

MEMORANDUM

April 10, 1997

TO: Nancy-Ann

FR: Chris J.

RE: Diabetes

Given the degree of interest in diabetes in the White House, we have asked NIH and CDC to assess their current spending levels and indicate what increases might be necessary to improve their programs. While Dr. Varmus believes that there is adequate funding of diabetes at NIH, the top scientists at the American Diabetes Association (ADA), not surprisingly, believe that research in this area is vastly underfunded. There was some consensus at our initial meeting with NIH, CDC, OMB, HCFA, and HHS ASPE that diabetes prevention programs are not adequately funded. We have received suggestions as to what improvements could be made in this area, which I have described in this memo.

In short, we are interested in OMB staff's assessment of these funding requests -- specifically whether they are needed increases in diabetes or rather wish lists that all advocates have for their programs. Bruce Reed is pressuring me to get back to him on this issue by the end of the week and would appreciate any help you might be able to give. It is clear that there will need to be a larger meeting with you, Erskine Bowles, Bruce Reed and possibly HHS to discuss how we might want to move forward on this issue. I am getting a sense that they are going to want to get a feeling for our options in very short order. (Is this something that Frank would need to be directly involved in?)

1) NIH

Issue: Based on our preliminary discussions with the scientific advisors of the American Diabetes Association, it appears a viable argument could be made that clinical research (not basic research) seems to be significantly underfunded. The ADA has sent us evidence (using NIH numbers) that shows that NIH numbers for diabetes is less than 1% of the direct costs of the disease. It is far less than a host of other diseases, including heart disease, alcoholism, arthritis, cancer, multiple sclerosis, and AIDS (see attached chart).

As a result, they believe that we are leaving important questions unanswered, such as what effect

diabetes has on pregnant women, the extent to which intensive treatment should be used on young children and on the elderly who may not be able to tolerate it. They believe that answering some of these questions would enable us to treat this disease more effectively and lower its costs.

Action: We are interested in finding out, if we were able to secure the funding, how much of an increase you believe is warranted in this area, if any.

2) CDC

Issue: As I mentioned to you previously, CDC has advised us that they need additional funding to expand their current prevention programs. As you know, CDC will spend \$26 million in FY 1997 on prevention programs. They believe that this funding is not sufficient. They say that many of their state programs are inadequate, some having as few as one employee.

The President's FY 1998 budget proposes to spend \$36 million. Of this \$10 million increase, CDC tells us that approximately 70% would go to improve prevention programs. However they believe that this will still not be enough to fully fund their programs.

In addition, CDC is announcing a National Diabetic Education Plan this June, that will focus on educating people with diabetes, physicians, policymakers, and the public about diabetes prevention and treatment. CDC has already allocated \$750,000 in their FY 1997 budget for NDEP. However, \$2 million of the \$10 million increase they are requesting in their budget will go to this.

Without the FY 1998 funding, CDC tells us that NDEP will not be able to target all of the constituencies listed above. They say they will target people who already have diabetes, but they will not be able to do a full public health strategy, targeting physicians, policymakers, and the public, particularly those who are at risk for the disease. **CDC tells us that they would need \$66 million (\$30 million above FY 1998 request) to fully fund prevention programs in all fifty states.** This funding would enable them to fully fund their prevention programs nation-wide and to pursue a multi-layered education campaign. We are interested in your thoughts on the necessity of this increase as well.

As you may know, of the 16 million Americans with diabetes, only 8 million are aware that they have to treat early onset of this disease, thus preventing much more expensive outcomes -- such as end stage renal disease. Many people do not find out they are diabetic until they have severe health problem associated with the disease. There was some consensus in our meeting with NIH, CDC, and OMB that improving prevention is one of the most cost-effective intervention currently available.

Again, we are interested in your thoughts on what funding is necessary to run an effective education program in this area.

Thanks again for all your help.

Diabetes

Diabetes mellitus in Native Americans: The problem and its implications

K.M. VENKAT NARAYAN

National Institutes of Health, Phoenix, Arizona, USA

Abstract. Since World War II, diabetes has become one of the most common serious diseases among Native Americans. Rates of diabetes and its complications, which include premature death, renal failure, and limb amputation, are substantially higher among Native Americans than among the US general population, and the frequency of diabetes among Native Americans is increasing. Several potentially modifiable factors, including obesity, dietary composition, and physical inactivity, are thought to be contributing to these high rates. The potential benefit from prevention of diabetes is considerable, and a population-based approach may be the most effective way of achieving sustainable lifestyle changes among Native Americans. Estimation of the social and economic costs of diabetes and assessment of the marginal costs and benefits of various diabetes control measures can support resource allocation decisions aimed at improving the health of Native American people.

Key words: Diabetes mellitus, American Indians, Prevention, Gila River Indian Community

1. Introduction

Diabetes mellitus is a group of metabolic disorders characterized by abnormally high levels of blood glucose secondary to inefficient insulin action and/or secretion. The disease often leads to significant disability, including renal failure, blindness, and limb amputation, and to premature death.

Diabetes was apparently rare among Native Americans until the middle part of the twentieth century (Joslin 1940; West 1974; Sievers & Fisher 1985). However, since World War II, it has become one of the most common serious diseases among many Native American tribes (Sievers & Fisher 1985); in 1987, there were at least 72,000 Native Americans in the USA with diagnosed diabetes (Newman et al. 1990). Diabetes occurring in Native Americans is almost exclusively the type referred to as NIDDM or non-insulin-dependent diabetes mellitus (Sievers & Fisher 1985). The Pima Indians have the highest recorded prevalence and incidence of NIDDM in the world (Knowler et al. 1978; King & Rewers 1991). High rates have also been observed among other Native American tribes (Sievers & Fisher 1985; Gohdes 1986; Young & Shah 1987), as well as in many diverse societies worldwide that have

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General Diabetic Statistics

PREVALENCE

Number of people diagnosed w/diabetes (1993)

- Women: 4.2 Million
- Men: 3.6 Million
- Children 19 and younger: About 100,000
- Adults 65 and older: 3.2 million

Percent of adults with diabetes by race and ethnicity (Diagnosed and undiagnosed)

- African American: 9.6 percent
- Mexican American: 9.6 percent
- Cuban American: 9.1 percent
- Puerto Rican American: 10.9 percent
- White Americans 6.2 percent
- American Indians: Ranges from 5 to 50 percent
- Japanese Americans: Japanese Americans 45-75 years of age in King County, WA, 20 percent of the men and 16 percent of the women had diabetes.

**THE PRESIDENT'S FY 1998 BUDGET
MEDICARE DIABETES BENEFIT IMPROVEMENTS**

- **Diabetes is a serious health problem for seniors.** One-third of new patients with diabetes are age 65 or older and covered by Medicare. Medicare also covers people less than 65 with end-stage renal disease, and thus is a major payer for diabetes care.
- **Improved diabetic care can prevent painful and debilitating complications.** Evidence suggests that diabetes-related blindness, amputations, and other complications could be substantially reduced with early intervention and disease management.

The President's budget expands Medicare benefits for diabetes outpatient self-management training and blood glucose monitoring

- **Diabetes outpatient self-management training services:** Under current law, Medicare covers diabetes outpatient self-management training only in hospital-based programs.

The President's budget will expand coverage to include outpatient training furnished by physicians and other certified providers.

The Secretary will consult with the American Diabetes Association (ADA) and other organizations in establishing payment amounts for diabetes outpatient self-management training provided by physicians. The Secretary will also set limits on duration and frequency of the benefit.

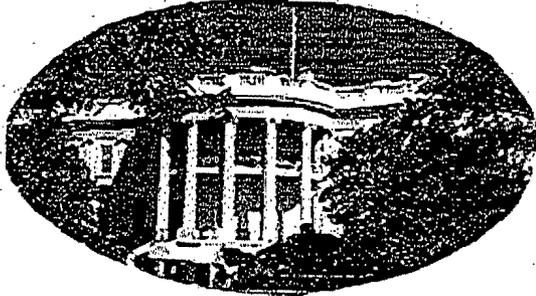
- **Blood glucose monitors and testing strips:** Under current law, Medicare covers blood glucose monitors (including testing strips) only for insulin-dependent diabetics.

The President's budget will expand coverage to pay for monitors and testing strips for all diabetics.

The President will invest \$1.4 billion between 1998 and 2002 in improved care for Medicare beneficiaries with diabetes (CBO scored this policy at \$2.4 billion)

- There are claims that this benefit will save Medicare money due to reduced incidence of severe complications for beneficiaries with diabetes. While the Health Care Financing Administration's Actuaries do not believe that this will occur, the President believes that these are important policies to improving the quality of beneficiaries' lives.

FAX COVER



DATE::

4/15

TO:

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COMMENTS:

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Number of pages (including cover) _____

To Christ -
FYI + let's
discuss

for 1:30pm

April 11, 1997



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Washington, D.C. 20503

Please route to:

Richard Turman
Barry Clendenin
Nancy-Ann Min

BC

ACTION REQUESTED:

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- For your information

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- ASAP
- Action Requested by _____
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TYPE OF DELIVERY:

With informational copies for: HPS, HPS Chron, W, T, H, T

Subject: HPS Assessment of Diabetes
Activities at CDC and NIH

From: Greg White & Vikki Wachino

GW

Phone: 202/395-4926
Fax: 202/395-3910
Room: NEOB #7002

Attached is our quick assessment of diabetes activities at CDC and NIH, as well as some observations about the recent outside requests to increase funding in this area. Part I discusses CDC issues. Part II discusses NIH. A summary funding table of the recent requests for increased funding is provided below.

CDC and NIH Funding for Diabetes (BA, \$ in millions)					
	FY 1997	Under FY 1998 President's Budget		Under Alternative Budget	
		FY 98 Request	FY 1998 - 2002 (estimate)	FY 1998	FY 1998 - 2002 (estimate)
CDC	26	36	29.7 47.7 before pass back	66	330
NIH	316	323	1,615	373 to 398	1,865 to 1,990
Total	342	359	1795	439 to 464	2195 to 2320

Please let us know if you have any questions.

Attachments

PART I -- Assessment of CDC Diabetes Activities

Provided below is an overview of CDC Diabetes activities and a HD assessment of a proposal made by some CDC staff to DPC to increase funding in this area above the FY 1998 Budget. It is based on materials provided to us by DPC as well as a conference call we had with CDC staff Thursday afternoon.

Overview of CDC Request

The FY 1998 Budget includes a \$10 million (38%) increase over FY 1997 for diabetes-related activities at CDC. We understand from DPC that some CDC staff (but not official CDC or HHS) are now seeking an additional \$30 million above the FY 1998 Budget (and \$150 million for the 5-year Budget window) for these activities. This request would increase funding for CDC diabetes activities to \$66 million, an increase of \$40 million (153%) above the FY 1997 level. (See table below)

	FY97	FY98 Budget	Requested Increase Above the Budget	New CDC FY 98 Budget Request
<i>Grants to States + Territories</i> Core State and Territory Programs (\$200K per state)	10	9	-9	0
Comprehensive State and Territory Programs (\$800k per state)	4	10	+30	40
State Total	14	19	+21	40
National Diabetes Education Program	1	3	+3	6
Public Health Surveillance Systems	6	7	+3	10
Applied Research (<i>tribes</i>)	6	7	+3	10
Total CDC Diabetes	26	36	+30	66

CDC's "Supplemental" Request for Diabetes During FY 1998 Budget Season

As you recall, one day before passback last year, HHS gave us a "supplemental" request for diabetes above the normal request in the OMBJ submitted to us in September. The original CDC request was for \$29.7 million, \$3.5 million above FY 1997. The supplemental request increased the CDC request to \$47.7 million, \$21.5 million above FY 1997. The eventual FY 1998 Budget level for CDC diabetes activities was \$36 million, \$10 million above FY 1997.

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things rather than top 3*

Summary of CDC Diabetes Activities

Unlike many other CDC prevention activities, CDC diabetes prevention funds are not used to provide direct screening or other disease prevention activities. From our conversations with CDC staff, it appears that program efforts are focused largely on encouraging and educating doctors to properly manage diabetes, and raise public awareness of the risks of diabetes, so that individuals with or at risk of diabetes may seek effective treatments. As a result, it could best be described as a "secondary" prevention program which is intended to prevent the consequences of diabetes (rather than diabetes itself, as opposed to a "direct" prevention program (e.g. immunizations)).

CDC staff advise that 95% of all diabetics have Type 2 diabetes, which is developed in the later stages of life due largely to eating habits or other factors. The remaining 5% have Type 1 diabetes which diabetics develop in childhood. CDC does not have specific program activities aimed at Type 1 diabetes; they advise that their programs are designed to address diabetes in general.

The CDC Diabetes program has four major components:

(1) Grants to States to Establish Either "Core" or "Comprehensive" Diabetes Programs. The majority of CDC diabetes funds is awarded to state health departments to establish either "core" diabetes planning or "comprehensive" diabetes control programs. In FY 1997, 45 states received grants (\$200K) to establish "core" diabetes planning programs. These programs are limited in scope and consist largely of a couple of planning staff and limited local education efforts at high-risk groups. In FY 1997, 5 states received grants (\$800K) to establish "comprehensive" diabetes control programs, which typically consist of more staff, state-wide diabetes education efforts and surveillance.

Of the \$10 million increase in the FY 1998 Budget, \$5 million would be directed to expand the number of "comprehensive" disease control programs from 5 to 13 and decrease the number of "core" states from 45 to 37.

Of the \$30 million increase over the FY 1998 Budget that some CDC staff are requesting, \$21 million would be directed to establish "comprehensive" diabetes control programs in all 50 states. This would increase state-based activities to \$40 million in FY 1998, an increase of \$26 million (186%) over FY 1997.

(2) National Diabetes Education Program. In 1995, CDC and NIH began a collaborative National Diabetes Education Program "to improve the outcome of persons with diabetes, promote early diagnosis, and ultimately prevent the onset of this disease." According to CDC, their efforts have been limited; the agency spent approximately \$500K on this activity in FY 1997.

Of the \$10 million increase in the FY 1998 Budget, CDC would use \$2 million to expand national diabetes education efforts and develop a strategic plan "to bring together existing and new prevention strategies as well as early detection and diabetes control efforts to achieved improved intervention quality, continuity, and effectiveness."

Of the additional \$30 million that some CDC staff are requesting above the FY 1998 Budget, CDC would use \$3 million to establish national advertising campaigns and targeted outreach to employers on the importance of diabetes education. This would increase CDC's contribution to this activity to roughly \$6 million in FY 1998.

(3) Surveillance. Like other disease-related activities, CDC funds national and state-based surveillance activities "to identify diabetes burden, monitor disease trends and evaluate program outcomes." In FY 1997, CDC spent roughly \$6 million on these activities.

Of the \$10 million increase in the FY 1998 Budget, CDC would use \$2 million to expand tracking of this disease as part of the Behavioral Risk Factor Survey System (BRESS). Of the \$30 million that CDC is requesting above the FY 1998 Budget, CDC would use an addition \$3 million to make further expansions in this area. ✓

(4) Applied Research. CDC currently conducts research focusing on the application of findings from recent clinical trials and scientific research related to diabetes. In FY 1997, CDC spent about \$6 million on such activities.

Of the \$10 million increase in the FY 1998 Budget, CDC plans to use \$2 million to expand research in this area on the following topics: (1) managed care settings; (2) primary prevention of Type 2 diabetes; (3) early detection of undiagnosed diabetes; and (4) standards of care for diabetes.

Of the \$30 million that CDC is requesting above the FY 1998 Budget, CDC would use \$3 million to expand further applied research in the areas mentioned above and increasing research on the understanding of diabetes in American Indians.

FD Assessment of the CDC Diabetes Staff Proposal

The FY 1998 Budget has a \$10 million (38%) increase over FY 1997 for CDC diabetes activities. In the context of a balanced budget, this does not appear to be "woefully under-funded" as some advocates would suggest. It is also not clear how effective these secondary prevention programs are in actually reducing the complications of diabetes. CDC has not provided extensive performance measures in this area.

If the goal is to establish comprehensive diabetes control programs in more of the states, CDC could devote less resources of its FY 1998 Budget request to its National Diabetes Education Program, Surveillance and Applied Research activities and more to its state-based programs. We are also unaware of any suggested offsets within CDC that could be taken to offset the proposed \$30 million increase in funds above the FY 1998 Budget.

PART II -- DRAFT PAPER ON NIH DIABETES RESEARCH

We understand that diabetes advocates are arguing:

- 1) NIH research funding on diabetes is lower than what NIH spends on other diseases, when measured by the ratio of NIH research funding dollars to health expenditure dollars related to various diseases;
- 2) Within NIH diabetes research, clinical research in particular is underfunded;
- 3) \$50 to \$75 million should be found to boost NIH's diabetes clinical research program, and these funds should be used to fund two to three new diabetes clinical trials.

This paper considers each of these claims in turn, and finds that:

- 1) *Although diabetes research appears to be "underfunded" relative to research on other diseases when measured by a ratio of research funding to funding for health care expenditures, when it is measured by other, more frequently-used public health measures, diabetes research is funded very well.*
- 2) *Funding for clinical trials, which is one possible definition of "clinical research," within the lead diabetes research Institute at NIH, the National Institute on Diabetes, Digestive and Kidney Disorders, is slightly less as a percentage of total Institute spending than it is for NIH as a whole. However, it is on par with other Institutes that focus on diseases for which there are treatments available.*
- 3) *All things considered, diabetes appears to be no more worthy of funding than most of the other diseases NIH researches, and \$50 to \$75 million is a generous estimate of the resources that would be required to boost NIH's clinical research program on diabetes.*

The attached pages examine each of these claims and HD's draft analysis of them.

1) Advocates' Claims About NIH Funding for Diabetes Research

Information the ADA sent to Chris Jennings asserts that NIH spending for diabetes research is less than 1% of the "direct costs" of diabetes -- which are costs related to providing health care services for individuals with diabetes. ADA asserts that spending for diabetes research compared to direct health expenditure costs for diabetes is lower than comparable ratios for many other diseases. Using data in a recent NIH report to the House Appropriations Committee, we tried to recompute these figures. Charts displaying our three main results are attached at Tab A.

Chart 1 -- NIH spending on diabetes when measured by direct, health expenditure costs and total costs, including health care costs plus economic costs of diseases to society. This chart shows that NIH research spending per "direct" cost dollar for diabetes is lower than it is for six other diseases. However, it is equal to or higher than NIH research spending per direct cost dollar in three other areas, including injury and pneumonia. When we included NIH's estimates of the "indirect" cost of diseases, diabetes' ranking relative to that of other diseases improved. Indirect costs are costs that the disease imposes on society as a whole, such as the economic loss associated with lost days of work. When indirect costs are included, the disparity between diabetes and other diseases closes. NIH research spending for diabetes as a proportion of total costs is exceeded by that of only four diseases -- cancer, heart disease, stroke and mental disorders. The ratio of research funding to total costs of alcohol abuse, disability, diseases related to smoking, pneumonia, is lower than that of diabetes.

Chart 2 -- Research funding by annual death for diabetes is high. Research spending per death for diabetes is second to only one other disease -- HIV.

Chart 3 -- Diabetes ranks first in research funding per "Years Per Life Lost" (YPLL) Diabetes exceeds eight major causes of death when measured by spending per average years of life lost due to the disease.

So the results of measuring spending for a disease depend in large part on what measure is used. When measured by dollars per direct cost, diabetes research funding appears fairly paltry, relative to that of other diseases. But by

This is disease not a threat to kill people to but rather debilitating

other measures -- including spending per death and spending per years of life lost -- **funding for diabetes research is comparatively generous.**

Moreover, NIH notes in the FY 1998 Congressional Justification that *NIDDK's FY 1996 funding for diabetes research "represents a 95 percent increase during the last decade, exceeding the 60 percent increase in the total NIDDK budget over the same period."*

None of these measures of research spending are ideal ways of making research funding decisions. As Dr. Varmus and previous NIH directors have argued, research funding decisions are best made by an assessment of available scientific opportunities. We would argue that an awareness of the burden the disease poses to society is also important, but with the caveat that there is no ideal method of measuring this burden. *One of the best available measures, used by CDC and other knowledgeable public health experts, is YPLL -- and as you can see from our tables, diabetes research is doing exceedingly well by this standard.*

On a more political note, we observe that House Labor/HHS Chairman Porter has become increasingly sensitive to funding allocations that are made more on a political basis than on a scientific rationale, and has asked pointed questions during hearings about which diseases the Administration has earmarked funds for. He plans to hold a hearing on how NIH makes its funding decisions next month.

2) Is NIH Funding an Appropriate Amount of Clinical Research?

We compared NIDDK's funding of clinical research to that of NIH as a whole and some other NIH Institutes, using a somewhat rough measure: the ratio of funding of clinical trials to total appropriated dollars. Most of clinical research is conducted through clinical trials, but defining clinical research as "clinical trials" excludes some activities, such as the development of clinical protocols before they are tested in humans. Similarly, using total appropriations for Institutes is inexact. The total NIDDK appropriation includes funds for digestive and kidney disorders, as well as diabetes, and also includes administrative costs that are not directly attributable to a particular disease. Although measuring clinical research in this manner is imperfect, it uses the best data that NIH presently has available.

→ this is a good measure

From Chart 4, one can observe that NIDDK spends 8% of its budget on clinical trials. This is slightly lower than the proportion of the entire NIH budget that is devoted to clinical research, which is just under 10%.

NIH staff inform us that Institutes normally devote more resources to clinical research for a particular disease if no treatment exists for the disease than if one does. The Cancer Institute, for example, devotes a large share of its resources to clinical research, because there are no effective treatments for most types of cancer. Diabetes, by comparison, is effectively treated with insulin. Although insulin treatment is probably not ideal in the eyes of people who suffer from diabetes, these individuals are, relative to people who suffer from some other diseases, fortunate.

Chart 4 includes data for some Institutes responsible for diseases for which there is no effective treatment (National Cancer Institute, Office of AIDS Research) as well as the National Heart, Lung, and Blood Institute, the lead NIH agency on heart disease. Heart disease, like diabetes, is effectively treated through pharmaceuticals and diet.

Chart 4 demonstrates that NIDDK's ratio of clinical trial spending to overall spending exceeds that of NHLBI, which addresses the disease that is most comparable to diabetes. And, consistent with the information NIH staff provided to OMB, NCI and OAR spend a much larger proportion of their budgets on clinical trials than does NIDDK. NIDDK's proportional spending on clinical trials also exceeds that of the National Institute of Neurological Disorders and Stroke -- the lead Institute on Alzheimer's disease, stroke, epilepsy, spinal cord industry, and multiple sclerosis -- and that of the Genome Institute, which probably spends the lowest portion of its budget on clinical trials.

Based on this analysis, HD staff do not find any strong evidence that NIDDK is under-funding clinical research, as measured by the proportion of the Institutes' funds that are spent on clinical trials.

3) Should NIH Diabetes Research Funding be Boosted \$50 to \$75 Million in FY 98 and by as much as \$1.9 billion over five years?

In FY 1997, NIH will spend \$316 million on diabetes-related research. Of this, the National Institute on Diabetes Digestive and Kidney Disorders will fund approximately \$200 million. About 40% (\$83 million) of NIDDK's diabetes research total will fund clinical research, NIDDK staff have informed us. This includes funding for three major clinical trials: one trial related to non-insulin dependent (Type II) diabetes; a second trial on preventing insulin dependent (Type I) diabetes; and the continuation of the Diabetes Control and Complications Trial, which is following 1,400 diabetic individuals over time.

NIH's fundamental mission is to fund basic research, not clinical research. The reasoning behind this goes to the definition of a "public good" -- while it may be in industry's interests to fund some clinical research, because they can obtain intellectual property rights for and make a profit from the results of this research, basic research is generally something that would not be funded in great quantities absent government support. NIDDK's present 40/60 ratio of clinical research on diabetes to basic research on diabetes seems consistent with this mission. We also note that NIDDK's past experience has shown that industry may step up to the plate when some promising clinical research opportunities are left unfunded. When NIDDK began planning a large, four-stage clinical trial to identify ways to prevent Type II diabetes, industry offered to cosponsor part of the trial to test new drugs. NIDDK estimates that industrial sources are contributing approximately \$15 to \$20 million to launch one arm of this clinical trial.

Moreover, as Dr. Gorden, the NIDDK director, pointed out in a recent conversation with us, advocates for all diseases tend to emphasize the short-term benefits of clinical research over the long-term benefits of basic research. Although advocates understandably want to bring the latest innovations directly to patients as quickly as possible, if NIH does not maintain a balanced investment in basic research, there will be no new discoveries to bring to patients down the road. Gorden noted that a number of promising basic science leads lie before NIDDK, such as understanding the genetic basis of diabetes.

As a final note, we understand that diabetes advocates have advised Chris Jennings' office that \$50 million would be sufficient to cover only two new clinical trials, which advocates claim cost \$25 million typically. **NIH staff have advised us that \$25 million exceeds the cost of most of the clinical trials the agency sponsors.** Their lowest-cost clinical trial costs \$300,000, and on average clinical



trials cost between \$1.5 and \$10 million. NIH's large, multi-center, cooperative pediatric AIDS trials, which are abnormally expensive, cost between \$20 and \$30 million. It is not clear to us exactly what type of research ADA believes NIH needs to perform, but they appear to be assuming that the research involves high-end costs.



FAX COVER SHEET

**OFFICE OF LEGISLATIVE &
INTER-GOVERNMENTAL AFFAIRS**

Number of Pages: 2 + cover page

Date:

To:	From:
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REMARKS:

Sarah -- Attached is the paper you requested describing strategies HCFA is (or will be) using to disseminate what we learn from our diabetes initiatives.

If you have further questions on this, please give me a call.

-- JOAN

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201



STRATEGIES FOR UTILIZING AND DISSEMINATING THE RESULTS OF HCFA'S DIABETES INITIATIVES

HCFA currently has underway two major pilot projects in 8 states to improve diabetes care, in conjunction with the Medicare Peer Review Organizations (PROs). The Ambulatory Quality Improvement Project (ACQIP) is based in fee-for-service settings, while the Medicare Managed Care Quality Improvement Project (MMCQIP) is focused on HMOs. In addition, every state's PRO is implementing a quality improvement project for diabetes care, reaching at least five percent of the diabetic Medicare beneficiaries in each state. As the results of these projects become available, HCFA will disseminate them as widely as possible, both internally within the Department of Health and Human Services, and externally through providers and professional organizations. These outreach efforts -- some upcoming, some already underway -- include the following examples:

- o Professional literature: Members of the HCFA Diabetes Team, working with participating PROs, have prepared an article on ACQIP for publication in the *Journal of the American Medical Association*. The article is currently in draft form and under review within HCFA.
- o Presentations at conferences: Over the last year, members of the HCFA Diabetes Team have made a number of presentations on both ACQIP and MMCQIP at conferences sponsored by professional groups and PROs throughout the U.S.
- o Managed care newsletter: An MMCQIP Newsletter will be printed this month (April 1997) and will be sent to managed care plans participating in the project and to all PROs, which will, in turn, distribute the newsletter to their panels of physicians. The Newsletter will also be distributed to members of the "Diabetes Resource Group", which was convened by HCFA at the start of its diabetes projects and includes professional and consumer organizations interested in improved diabetes care. These groups include the American Medical Association, American Diabetes Association, American Association for Retired Persons, American Pharmaceutical Association, American College of Physicians, and others.

The Newsletter will also go to groups involved in general "quality improvement" activities (such as the Institute for Healthcare Improvement, comprised of many of the nation's leading medical institutions), as a model of what can be achieved through collaboration between HCFA, the PROs, managed care plans, and individual physicians.

- o Models from managed care pilot project: In early May 1997, HCFA will convene all of the MMCQIP participants (plans and PROs) to discuss each group's activities in attempting to improve diabetes care. The meeting will focus on "lessons learned" from their experiences throughout the project, to provide models for both the participants' future activities and for all PROs throughout the U.S. (which are each engaged in individual state diabetes quality improvement projects).

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- o Fee-for-service project highlights: In the next few months, the HCFA Diabetes Team will begin issuing a series of six "highlights" on our findings under ACQIP, to present baseline data and describe opportunities for quality improvement that have been identified by the project so far. This information will be disseminated to the PROs and the diabetes treatment and advocacy communities. 
- o Educational campaign: The PROs, through their national organization, are organizing an intensive educational campaign on improving care for diabetic Medicare beneficiaries through quality improvement activities. HCFA's on-going experience with ACQIP and MMCQIP will serve as a significant basis for this educational initiative.
- o Data from Arizona: Recent quality improvement efforts guided by the Arizona PRO have yielded striking improvement in diabetes care provided by that state's managed care plans. The PRO has already published its baseline data in a professional journal, and presented its early findings on intervention strategies through the nationwide network of PROs. Now that new data are available demonstrating improvements in plans' diabetes care, the PRO will be pursuing further publications and presentations, directed at a wider audience. *When announced*



Division of Diabetes Translation
 National Center for Chronic Disease Prevention and Health Promotion
 Centers for Disease Control and Prevention



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Subject:		FAX:	<i>770-488-5966</i>
Total	<i>5</i>	<i>(including this cover sheet)</i>	

Transmittal Message

\$20 Million Increase

These additional funds will be used for the following major programs:

Establishment of Comprehensive Diabetes Control Program in 15-20 additional States (\$10 million)

In FY 1997, all 50 states will have established minimum, core-capacity level diabetes control programs; and 5 states will have received additional funds to expand their core programs into comprehensive programs. Core programs focus on building expertise, assessing the burden of diabetes, and planning diabetes control activities. Comprehensive programs emphasize implementation of public health strategies and interventions throughout the entire state, with an expected improvement in access to, and availability and affordability of quality diabetes services and care. Priority and emphasis is placed on targeting high risk and disadvantaged populations, establishing linkages with managed care organizations, and building partnerships to influence the existing health care system.

National Diabetes Education Program (\$2 million)

CDC and NIH joined forces in 1995 to provide leadership to develop and launch a major new program, the National Diabetes Education Program (NDEP). The NDEP is a collaborative effort to improve the outcome of persons with diabetes, promote early diagnosis, and ultimately, prevent the onset of this disease. A Strategic Plan will bring together existing and new prevention strategies as well as early detection and diabetes control efforts to achieve improved intervention quality, continuity, and effectiveness. It will initially address priority target audiences and the needs of minority and other special populations. CDC will have responsibility for coordinating the implementation of the **public health components** of the NDEP.

Strengthening Public Health Surveillance for Diabetes (\$4 million)

In order to identify the diabetes burden, monitor trends, and evaluate program outcomes, basic infrastructure, especially existing public health surveillance systems for diabetes, needs to be strengthened, especially at the state level, in order to provide ongoing data on this growing public health problem.

Conducting Applied Research (\$4 million)

It is vitally important for CDC to understand how to effectively apply clinical diabetes research findings in today's health care system. Applied research focuses on identifying and understanding the public health implications of the results from clinical trials and scientific studies. Applied research for diabetes prevention and control is needed in the following areas: (1) access to and quality of care of diabetes, with an emphasis on managed care organizations, (2) early detection of undiagnosed diabetes, (3) primary prevention of Type 2 diabetes, and (4) standards of care for diabetes.

FY 1998 - President's Budget
\$10 Million Increase

These additional funds will be used for the following major programs:

Establishment of Comprehensive Diabetes Control Program in 7-9 additional States (\$4 million)

In FY 1997, all 50 states will have established minimum, core-capacity level diabetes control programs; and 5 states will have received additional funds to expand their core programs into comprehensive programs. Core programs focus on building expertise, assessing the burden of diabetes, and planning diabetes control activities. Comprehensive programs emphasize implementation of public health strategies and interventions throughout the entire state, with an expected improvement in access to, and availability and affordability of quality diabetes services and care. Priority and emphasis is placed on targeting high risk and disadvantaged populations, establishing linkages with managed care organizations, and building partnerships to influence the existing health care system.

National Diabetes Education Program (\$2 million)

CDC and NIH joined forces in 1995 to provide leadership to develop and launch a major new program, the National Diabetes Education Program (NDEP). The NDEP is a collaborative effort to improve the outcome of persons with diabetes, promote early diagnosis, and ultimately, prevent the onset of this disease. A Strategic Plan will bring together existing and new prevention strategies as well as early detection and diabetes control efforts to achieve improved intervention quality, continuity, and effectiveness. It will initially address priority target audiences and the needs of minority and other special populations. CDC will have responsibility for coordinating the implementation of the **public health components** of the NDEP.

Strengthening Public Health Surveillance for Diabetes (\$2 million)

In order to identify the diabetes burden, monitor trends, and evaluate program outcomes, basic infrastructure, especially existing public health surveillance systems for diabetes, needs to be strengthened, especially at the state level, in order to provide ongoing data on this growing public health problem.

Conducting Applied Research (\$2 million)

It is vitally important for CDC to understand how to effectively apply clinical diabetes research findings in today's health care system. Applied research focuses on identifying and understanding the public health implications of the results from clinical trials and scientific studies. Applied research for diabetes prevention and control is needed in the following areas: (1) access to and quality of care of diabetes, with an emphasis on managed care organizations, (2) early detection of undiagnosed diabetes, (3) primary prevention of Type 2 diabetes, and (4) standards of care for diabetes.

Resources Needed for National Diabetes Prevention and Control Program**(\$40 million)**

In order to fully fund a diabetes prevention and control program, an additional \$40 million is needed. These resources would enable CDC to:

- Establish **comprehensive diabetes prevention and control programs** in all 50 states, with an emphasis on improving access to, and availability and affordability of quality diabetes care throughout the nation. (\$25 million)
- Implement the **public health components of the National Diabetes Education Program**, which is a CDC-NIH collaborative effort, to improve the treatment and outcomes for persons with diabetes, promote early diagnosis, and ultimately, to prevent the onset of this disease. (\$5 million in year 1; an additional \$5 million would be needed in year 2)
- Develop and implement **public health surveillance systems**, nationally and at the state level, for identifying the diabetes burden and for monitoring trends. (\$5 million)
- Conduct **applied research** in order to understand how to more effectively apply scientific findings in today's health care system. (\$5 million)

Division of Diabetes Translation
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

Budget Appropriations History (FY92-97)
(In Millions)

<u>FY 1992</u>	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>	<u>FY 1996</u>	<u>FY 1997</u>
\$ 7.156	\$ 9.50	\$17.910	\$19.765	\$22.991	\$26.247



National Center
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To prevent and cure diabetes
and to improve the lives of
all people affected by diabetes.

March 10, 1997

Officers

Alan Altschuler
Chair of the Board

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President

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*President,
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*Vice President
Health Care & Education*

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Chief Executive Officer

Dear Member of Congress:

On behalf of the American Diabetes Association, we are writing to encourage you to significantly increase funding levels for diabetes research, prevention and disease control programs at the the Department of Health and Human Services, including the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC) and the Indian Health Services (IHS).

Diabetes is a very serious chronic disease and a major public health issue. Diabetes is the nation's fourth leading cause of death by disease, killing more than 160,000 Americans every year. It is a leading cause of heart disease, stroke, amputations, blindness and kidney disease, and it is the single most prevalent chronic illness among children. Alarmingly, half of the 16 million Americans with diabetes do not even know they have this life threatening disease.

Diabetes is increasing at a shocking rate. The number of cases of diabetes has tripled since the 1960's. The direct cost of diabetes to the American taxpayer has doubled since 1992, to its current sum of \$91.1 billion a year. This figure does not begin to account for the staggering losses in productivity, well-being and private health care expenditures created by diabetes. When indirect costs are included, diabetes is costing our economy \$138 billion a year, more than any other single disease. The only way America can hope to lower these costs is through a strong commitment to research, prevention and disease control.

In promoting advances in diabetes research, prevention and disease control, we strongly urge you to provide additional funding for three diabetes programs: first, a 9% increase for NIH and 12% increase for NIDDK; second, a \$10 million increase for CDC's division of Diabetes Translation; and third, a \$2.5 million increase for the IHS diabetes program. The American Diabetes Association is committed to supporting your action on this matter.

Sincerely,

Alan Altschuler
Chair of the Board

Philip E. Cryer, MD
President

Belinda P. Childs, RN, MN, CDE
President, Health Care & Education

Facsimile Cover Sheet

To: Chris Jennings
Company: Assistant to the President for Health Policy
Phone:
Fax: 202/456-5557

From: John Pepper
Company: Procter & Gamble
Phone:
Fax:

Date: 04/10/97

Pages including this cover page: 3

Comments:

Procter & Gamble

JOHN E. PEPPER
Chairman of the Board and
Chief Executive

General Offices
The Procter & Gamble Company
One Procter & Gamble Plaza
Cincinnati, Ohio 45202-3315

April 10, 1997

The President
The White House
Washington, DC 20500

Dear Mr. President:

It was with great interest that I noted your recent appointments to the Advisory Commission on Consumer Protection and Quality in the Health Care industry. However, when reviewing the individuals selected, it became apparent there is a significant lack of representation from large businesses, the one sector of our economy which historically has provided workplace health insurance coverage. The continuing escalation in costs to employers providing workplace insurance remains a major concern among my colleagues on the Business Roundtable.

It is my understanding that you will soon be making additional appointments to this Commission. Hopefully, you will add balance to the Commission by appointing representatives of large employers. Accordingly, I am writing to urge your consideration of the nomination of Mr. Thomas M. Ryan.

Mr. Ryan is Vice Chairman and Chief Operating Officer of CVS Corporation, which will become the nation's largest retail community drug store company with annual sales approaching \$11 billion when it completes the process of acquiring Revco Drug Stores. The new company will have over 82,000 employees working in nearly 4,000 locations around the country.

Mr. Ryan is responsible for day-by-day operations of this major employer and top Fortune 500 company. He is intimately familiar with the business challenge of providing high quality, accessible health care to employees at reasonable cost to employers. An added value Mr. Ryan can bring to the Commission beyond his business acumen is his knowledge of how managed health care operates and the increasing role pharmacists play in providing care to the patients they serve, including millions of elderly and disadvantaged citizens.

A well respected business leader, Mr. Ryan is considered to be an outstanding executive and public servant. He serves on the Board of Trustees of the University of Rhode Island, the Rhode Island Public Expenditures Council, the Justice Assistance Board of Directors and the Rhode Island Economic Development Council (A copy of Mr. Ryan's biography is enclosed).

As a member of the Policy Committee on the Business Roundtable, one of my objectives is to assure that the perspectives of major corporations are appropriately considered by policy makers as they deliberate the future of our country's health care delivery system. I am confident Mr. Ryan will adequately represent the views of business and consumers on this panel, and therefore, support his nomination.

Sincerely,


John E. Pepper

BIOGRAPHY

THOMAS M. RYAN PRESIDENT AND CEO CVS WOONSOCKET, RHODE ISLAND

Thomas M. Ryan was named President and CEO of CVS in January, 1994. He was also appointed Vice Chairman and COO of CVS Corporation, parent company of CVS.

Mr. Ryan joined CVS in 1975 as a Pharmacist and has held a number of managerial and professional positions in the company. In 1985, he became Vice President - Pharmacy Operations. In 1988, he was named Senior Vice President - Pharmacy. Two years later, he was appointed Executive Vice President - Stores.

Mr. Ryan is Vice Chairman of the National Association of Chain Drug Stores (NACDS) Board of Directors, on the Board of Trustees of the University of Rhode Island, the Rhode Island Public Expenditures Council (RIPEC), the Justice Assistance Board of Directors, the Board of Directors of Citizens Bank of Rhode Island, and the Board of Directors of the Sports Council of Rhode Island. He is also a member of the Governor-appointed Rhode Island Economic Development Council.

Born in New Jersey, Mr. Ryan holds a B.S. Degree in Pharmacy from the University of Rhode Island. Mr. Ryan, 44, lives in Providence, Rhode Island, with his wife, Cathy, and their four children.



Legislative Fact Sheet

FY 1998 Funding for the CDC Division of Diabetes Translation

Background

The Centers for Disease Control and Prevention (CDC) is the nation's primary public health agency. The CDC's main responsibility is to diminish the impact of disease in America, including diabetes. Activities related to diabetes are conducted through the CDC's Division of Diabetes Translation

The Division of Diabetes Translation is funded through an annual appropriation from Congress. State health departments then apply for money to conduct community based diabetes prevention and control programs. These programs help diagnose people with diabetes and provide information that enables people to avoid the costly and unnecessary complications of the disease.

President Clinton, in his FY98 budget request, has called for a 38% or \$10 million increase for the CDC diabetes program. This increase will fund diabetes control programs in all states, fund a National Diabetes Education Program and conduct research focusing on applying findings from recent diabetes studies.

Recommendation

The American Diabetes Association strongly supports President Clinton's \$10 million increase for CDC's Division of Diabetes Translation.



Legislative Fact Sheet

FY 1998 Funding for the Indian Health Services Diabetes Program

Background

The U.S. government has the responsibility for providing health care for the approximately 1.4 million Native Americans who are members of federally recognized tribes. This legal agreement was defined in federal treaty obligations stipulating that health care is to be provided to Native Americans, at no direct cost, in exchange for tribal land ceded to the government. Since 1955, The Indian Health Service (IHS) has been the federal agency responsible for carrying out this agreement.

Currently, diabetes is growing at epidemic proportions in the Native American Community. With one in three Native American adults being diagnosed with diabetes it is critical that the IHS diabetes program have adequate resources to provide for the Native American Community. Recent comments by IHS officials indicate that the diabetes program was funded at only 75% of need.

Recommendation

The American Diabetes Association supports an increase of \$2.5 million for IHS diabetes funding.



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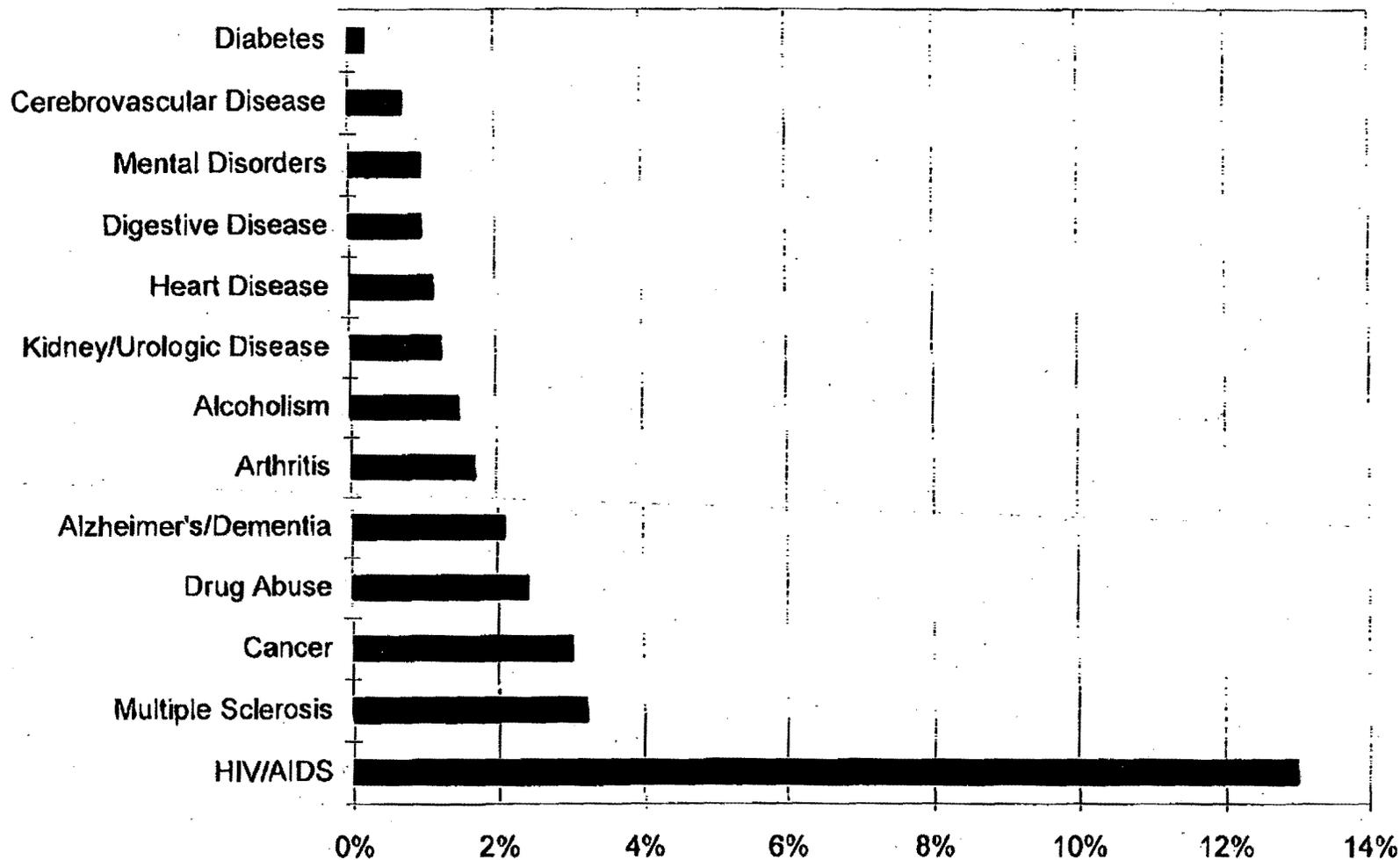
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MESSAGE FOLLOWS

*The mission of the American Diabetes Association is to prevent and cure diabetes
and to improve the lives of all people affected by diabetes.*

NIH RESEARCH SUPPORT

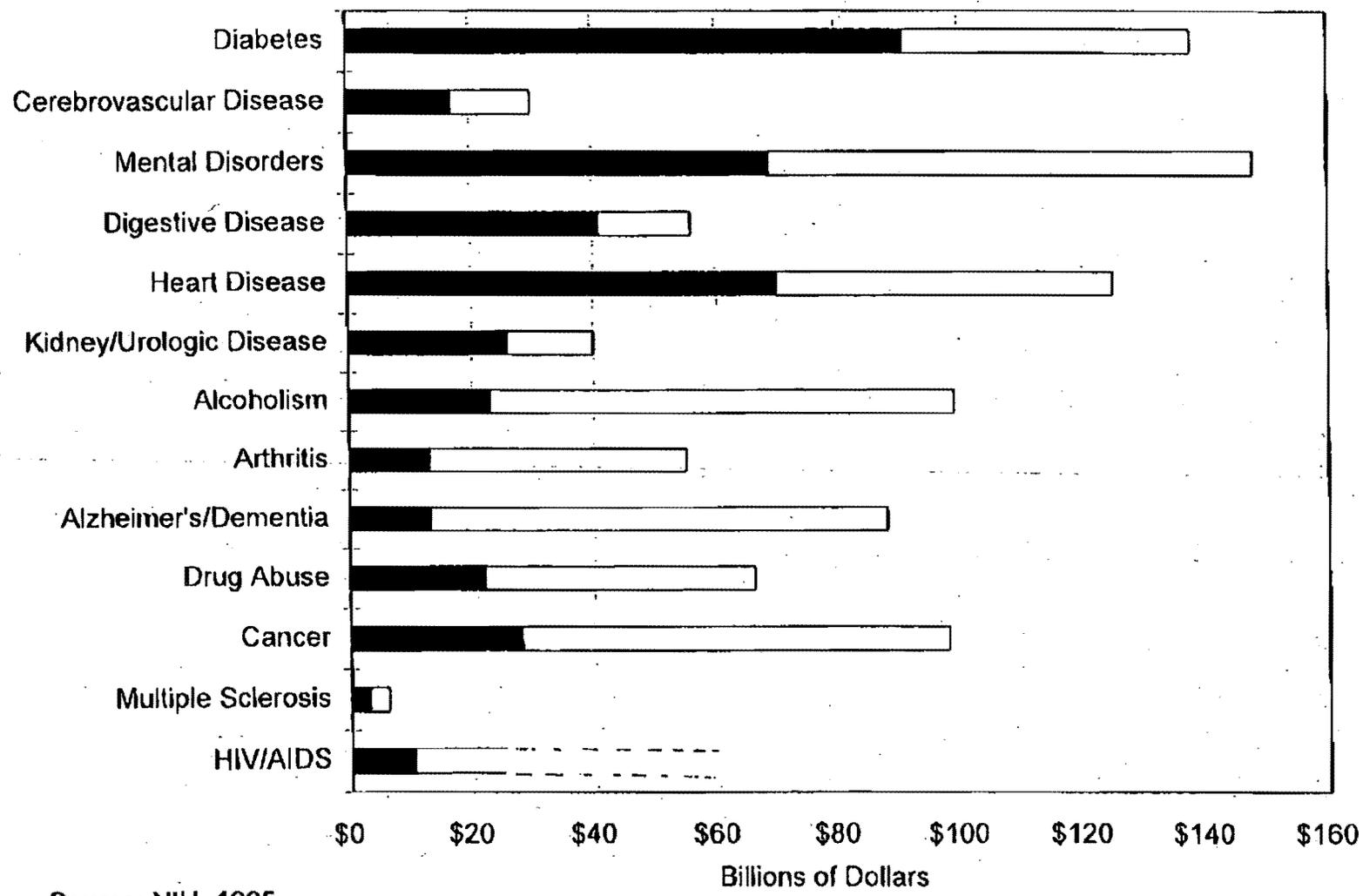


Source: NIH, 1995

PERCENT OF DIRECT DISEASE COSTS

HEALTH CARE COSTS

■ Direct Costs □ Indirect Costs



Source: NIH, 1995

**FAX COVER SHEET****OFFICE OF LEGISLATIVE &
INTER-GOVERNMENTAL AFFAIRS**

Number of Pages: 10 + cover page

Date: 4/04/97

To:	From:
Sarah Bianchi OEOB - Room 216	JOAN STIEBER Medicare Part B Analysis Division
Fax: (202) 456-5557 Phone: (202) 456-5585	Fax: (202) 690-8168 Phone: (202) 690-6884

REMARKS:

Hi Sarah! -- Peter Hickman said that you had asked for some information comparing H.R. 15 (the Thomas prevention bill) to the prevention provisions in the Administration's bill -- see attached summary and side-by-side. These documents are currently in clearance in the Department so these copies should be considered "draft".

As noted in my phone message, we should have something for you on Monday re: some proposed diabetes activities.

-- JOAN

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

DRAFT

COMPARISON BETWEEN H.R. 15 (THOMAS BILL) AND ADMINISTRATION PROPOSALS FOR PREVENTION SERVICES

On January 7, 1997, Representatives Thomas (R-CA), Bilirakis (R-FL), and Cardin (D-MD) introduced the "Medicare Preventive Benefit Improvement Act of 1997" (H.R. 15). This bill contains both similarities and differences from the prevention proposals included in the President's FY '98 budget package, as summarized below.

PROPOSALS INCLUDED IN BOTH H.R. 15 AND THE ADMINISTRATION'S BILL

- Mammography:

Coverage of annual screening mammography for women 65 and over, without a deductible. (Annual screening mammograms are already covered for women age 50-64, and those at high risk age 40-49. Screening mammograms for women 65 and over, and women at normal risk age 40-49, are currently covered every two years.)
- Colorectal screening:

Coverage of common colorectal cancer screening procedures, including fecal-occult blood tests, flexible sigmoidoscopy, colonoscopy, barium enemas, and other procedures as determined by the Secretary. (Some risk level, age, and frequency parameters are different under H.R. 15 than the Administration's bill.)
- Diabetes:

Coverage expanded to include outpatient self-management training in non-hospital-based programs (already covered in hospital-based programs), and blood glucose testing strips for all diabetics (already covered for insulin-dependent diabetics).

MAJOR DIFFERENCES BETWEEN H.R. 15 AND THE ADMINISTRATION'S BILL

- Mammography:
 - o The Administration's bill would also cover annual screening mammograms for all women age 40-49.
 - o H.R. 15 waives only the deductible for screening mammography. The Administration's bill waives both the deductible and co-insurance for both screening and diagnostic mammography.
- Diabetes:
 - o The Administration's bill expands coverage for both blood glucose monitors and testing strips. H.R. 15 expands coverage only for testing strips.

DRAFT

- o The Administration's bill would reduce payment for testing strips by 10 percent. H.R. 15 does not include a payment reduction.
- o H.R. 15 sets no boundaries on the duration or frequency of the outpatient self-management training benefit, and would allow any type of Medicare provider to furnish such services. The Administration's bill would cover training services according to timeframes set by the Secretary, and defines an eligible provider as a physician or other entity designated by the Secretary.

- Pap smears:

H.R. 15 includes a provision for coverage of screening pap smears every 3 years (or annual for high risk), including a pelvic exam and clinical breast exam, without a deductible. The Administration's bill does not include a pap smear provision.

NOTE: It is not clear that this provision of H.R. 15 really provides new services. Current law already covers screening pap smears every 3 years (or more often for high risk), and we believe that many beneficiaries already receive pelvic exams as part of an office visit (billed with a "diagnostic code"), along with their receipt of a screening pap smear.

- Prostate cancer screening:

H.R. 15 includes a provision for coverage of annual digital rectal exams, prostate-specific antigen (PSA) blood tests, and other procedures as determined by the Secretary for men over 49. The Administration's bill does not include a prostate cancer screening benefit.

NOTE: We question whether this provision is warranted given inconclusive evidence that PSA tests are useful for routine screening in asymptomatic men.

- Vaccines:

The Administration's bill increases payment for administration of pneumonia, flu, and hepatitis B vaccines, and waives the deductible and co-insurance for the administration of hepatitis B vaccine (already waived for pneumonia and flu vaccines). H.R. 15 does not include a vaccine provision.

DRAFT**PREVENTION BENEFITS UNDER MEDICARE**

BENEFIT	CURRENT LAW	ADMIN. BILL	THOMAS BILL
Screening Mammography	<p><u>Frequency</u></p> <ul style="list-style-type: none"> o Age 40-49 normal risk: ev. 2 yrs o Age 40-49 high risk: annual o Age 50-64: annual o Age 65+: ev. 2 yrs <p><u>Cost-sharing</u> Must pay deductible + co-insurance</p>	<p><u>Frequency</u></p> <ul style="list-style-type: none"> o 40-49: annual o 50-64: no change o 65+: annual <p><u>Cost-sharing</u> Waives deductible + co-insurance for both screening and diagnostic</p>	<p><u>Frequency</u></p> <ul style="list-style-type: none"> o 40-49 no change o 50-64: no change o 65+: annual <p><u>Cost-sharing</u> Waives <u>only</u> deductible, <u>only</u> for screening</p>
Pap Smears	<p><u>Frequency</u></p> <ul style="list-style-type: none"> o Ev. 3 yrs or o More frequent for high risk <p><u>Includes pelvic exam?</u></p> <ul style="list-style-type: none"> o Pap smear coverage includes "related med. necessary svcs ... incl. collection of sample cells") o But does not cover full-scale <u>screening</u> pelvic exam. <p><u>Cost-sharing</u> Must pay deductible + co-insurance for pelvic exam (but not for pap smear lab test).</p>	No provision	<p><u>Frequency</u></p> <ul style="list-style-type: none"> o Ev. 3 yrs or o Annual for: <ul style="list-style-type: none"> - childbearing age and "positive" test w/in last 3 yrs or - high risk for cervical cancer <p><u>Includes pelvic exam?</u> Explicitly included (and defined to include a "clinical breast exam")</p> <p><u>Cost-sharing</u> Waives deductible for pap smear and pelvic exam</p>

BENEFIT	CURRENT LAW	ADMIN. BILL	THOMAS BILL
<p>Colorectal Screening</p> <p><u>Fecal-occult blood</u></p>	<p>Covers only as diagnostic test</p>	<p><u>Frequency</u></p> <ul style="list-style-type: none"> o Under age 65: frequency set by Sec'ry o Age 65+: annual o Sec'ry may periodically revise frequency consid'g age + other factors. 	<p><u>Frequency</u></p> <ul style="list-style-type: none"> o No benefit under age 50 o Age 51+: annual o Beg'g 2001, Sec'ry may revise frequency consid'g age + other factors <p><u>Payment</u></p> <ul style="list-style-type: none"> o Sets payment limit: <ul style="list-style-type: none"> - 1998: up to \$5 - after '98: prior yr limit adjusted acc. to clin. lab fee schedule. o After 2000, Sec'ry may reduce paym't limit (nat. or in any area) as req'd to assure access + quality.

BENEFIT	CURRENT LAW	ADMIN. BILL	THOMAS BILL
<p>Colorectal Screening</p> <p><u>Flexible sigmoidoscopy</u></p>	<p>Covers only as diagnostic test</p>	<p><u>Frequency</u></p> <ul style="list-style-type: none"> o Covered only for individuals not at high risk: <ul style="list-style-type: none"> - No benefit under age 50 - Age 51+: ev. 5 yrs o Sec'ry may periodically revise frequency consid'g age + other factors 	<p><u>Frequency</u></p> <ul style="list-style-type: none"> o No benefit under age 50 o Age 51+: ev. 4 yrs o Beg'g 2001, Sec'ry may revise frequency consid'g age + other factors. <p><u>Payment</u></p> <ul style="list-style-type: none"> o Payment amt set by physician fee sched. consistent w/ amts for similar/related svcs. o Nonpar. provider may not charge more than limiting charge (sanctions apply).

BENEFIT	CURRENT LAW	ADMIN. BILL	THOMAS BILL
<p>Colorectal Screening</p> <p><u>Colonoscopy</u></p>	<p>Covers only as diagnostic test</p>	<p><u>Frequency</u></p> <ul style="list-style-type: none"> o Covered only for high risk individ's: <ul style="list-style-type: none"> - Ev. 4 yrs o Sec'ry may periodically revise frequency consid'g age + other factors. 	<p><u>Frequency</u></p> <ul style="list-style-type: none"> o Covered only for high risk individ's <ul style="list-style-type: none"> - Ev. 2 yrs o Beg'g 2001, Sec'ry may revise frequency consid'g age + other factors. <p><u>Payment</u></p> <ul style="list-style-type: none"> o Payment amt set by physician fee sched. consistent w/ amts for similar/related svcs. o Nonpar. provider may not charge more than limiting charge (sanctions apply).

BENEFIT	CURRENT LAW	ADMIN. BILL	THOMAS BILL
<p>Colorectal Screening</p> <p><u>Barium enema</u></p>	<p>Covers only as diagnostic test</p>	<p><u>Frequency</u></p> <ul style="list-style-type: none"> o Individuals not at high risk: <ul style="list-style-type: none"> - No benefit under age 50 - Age 51+: ev. 5 yrs o Individuals at high risk: <ul style="list-style-type: none"> - Ev. 4 yrs. o Sec'ry may periodically revise frequency consid'g age + other factors. 	<ul style="list-style-type: none"> o Covered only if found by Sec'ry w/in 2 yrs to be approp. alt. to flex. sigmoidoscopy or colonoscopy. <p><u>Frequency</u></p> <p>If covered, Sec'ry shall set frequency consistent w/ other colorectal screening tests (and beg'g 2001, may periodically revise based on age + other factors)</p> <p><u>Payment</u></p> <p>If covered, payment limits (incl. nonpar. phys'n charges) consistent w/ limits under Part B for <u>diagnostic barium enemas</u>.</p>

BENEFIT	CURRENT LAW	ADMIN. BILL	THOMAS BILL
<p>Colorectal Screening</p> <p><u>Other procedures</u></p>	<p>Covers only as diagnostic test</p>	<p>Covered as determ'd by Sec'ry</p> <p><u>Frequency</u></p> <ul style="list-style-type: none"> o Individuals not at high risk: <ul style="list-style-type: none"> - No benefit under age 50 - Age 51+: ev. 5 yrs o Individuals at high risk: <ul style="list-style-type: none"> - Ev. 4 yrs. o Sec'ry may periodically revise frequency consid'g age + other factors. 	<p>Covered after 2002, as determ'd by Sec'ry</p> <p><u>Frequency</u></p> <ul style="list-style-type: none"> o Frequency set by Sec'ry o Sec'ry may periodically revise frequency consid'g age + other factors.
<p>Prostate Cancer Screening</p>	<p>Covers only as diagnostic test</p>	<p>No provision.</p>	<p><u>Benefit includes:</u></p> <ul style="list-style-type: none"> o digital rectal exam o prostate-specific antigen (PSA) blood test o Beginning 2002: other procedures found appropriate by the Sec'ry. <p><u>Frequency</u></p> <ul style="list-style-type: none"> o Under 50: no benefit o Age 51+: annual <p><u>Payment</u></p> <p>PSA to be paid for under clinical diagnostic lab test fee schedules.</p>

BENEFIT	CURRENT LAW	ADMIN. BILL	THOMAS BILL
Diabetes Benefits	<p><u>Out-patient self management training</u> Covered in hospital-based programs.</p> <p><u>Blood glucose monitors (including testing strips)</u> o Covered for insulin-dependent diabetics o Based on statutorily prescribed fee schedule method.</p>	<p><u>Out-patient self management training</u> o Expands coverage to non-hospital based programs. o Sec'ry may set parameters on timeframe for training, and eligibility of providers o Payment amt. set by phys'n fee schedule w/ consult'n w/ ADA + other grps</p> <p><u>Blood glucose monitors (including testing strips)</u> o Expands coverage to all diabetics. o Reduces payment for strips by 10 percent.</p>	<p><u>Out-patient self management training</u> o Expands coverage to non-hospital based programs. o Payment amt. set by phys'n fee schedule w/ consult'n w/ ADA + other grps</p> <p><u>Blood testing strips</u> o Expands coverage to all diabetics. o Payment based on method for inexpensive and routinely purchased equipment.</p> <p><u>Outcome measures</u> o Sec'ry shall establish outcome measures to evaluate improvement in health status of diabetic bene's. o Based on outcome measures, Sec'ry shall periodically recommend coverage modifications to Congress.</p>