disease, fueled by rising rates of obesity and gains in life expectancy, positions us to be an ever-sicker population. But age may be a modifiable risk factor. As such, rather than solely targeting specific diseases, an increased focus on understanding and modifying the underlying biology of aging itself is warranted.

Recent scientific advances suggest it may be possible to slow the aging process and delay the onset of multiple age-related chronic diseases simultaneously. This approach holds tremendous potential to extend healthy lifespans and compress illness and disability into a shorter period at the end of life.(11)

Researchers have made significant progress in understanding the hallmarks of aging and identifying potential interventions to slow these processes. For example:

- Incretin therapies may directly help reduce rates of Parkinson's and Alzheimer's disease and potentially help with smoking cessation and alcohol abuse.(12)
- Use of current and developing medications to reduce lipids and other cardiovascular risk factors.(13)
- Integrating wearable technologies into systems of behavior modification and disease surveillance.(14)
- Use of blood-based cancer screening to change the paradigm for diagnosing and treating malignancy

Preliminary economic modeling indicates that even modest success in delaying aging could yield enormous health and economic benefits. One analysis found that slowing aging by just 2.2 years could reduce the incidence of major diseases by 7-12% and save over \$7 trillion in healthcare costs over 50 years.(15)

Policies That Incentivize Paying for Health and Prevention, Rather Than Sickness

As a physician treating diabetes patients in both affluent and underserved communities, I have seen firsthand how social and economic factors profoundly impact health outcomes. Fortunately, there are policy solutions that could bend the curve towards investing in health:

- **Physicians could be partially reimbursed for incremental outcome improvements:** Understanding the multi-faceted causes of sickness in a patient, including social, economic, mental and biological, takes time. Most physicians, and especially those treating patients with chronic conditions, do not have the time to invest in the patient fully. Furthermore, an increasingly large share of our time is spent updating EHRs, filling out prior authorization and denial paperwork from insurers and other administrative tasks that are not about patient health. Reimbursing physicians for the outcomes for the patients, while reducing the administrative burden of payment, should be a priority.
- **Multi-year contracts for insurers:** Incentivizing multi-year insurance contracts, especially at large employers who have a consistently long-tenured staff, would incentive their bottom line towards prevention and health, rather than paying for treating sickness.
- **Innovators must be paid socially desirable returns:** This is crucial to incentivize continued innovation in areas with high societal impact.⁽¹⁶⁾ Ensuring that innovators are paid socially desirable returns for their investments in biomedical research and development can help us find new solutions to promoting prevention.
- **The field is currently tilted against prevention and cures:** Lifestyle factors like physical activity have been shown to substantially reduce mortality risk, prevent multiple chronic conditions and improve health.⁽¹⁷⁾ But innovation incentives are not currently set up to foster creative ways to get populations active.
- **Value-based reimbursement and flexible regulatory approaches would substantially help:** These arrangements must allow for the ability to change both price and labelling as long-term evidence emerges. For example, a three-part pricing strategy developed at the Schaeffer Center would allow for a low initial price as real-world evidence is collected. Once evidence emerges, the price could increase (or decrease) to correspond with the value of the new treatment. After a period of time, new entrants and generic competition would bring the price down.^(18,19)

Conclusion: These changes are vital if we are going to tackle high prevalence diseases

Currently, our healthcare system is tilted towards treating diseases rather than preventing them or finding cures. This short-term focus can lead to higher overall costs and poorer health outcomes. By rebalancing our approach to favor prevention and cures, we can potentially reduce the long-term burden of chronic diseases on individuals and the healthcare system.(1)

The policy recommendations I've suggested are designed to create a more balanced and forward-thinking approach to healthcare and biomedical innovation. By ensuring that innovators are appropriately rewarded for their investments, we can encourage continued research and development in areas that have the potential for significant societal impact, such as treatments that delay aging or prevent chronic diseases.

The implementation of value-based reimbursement and flexible regulatory approaches is crucial for promoting innovation in areas where the full benefits of a treatment may not be immediately apparent. For instance, a drug that delays the onset of Alzheimer's disease might show modest short-term benefits but significant long-term value. By allowing for price and labeling adjustments as new evidence emerges, we can create a system that more accurately reflects the true value of these interventions over time.(18)

The challenges posed by chronic diseases are immense, but so is the opportunity before us. With strategic investments and policy changes, we can usher in a new era of health and longevity for all Americans. Thank you for your attention to this critical issue. I look forward to your questions.

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