

File Breast Cancer



Fax Transmittal
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Health Promotion Branch

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To Sarah Bianchi

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From Nelvis Castro

Cover Sheet plus 14 Pages Transmitted

Message

Attached are the following documents:

- Press release
- Cancer Facts Q&A's
- Kit backgrounder
- Agencies summaries
- List of sources of info

Call me if you need more information. Nelvis

CC: Michelle Amberson
(202) 690-5673

DRAFT

National Institutes of Health

October 4, 1997

NCI Press Office

(301) 496-6641

The National Cancer Institute Launches Educational Campaign on Mammography and Breast Cancer Risk

The National Cancer Institute (NCI) today launched a new national education campaign by releasing publications and resources that are designed to provide clear, reliable information on breast cancer and mammography for women and health professionals.

NCI developed new educational materials after accepting the recommendations of its National Cancer Advisory Board in March that women in their 40s and older get screening mammograms on a regular basis, every one to two years. Richard D. Klausner, M.D., NCI Director, said that NCI is committed to providing women with reliable, up-to-date information about screening mammograms and the risk factors for breast cancer. Results from several in-depth interviews and focus groups conducted by NCI revealed that many women are not aware of the fact that breast cancer risk increases with age or that most women who develop breast cancer have no family history of the disease.

To address these and other related issues, the following new materials were developed:

- **Resources for the Public:** These include a comprehensive breast health booklet titled, *Understanding Breast Changes, The Facts About Breast Cancer and Mammograms*, a pamphlet that explains the risk factors for breast cancer and the benefits and limitations of mammography; and *Mammograms...Not just once, but for a lifetime* an easy-to-read publication and bookmark that explain the importance of regular mammograms for women in their 40s and older.
- **Resources for Health Professionals:** These include *Why Get Mammograms?*, a physician's pad with tear-off fact sheets on mammograms for patients; and *Over*

(more)

40? Consider Mammograms, a set of five posters each featuring a woman of a different racial/ethnic background.

- **Breast Cancer and Mammography Fact Sheets:** Information describing the incidence and mortality rates for breast cancer among racial/ethnic groups, as well as the proportion of women from each group that gets regular mammograms; and, information describing NCI's screening position, the risks and limitations of mammograms, and factors placing women at increased risk of developing breast cancer.

The materials in the kit can be ordered by calling NCI's Cancer Information Service (CIS) at 1-800-4-CANCER. The CIS is a nationwide information and education network for patients, the public, and health professionals that also can provide information from NCI's PDQ (Physician Data Query) database about controlled, randomized clinical trials on breast cancer screening, prevention and treatment.

The new information is also available on the NCI Internet website for patients and the public at <http://rex.nci.nih.gov> (click on the "About Mammograms" button). This page is part of the overall NCI website at <http://www.nci.nih.gov/>.

Breast cancer is the most commonly diagnosed cancer among American women, with 181,600 new cases expected this year. It is also the second leading cause of death, after lung cancer, in American women. In 1997, there will be an estimated 43,900 deaths from breast cancer in the U.S.

Because high-quality mammograms along with a clinical breast exam is the most effective way to detect breast cancer as early as possible, the NCI recommends that women in their 40s and older get a mammogram on a regular basis, every one to two years. Women at increased risk for breast cancer because of personal or family history, or other risk factors should also talk to their doctors about when to begin getting regular mammograms and how often to get them.

Several studies show that regular screening mammograms can help to decrease the chance of dying from breast cancer. Estimates show that if 10,000 women age 40 were screened every year for 10 years, about four lives would be saved. In comparison, regular screening of 10,000 women age 50 would save about 37 lives.

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By launching this educational campaign, the NCI is encouraging women to make regular mammograms and clinical breast exams a routine part of their health care.

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Sources of National Cancer Institute Information**Cancer Information Service**

Toll-free: 1-800-4-CANCER (1-800-422-6237)

TTY: 1-800-332-8615

NCI Online**CancerNet™*****Internet***<http://cancernet.nci.nih.gov> and <http://rex.nci.nih.gov><gopher://gopher.nih.gov>***CancerMail Service***

To obtain a contents list, send E-mail to cancernet@icicc.nci.nih.gov with the word "help" in the body of the message.

CancerFax® fax on demand service

Dial 301-402-5874 and listen to recorded instructions.

CANCER FACTS

National Cancer Institute • National Institutes of Health

Screening Mammograms

1. What is a screening mammogram?

A screening mammogram is an x-ray of the breast used to detect breast changes in women who have no signs of breast cancer. It usually involves two x-rays of each breast. Using a mammogram, it is possible to detect a tumor that cannot be felt.

2. What is a diagnostic mammogram?

A diagnostic mammogram is an x-ray of the breast used to diagnose unusual breast changes, such as a lump, pain, nipple thickening or discharge, or a change in breast size or shape. A diagnostic mammogram is also used to evaluate abnormalities detected on a screening mammogram. It is a basic medical tool and is appropriate in the workup of breast changes, regardless of a woman's age.

3. What is the position of the National Cancer Institute (NCI) on screening mammograms?

The National Cancer Institute recommends that women in their forties or older get screening mammograms on a regular basis, every 1 to 2 years.

Women who are at increased risk for breast cancer should seek medical advice about when to begin having mammograms and how often to be screened. (For example, a doctor may recommend that a woman at increased risk begin screening before age 40 or change her screening intervals to every year.)

4. What are the factors that place a woman at increased risk for breast cancer?

Every woman has some risk for developing breast cancer during her lifetime, and that risk increases as she ages. However, the risk of developing breast cancer is not the same for all women. These are the factors known to increase a woman's chance of developing this disease:

- **Personal History:** Women who have had breast cancer are more likely to develop a second breast cancer.

- **Family History:** The risk of getting breast cancer increases for a woman whose mother, sister, or daughter has had the disease; or who has two or more close relatives, such as cousins or aunts, with a history of breast cancer (especially if diagnosed before age 40). About 5 percent of women with breast cancer have a hereditary form of this disease.
- **Genetic Alterations:** Specific alterations in certain genes, such as those in the breast cancer genes BRCA1 or BRCA2, make women more susceptible to breast cancer.
- **Abnormal Blospsy:** Women with certain abnormal breast conditions, such as atypical hyperplasia or LCIS (lobular carcinoma *in situ*), are at increased risk.
- **Other conditions associated with an increased risk of breast cancer:** Women age 45 or older who have at least 75 percent dense tissue on a mammogram are at elevated risk. (This is not only because tumors in dense breasts are more difficult to "see," but because, in older women, dense breast tissue itself is related to an increased chance of developing breast cancer.)

Women who received chest irradiation for conditions such as Hodgkin's disease at age 30 or younger are at higher risk for breast cancer throughout their lives and require regular monitoring for breast cancer.

A woman who has her first child at age 30 or older has an increased risk of breast cancer.

Recent evidence suggests that menopausal women who have long-term exposure (greater than 10 years) to hormone replacement therapy (HRT) may have a slightly increased risk of breast cancer.

5. What are the chances that a woman in the United States might get breast cancer?

Age is the most important factor in the risk for breast cancer. The older a woman is, the greater her chance of getting breast cancer. No woman should consider herself too old to need regular screening mammograms. A woman's chance...

by age 30... 1 out of 2,525
 by age 40... 1 out of 217
 by age 50... 1 out of 50
 by age 60... 1 out of 24
 by age 70... 1 out of 14
 by age 80... 1 out of 10

(Source: NCI's Surveillance, Epidemiology, and End Results Program & American Cancer Society, 1993)

About 80 percent of breast cancers occur in women over the age of 50; the number of

cases is especially high for women over age 60. Breast cancer is uncommon in women under age 40.

6. What is the best method of detecting breast cancer as early as possible?

A high-quality mammogram, with a clinical breast exam (an exam done by a professional health care provider), is the most effective way to detect breast cancer early when it is most treatable. Using a mammogram, it is possible to detect breast cancer that cannot be felt. However, like any test, mammograms have both benefits and limitations.

When a woman examines her own breasts, it is called breast self-exam (BSE). Studies so far have not shown that BSE alone reduces the numbers of deaths from breast cancer. Therefore, it should not be used in place of clinical breast exam and mammography.

7. What are the benefits of screening mammograms?

- **Saved lives:** Several studies have shown that regular screening mammograms can help to decrease the chance of dying from breast cancer. The benefits of regular screening are greater for women over age 50. For women in their forties, there is recent evidence that having mammograms on a regular basis reduces their chances of dying from breast cancer by about 17 percent. For women between the ages of 50 and 69, there is strong evidence that screening with mammography on a regular basis reduces breast cancer deaths by about 30 percent.

Estimates show that if 10,000 women age 40 were screened every year for 10 years, about four lives would be saved. In comparison, regular screening of 10,000 women age 50 would save about 37 lives.

- **More treatment options:** In some cases, finding a breast tumor early may mean that a woman can choose surgery that saves her breast. Also, a woman whose breast tumor is detected in its early stages may not have to undergo chemotherapy.

8. What are some of the limitations of screening mammograms?

- **Detection does not always mean saving lives:** Even though mammography can detect most tumors that are 5 millimeters in size, (5 millimeters is about 1/4 inch) and some as small as 1 millimeter, finding a small tumor does not always mean that a woman's life will be saved. Mammography may not help a woman with a fast-growing or aggressive cancer that has already spread to other parts of her body before being detected.
- **False Negatives:** False negatives occur when mammograms appear normal even though breast cancer is actually present. False negatives are more common in younger women than in older women. The dense breasts of younger women contain many glands and ligaments, which make breast cancers more difficult to spot in mammograms. As women age, breast tissues become more fatty and breast

cancers are more easily "seen" by screening mammograms.

Screening mammograms miss up to 25 percent of breast cancers in women in their forties compared with about 10 percent of cancers for older women.

- **False Positives:** False positives occur when mammograms are read as abnormal, but no cancer is actually present. For women at all ages, between 5 percent and 10 percent of mammograms are abnormal and are followed up with additional testing (a diagnostic mammogram, fine needle aspirate, ultrasound, or biopsy). Most abnormalities will turn out *not* to be cancer.

False positives are more common in younger women than older women.

About 97 percent of women ages 40 to 49 who have abnormal mammograms turn out *not* to have cancer, as compared with about 86 percent for women age 50 and older. But all women have to undergo followup procedures when they have an abnormal mammogram.

- **DCIS:** Over the past 30 years, improvements in mammography have resulted in an ability to detect a higher number of small tissue abnormalities called ductal carcinomas *in situ* (DCIS), abnormal cells confined to the milk ducts of the breast. Some of these can eventually go on to become actual cancers, but many do not.

Because it is not possible to predict which ones will progress to invasive cancer, DCIS is commonly removed surgically; some are treated with mastectomy, some with breast-sparing surgery. There is disagreement among experts about the extent of surgery necessary for DCIS.

Younger women have a higher proportion of DCIS than older women.

Approximately 45 percent of breast cancers detected by screening mammograms in women ages 40 to 49 are DCIS compared with about 20 to 30 percent of those detected in women age 50 and older.

9. How much does a mammogram cost?

Most screening mammograms cost between \$50 and \$150. Most states now have laws requiring health insurance companies to reimburse all or part of the cost of screening mammograms. Details can be provided by insurance companies and health care providers. Currently, Medicare pays for part of the cost of one screening mammogram every 2 years for women who are eligible for Medicare benefits. On January 1, 1998, this coverage will increase to one screening mammogram every year. Information on coverage is available through the Medicare Hotline at 1-800-638-6833.

Some state and local health programs and employers provide mammograms free or at low cost. Information on low-cost or free mammography screening programs is available through the NCI's Cancer Information Service at 1-800-4-CANCER.

10. Where can a woman get a high quality mammogram?

Women can get high quality mammograms in breast clinics, radiology departments of hospitals, mobile vans, private radiology offices, and doctors' offices.

Through the Mammography Quality Standards Act, all mammography facilities are required to display certification by the Food and Drug Administration (FDA). To be certified, facilities must meet standards for the equipment they use, the people who work there, and the records they keep. Women should go to an FDA-certified facility and look for the certificate and expiration date. Women can ask their doctors or staff at the mammography facility about FDA-certification before making an appointment. Information about local FDA-certified mammography facilities is available through NCI's Cancer Information Service at 1-800-4-CANCER.

11. What technologies are under development for breast cancer screening?

The NCI is supporting the development of several new technologies to detect breast tumors. This research ranges from technologies under development in research labs to those that have reached the stage of testing in humans, known as clinical trials.

Efforts to improve conventional mammography include digital mammography, where computers assist in the interpretation of the x-rays. Other studies are aimed at developing teleradiology, sending x-rays electronically, for long-distance clinical consultations. A non-X-ray based technology under development is magnetic resonance imaging (MRI).

In addition to imaging technologies, NCI-supported scientists are exploring methods to detect markers of breast cancer in blood, urine, or nipple aspirates that may serve as early warning signals for breast cancer.

12. What studies is NCI supporting to find better ways to prevent and treat breast cancer?

NCI is supporting many studies that are looking for improved prevention and treatment for breast cancer.

- **Basic Research:** Many studies are taking place to identify the causes of breast cancer, including an analysis of the role that alterations in the BRCA1 and BRCA2 genes play in the development of cancer. Scientists also are looking

at how these genes interact with other genes and with hormonal, dietary, and environmental factors to determine what influences the development of breast cancer.

- **Prevention:** Researchers are looking for ways to prevent breast cancer in women who are at increased risk. In addition, studies currently under way involving diet, nutrition, and environmental factors could also lead to new prevention strategies.
- **Treatment:** Several studies are aimed at finding treatments for breast cancer that are more effective and less toxic than current methods.

Women who would like more information on cancer prevention, treatment, or screening studies can call NCI's Cancer Information Service at 1-800-4-CANCER.

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Sources of National Cancer Institute Information

Cancer Information Service

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CancerFax® fax on demand service

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NEW Breast Cancer and Mammography Information

Throughout the 1990's, nearly one-half million women will die of breast cancer and over 1.5 million new cases of the disease will be diagnosed. The U.S. Department of Health and Human Services (DHHS) has been the government's leader in responding to breast cancer, through education and research at the National Cancer Institute, the Centers for Disease Control and Prevention, and the Agency for Health Care Policy and Research; through certification of mammography facilities by the Food and Drug Administration; through health benefit programs like Medicare and Medicaid; through the initiatives of the U.S. Public Health Service's Office on Women's Health (PHS OWH) and the National Action Plan on Breast Cancer, coordinated by the PHS OWH; and through a host of other programs seeking to improve breast cancer prevention, detection, diagnosis, and treatment. Furthermore, the National Cancer Institute collaborates with researchers at laboratories, cancer centers, and universities all across the country to better understand breast cancer and reduce its impact on women's lives.

The National Cancer Institute (NCI) recommends that women in their 40s and older get mammograms on a regular basis, every one to two years. In conjunction with this recommendation, the Clinton administration is leading efforts to expand screening mammography benefits in Medicare and Medicaid programs to help ensure access to quality care.

All of the agencies involved in this important work have been brought together to improve communications and coordination, facilitate access to information by non-government partners, and to describe the government's efforts to find answers to the problem of breast cancer.

The enclosed materials are designed to help national and community organizations and media leaders disseminate information to the public on breast cancer and mammography.

- **Breast Cancer and Mammography Education Programs** — document describing the breast cancer and mammography resources available through DHHS agencies, including screening programs, education, and research.

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- **Sources of Breast Cancer and Mammography Information** — a listing of the DHHS agencies' Internet websites, telephone and fax numbers for quick access to information about breast cancer and mammography.
- **NEW Mammography Materials** — samples of new NCI/PHS Office on Women's Health mammography materials, including an easy-to-read pamphlet and bookmark, available for free by calling NCI's Cancer Information Service at 1-800-4-CANCER.
- **Breast Cancer and Mammography Facts** — information on the incidence and mortality of breast cancer, breast cancer risk, and mammography screening rates.
- **Screening Mammograms** — questions and answers about screening mammograms and breast cancer, as well as information on risk factors for breast cancer.
- **Feedback Fax Form** — form to be faxed that allows users to describe the usefulness of the kit materials.

Additional breast cancer and mammography information is available by calling NCI's Cancer Information Service (CIS) at 1-800-4-CANCER. The CIS is a nationwide information and education network for patients, the public, and health professionals. The CIS can provide information from NCI's PDQ (Physician Data Query) database, which contains the latest information from controlled, randomized clinical trials on breast cancer screening and treatment.

Cancer information is also available on the NCI Internet website at <http://cancernet.nci.nih.gov> and <http://rex.nci.nih.gov> (click on the "About Mammograms" button). Information can also be obtained on the website of the National Action Plan on Breast Cancer at <http://www.napbc.org/>.

This information is brought to you by the National Cancer Institute, the U.S Public Health Service's Office on Women's Health, and the following DHHS Agencies:

*Administration on Aging
Agency for Health Care Policy and Research
Centers for Disease Control and Prevention
Food and Drug Administration*

*Health Care Financing Administration
Indian Health Service
The Substance Abuse and Mental Health
Services Administration*

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Breast Cancer and Mammography Education Programs

U.S. Department of Health and Human Services • U.S. Public Health Service

Administration on Aging (AOA)

The Administration on Aging's mission is to administer programs and services under the Older Americans Act, which are designed to assist older persons in remaining independent in their own homes and communities for as long as possible. Programs and services include those dealing with nutrition, health, abuse and violence, and preventive health screening. Selected agency initiatives include: (1) supporting efforts to address issues including Medicare benefits, mammograms and breast cancer screening, and domestic violence/abuse; (2) supporting the National Policy and Resource Center on Women and Aging, which empowers mid-life and older women to take charge of their own aging; (3) participating in educating older women about the Medicare benefits for mammograms and breast cancer screening; and (4) participating in the Federal Coordinating Committee on Breast Cancer. The AOA also provides information for seniors in need of finding community assistance. By calling the Eldercare Locator at 1-800-677-1116, one can find assistance and information for a wide variety of services, including meals, home care, transportation, housing alternative home repair, recreational and social activities, and legal services. More information about the AOA can be found on their Internet website at <http://www.aoa.dhhs.gov> or by calling the National Aging Information Center at (202) 619-7501.

Agency for Health Care Policy and Research (AHCPR)

AHCPR is the lead government agency charged with supporting research designed to improve the quality of health care, reduce its cost, and broaden access to essential services. Research includes a number of studies concerning breast cancer and mammography, including projects addressing statistical variation in the accuracy of mammography readings, effectiveness of methods for recruiting low-income women into breast and cervical cancer screening programs, cancer prevention for minority women in a Medicaid HMO, breast cancer treatment for older women, and treatment for early-stage breast cancer. Recognizing the importance of the quality of screening mammography in the early detection of breast cancer, AHCPR developed the clinical practice guideline *Quality Determinants of Mammography*, defining the areas of responsibility for every member of the health care team delivering mammograms. An accompanying consumer guide, *Things to Know About Quality Mammograms*, provides information and recommendations for women. Information about the agency, its research, and its publications are available at AHCPR's Internet web site at <http://www.ahcpr.gov/>. Sources of breast cancer and mammography information can be found by clicking onto "Research Portfolio," "Guidelines and Medical Outcomes/Clinical Practice Guidelines Online," and "Consumer Health." Contact the AHCPR Publications Clearinghouse at 1-800-358-9295 to order print copies of guideline products (including the consumer guide in English, Spanish, and several other languages) at no charge.

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DRAFT***Centers for Disease Control and Prevention (CDC)***

The Breast and Cervical Cancer Mortality Prevention Act of 1990 authorized the CDC to implement a national program to ensure that every woman for whom it is deemed appropriate receives regular screening for breast and cervical cancer, prompt follow-up if necessary, and certitude that the tests are performed in accordance with current recommendations for quality assurance. In the Fiscal Year 1997, CDC entered into the seventh year of this national program, maintaining the National Breast Cancer and Cervical Cancer Early Detection Program (NBCCEDP) in all fifty states, five territories, the District of Columbia, and 13 American Indian/Alaskan Native organizations. This program brings critical breast and cervical cancer screening services to underserved women including older women, women of low income, uninsured or underinsured women, or women of racial/ethnic minority groups. CDC also coordinates with third party payers, such as Medicare and Medicaid, to provide a system for billing and reimbursement of mammography and screening services. More information about the National Breast Cancer and Cervical Cancer Early Detection Program can be found on the Internet at <http://www.cdc.gov/ncccdphp/dcpc/>.

Food and Drug Administration (FDA)

The FDA works to protect, promote, and enhance the health of the American people. The FDA principally serves the general public in its health and safety mission. The FDA also recognizes its responsibilities to the industries that it regulates and works with them in bringing new technologies to the marketplace. Thus, it strives to maximize public health protection while minimizing regulatory burden. Under the Mammography Quality Standards Act (MQSA), the FDA is responsible for overseeing annual inspections of more than 10,000 mammography facilities and for evaluating facility personnel. MQSA was passed into law by Congress in 1992, and stipulates that all mammography facilities must provide the highest quality mammography services possible for all women to receive. MQSA also put into place new training and experience requirements for all those involved in providing mammography services. Information about breast cancer and mammography is available at FDA's Internet website at <http://www.fda.gov/odrh/dmgrp.html/>. Also available is *Mammography Matters*, a quarterly newsletter for mammography facilities; a consumer brochure (publication in cooperation with the Agency for Health Care Policy and Research); and a list of FDA-Certified facilities, provided through the National Cancer Institute's Cancer Information Service at 1-800-4-CANCER. This list is also available on the MQSA Internet website.

Health Care Financing Administration (HCFA)

HCFA is the government agency responsible for administering the Medicare and Medicaid programs, providing health insurance for over 72 million beneficiaries through these programs. On August 5, 1997, President Clinton signed a new law that will provide Medicare coverage for *annual* screening mammograms for all Medicare-eligible women ages 40 and older beginning January 1, 1998. Additionally, the new law *waives the Part B deductible* for screening mammograms, effective for services provided on or after January 1, 1998. There are several programs under HCFA's National Mammography Campaign. The Multi-City Mammography HORIZONS Project is a three-year commitment being conducted in six major U.S. cities targeting Hispanic American and African American communities in order to increase mammography screening services for Medicare beneficiaries in these areas. The pilot cities include Atlanta, Chicago, Cleveland, Los Angeles, Philadelphia, and San Antonio. The Preventive Screening Services Project, a collaborative effort with CDC and Maryland's Department of Health and Mental Hygiene, is being conducted to evaluate the effectiveness of physician referral for mammography and cervical cancer screening utilization for African American Medicare beneficiaries ages 65 and older. In addition to these programs, HCFA has also developed mammography campaign print materials, in both English and Spanish, to be distributed to Medicare beneficiaries through HCFA's offices and various partners (health departments, breast cancer groups, advocacy groups, etc.). More information about HCFA's programs can be found on their Internet website at <http://www.hcfa.gov>, or by calling 1-800-638-6833.

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The IHS actively collaborates with the CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) to bring mobile mammography services to American Indian and Alaskan Native women at remote reservation sites. The IHS established the IHS Alaska Native Cancer Surveillance Project, a comprehensive cancer registry for all Alaska Native/American Indian residents. The IHS also collaborates with other organizations to develop and distribute Alaska Native/American Indian-specific breast cancer educational materials. More information about the IHS can be found on their Internet website at <http://www.tucson.ihs.gov/>.

National Cancer Institute (NCI)

NCI is the lead government agency working for cancer research. Drawing on the knowledge and expertise of researchers at laboratories, cancer centers, and universities across the country, the NCI strives to conduct and sponsor research and translate the results into information that will continue to benefit everyone. NCI's national breast cancer and mammography education campaign is designed to give clear information to women about when to begin getting regular mammograms, and to increase the level of understanding about the risk factors associated with breast cancer and the benefits and limitations of mammography. This information is made available to the public through numerous publications, the Internet at <http://rex.nci.nih.gov> and <http://www.nci.nih.gov>, and through the NCI's Cancer Information Service (CIS). The CIS, a national information and education network, provides the latest, most accurate cancer information for patients, the public, and health professionals. Specially trained staff provide the latest scientific information in understandable language, as well as a list of FDA-certified mammography facilities organized by states. CIS staff answer questions in English and in Spanish and distributes NCI materials. The toll-free telephone number for the CIS is 1-800-4-CANCER (1-800-422-6237). People with TTY equipment may call 1-800-332-8615.

The Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA's mission within the Nation's health system is to improve the quality and availability of substance abuse prevention, addiction treatment, and mental health services in order to improve health and reduce illness, death, disability, and cost to society. SAMHSA's commitment includes efforts to promote quality services to women and their families. Over the years, SAMHSA has supported several women-focused grant projects and cooperative agreements, meetings and conferences, the National Women's Resource Center, and numerous publications. Many women who receive substance abuse or mental health services do not receive adequate primary health care. As a result, many of the grant programs focus on providing medical services to women, and breast cancer prevention and treatment is a primary concern. These services include education on self-examination and mammography services, and counseling on risks for breast cancer. More information about these services can be found on SAMHSA's Internet website at <http://www.samhsa.gov>, or by calling the clearinghouse at 1-800-729-6686.

U.S. Public Health Service's Office on Women's Health (PHS OWH)

The U.S. Public Health Service's Office on Women's Health was established to redress the inequities in research, health services, and education that have placed the health of American women at risk. Its mission is to direct, stimulate, and coordinate women's health research, healthcare services, and public and health care professional education and training across the agencies, offices and regions of the Department of Health and Human Services (DHHS) and to collaborate with other government organizations, foundations, private industry, consumer and health care professional groups to advance women's health. The PHS OWH supports initiatives and programs on breast cancer. The Office established and coordinates the Federal Breast Cancer Coordinating Committee with senior-level representation from all departments and agencies of the Federal government that fosters collaboration and supports cross-cutting initiatives across agencies on breast cancer; coordinates the implementation of the National Action Plan on Breast Cancer (NAPBC), a public/private partnership that catalyzes new actions in research, service delivery, and education; and works with the intelligence, defense, and space communities on the "From Missiles to Mammograms" initiative, to adapt imaging technologies used for target and missile recognition to improve the early detection of breast cancer. The Office also worked with HCFA to develop mammography materials for Medicare-eligible women. The NAPBC Internet website at <http://www.napbc.org> serves as a gateway to breast cancer information.

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Sources of Breast Cancer and Mammography Information

U.S. Department of Health and Human Services • U.S. Public Health Service

AGENCY	WEBSITE & PHONE NUMBER INFORMATION
Administration on Aging	National Aging Information Center: (202) 619-7501 Eldercare Locator (Toll Free): 1-800-677-1116 Website Address: http://www.aoa.dhhs.gov
Agency for Health Care Policy and Research	Clearinghouse (Toll Free): 1-800-358-9295 TTY: 1-888-586-6340 InstantFAX: (301) 594-2800 - call from a fax machine with a telephone handset. Website Address: http://www.ahcpr.gov
Centers for Disease Control and Prevention	Division of Cancer Prevention: 770-488-4751 FAX: 770-488-4760 email: cancerinfo@cdc.gov Website Address: http://www.cdc.gov/nccdphp/dcpc
Food and Drug Administration	List of FDA-certified Mammography Sites (Toll Free): 1-800-4-CANCER Mammography Quality Standards Act Hotline (Toll Free): 1-800-838-7715 FAX: (301) 986-8015 Website Address: http://www.fda.gov/cdrh/dmgrp.html

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Health Care Financing Administration

Medicare Hotline (Toll Free): 1-800-638-6833**Press Office: (202) 690-6145****Website Addresses:*****Mammography Data:***<http://www.hcfa.gov/stats/mamm/mammover.htm>***Abstract of Programs:***<http://www.hcfa.gov/medicare/hsqb/hsqb3f.htm>***Fact Sheet:***<http://www.hcfa.gov/medicare/hsqb/hsqb6f.htm>

Indian Health Service

Website Address: <http://www.tucson.ih.gov>

National Cancer Institute

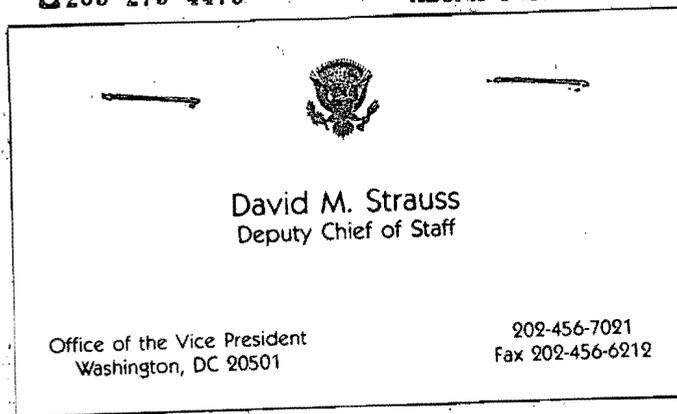
Cancer Information Service (Toll Free): 1-800-4-CANCER**TTY: 1-800-332-8615****Website Addresses: <http://rex.nci.nih.gov>****<http://www.nci.nih.gov>**

The Substance Abuse and Mental Health
Services Administration**Clearinghouse (Toll Free): 1-800-729-6686****Website Address: <http://www.samhsa.gov>**

U.S. Public Health Service's
Office on Women's Health**General Information: (202) 690-7650****National Women's Health****Information Center (Toll Free): 1-800-994-WOMAN****Website Addresses:*****PHS Office on Women's Health:***<http://www.os.dhhs.gov/progorg/ophs/owh.htm>***National Action Plan on Breast Cancer:***<http://www.napbc.org>

**For more information on these and other DHHS agencies, visit these Internet Websites at
<http://www.dhhs.gov> & <http://www.healthfinder.gov/>.**

Chris
F + F
DS



Contact:
Jill B. Griffiths
215-283-6890

AETNA U.S. HEALTHCARE TO COVER AND RECOMMEND ANNUAL MAMMOGRAM SCREENING AT AGE 40 FOR HMO MEMBERS

**-- Aetna U.S. Healthcare's HealthcareCheck® Program Already Downstaging
Incidence of Breast Cancer --**

BLUE BELL, PA and MIDDLETOWN, CT, April 2, 1997 – Aetna U.S. Healthcare announced today that the company, effective immediately, recommends and covers annual screening mammograms for its female HMO members beginning at age 40. In addition, Aetna U.S. Healthcare will continue to cover mammograms for members at any age when the woman's physician feels that the test is indicated. Aetna U.S. Healthcare is the first national managed care insurer to follow the new guidelines recently issued by the American Cancer Society and the National Cancer Institute.

"As the leading health benefits company in the country, we believe it is important to ensure that women have every opportunity for early diagnosis of breast cancer, which increases the likelihood of a cure for this potentially deadly disease," said Arnold W. Cohen, MD, Aetna U.S. Healthcare's Senior Medical Director for Women's Health.

"The underlying principle of managed care is prevention and wellness," said Michael J. Cardillo, president of Aetna U.S. Healthcare. "Aetna U.S. Healthcare has always supported women's health programs, such as screening for breast cancer and cervical cancer, and management of high risk pregnancies. We know that mammograms are a critical step in the early diagnosis of breast cancer, so it makes sense to provide women with early and regular access to this critical tool."

Aetna/2

"Aetna U.S. Healthcare has shown outstanding responsiveness by acting so quickly to put these new mammography guidelines to work immediately to save lives from breast cancer," said John R. Seffrin, PhD, Chief Executive Officer of the American Cancer Society. "We have worked hard to establish the scientific basis for recommending annual mammograms beginning at age 40. We hope that all healthcare insurers nationwide will follow the lead of Aetna U.S. Healthcare's important announcement."

Aetna U.S. Healthcare's pioneering Healthcare Check® program is a sophisticated screening program which will now provide referrals to a radiologist for all women beginning at age 40 on an annual basis. Since its inception in 1986 Healthcare Check has been nationally acclaimed as the model breast cancer screening program. The program's success at promoting breast cancer screening including self examination and mammography has been reported in over a dozen articles in the medical literature. Until now, Healthcare Check has followed national medical guidelines in recommending that all female members at age 50 and high-risk members at age 40 obtain annual mammograms; while lower risk women were referred to a radiologist every other year between the ages of 40 and 50.

"Aetna U.S. Healthcare has reported our success at finding breast cancer at an earlier stage through regular screening," said Cohen. "Our results also show that breast cancers detected in women through mammography screening were more likely to be eligible for breast conserving surgery. In fact, nearly two thirds of the Aetna U.S. Healthcare members who have had their breast cancer found through the Healthcare Check screening program have had their cancer treated without the need for a mastectomy."

Aetna/3

Comprehensive breast cancer treatment and detection programs at Aetna U.S.

Healthcare include the following:

- **A multi-disciplinary approach to breast cancer treatment which includes information and resources on breast conserving surgery, coordination of reconstructive surgery and access to support services to help women deal with the emotional aspects of both the disease and its treatment.**
- **Access to an Aetna U.S. Healthcare nurse case manager who specializes in support of women with breast cancer.**
- **The Aetna U.S. Healthcare second opinion program for women who are interested in breast conserving surgery.**
- **Mobile mammography units which bring mammography services to the work site and into the community where women can have a mammogram in a private setting without ever having to go to a doctor's office or radiologist's office.**
- **Three-pronged approach to early detection of breast cancer: mammograms annually beginning at age 40, breast self examination performed monthly, and breast physical examination performed annually by an Ob/Gyn or primary care doctor.**

Aetna U.S. Healthcare is the health business unit of Aetna Inc. (NYSE: AET). Aetna U.S. Healthcare is the nation's leading health benefits organization, providing a variety of managed care, specialty health, indemnity, worker's compensation managed care and other products to over 23 million Americans nationwide.

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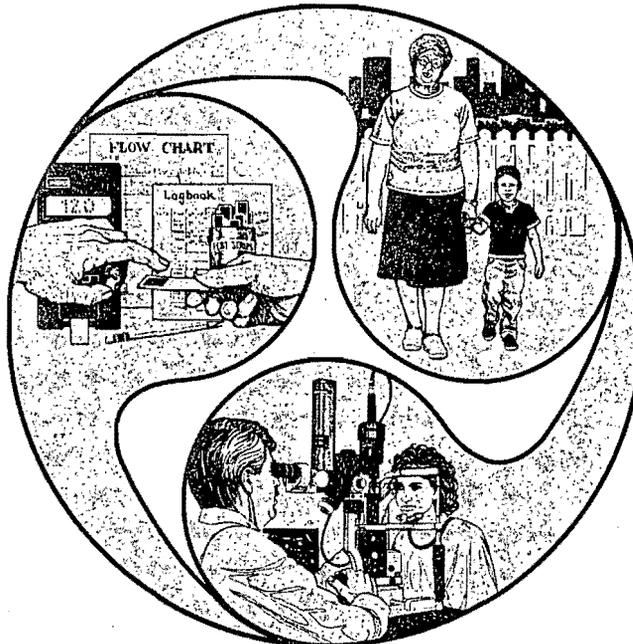
Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

Diabetes

A Serious Public Health Problem

AT-A-GLANCE

1996



Translating Science Into Care

*Those who suffer losses due to diabetes are not just statistics on a chart.
They are people whose talents and wisdom are needed and whose problems deserve our unified efforts.
Together we can join to make life more just and more joyful for generations to come.*

David Satcher, MD, PhD, Director, Centers for Disease Control and Prevention



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention



BACKGROUND FACTS ON OSTEOPOROSIS AND DIABETES

OSTEOPOROSIS

- **Twenty-five million Americans have osteoporosis -- 80% are women.**
- **One out of two women over the age of 50 will have an osteoporosis-related fracture during her lifetime.**
- **Osteoporosis is frequently called the "silent killer" because many women do not know they have it until they have a broken bone.**
- **In fact, sixty percent of women over the age of 45 are not familiar with a disease called osteoporosis.**
- *1.5 million fractures per year*

DIABETES

- **16 million Americans have diabetes. More than one-third have not been diagnosed. There are 800,000 new cases of diabetes diagnosed every year.**
- **Nearly 20 percent of Americans over the age of 65 have diabetes. (6.3 million). (6.3 million and over 3 million have been diagnosed).**
- **People with diabetes are more likely to suffer from heart disease, high blood pressure, and strokes. People with diabetes are 2 to 4 times more likely to suffer from cardiovascular disease, and 2 to 4 times more at risk for a stroke. High blood pressure affects nearly two-thirds of people with diabetes.**
- **Diabetes is the leading cause of end-stage renal disease (ERSD), non-traumatic amputations, and blindness. Diabetes accounts for 36 percent of new ERSD cases (kidney disease) -- about 20,000 cases each year. In addition, 54,000 amputations are performed on diabetics each year, and up to 24,000 adults are blinded each year from diabetes.**

National Institute on Aging

AgePage

Osteoporosis: The Silent Bone Thinner

Osteoporosis is a disease that thins and weakens bones to the point where they break easily--especially bones in the hip, spine, and wrist. Osteoporosis is called the "silent disease" because you may not notice any symptoms. People can lose bone over many years but not know they have osteoporosis until a bone breaks. About 25 million Americans have osteoporosis--80 percent are women.

Experts do not fully understand all the causes of osteoporosis. They do know that when women go through menopause, levels of the female hormone estrogen drop. Lower hormone levels can lead to bone loss and osteoporosis. Other causes of bone loss and osteoporosis include a diet too low in calcium and not getting enough exercise.

Who Gets Osteoporosis?

One out of two women and one in eight men over age 50 will have an osteoporosis-related fracture. White and Asian women are most likely to get osteoporosis. Women who have a family history of osteoporosis, an early menopause, or who have small body frames are at greatest risk. Men have less risk of getting osteoporosis because they do not have the same kinds of hormone losses as women. Osteoporosis can strike at any age but the risk increases as you get older.

Diagnosis

Losing height or breaking a bone may be the first sign of osteoporosis. Doctors use several different tests to find osteoporosis. The **dual energy x-ray absorptiometry (DEXA)** is the most exact way to measure bone density in the wrist, hip, and lower spine. Other tests the doctor may use include **single photon absorptiometry, dual energy absorptiometry, and quantitative computed tomography**. Ask your doctor about these tests if you think you are at risk for osteoporosis.

Prevention

Osteoporosis is preventable. A diet that is rich in calcium and vitamin D and a lifestyle that includes regular weight-bearing exercise are the best ways to prevent osteoporosis.

Calcium. Getting enough calcium throughout life is important because it helps to build and keep strong bones. Men and women age 25 to 65 should have 1,000 milligrams (mg) of calcium every day. Women near or past menopause should have 1,500 mg of calcium daily. Make foods that are high in calcium part of your diet. Healthy foods that are rich in calcium are:

- low-fat dairy products such as cheese, yogurt, and milk
- canned fish with bones you can eat, such as salmon and sardines
- dark-green leafy vegetables, such as kale, collard, and broccoli
- breads made with calcium-fortified flour.

If you don't get enough calcium from your food, you might think about taking a calcium supplement.

Always check with your doctor before taking any dietary supplement.

Vitamin D. Your body uses vitamin D to absorb calcium. Being out in the sun for even a short time every day gives most people enough vitamin D. You can also get this vitamin from supplements, as well as from cereal and milk fortified with vitamin D.

Exercise. Exercise builds bone strength and helps prevent bone loss. It also helps older people stay active and mobile. Weight-bearing exercises, done on a regular basis, are best for preventing osteoporosis. Walking, jogging, and playing tennis are all good weight-bearing exercises. Always check with your doctor before starting an exercise program.

Treatment

Treatment of osteoporosis aims to stop bone loss and prevent falls. Falls often cause broken bones that can mean a trip to the hospital or a long-term disabling condition. Osteoporosis is the cause of 1.5 million fractures each year, including more than 300,000 hip fractures.

Doctors sometimes prescribe estrogen to replace the hormones lost during menopause and to slow the rate of bone loss. This treatment is called hormone replacement therapy (HRT). HRT also protects against heart disease and stroke. However, experts do not know all the risks of long-term use of HRT.

Women should discuss benefits, risks, and possible side effects of HRT with their doctors. Calcitonin is a naturally occurring hormone that increases bone density in the spine and can reduce pain of fractures. It comes in two forms--injection or nasal sprays. You can also ask your doctor about the drug alendronate. This drug increases bone mass in women past menopause.

The best way to prevent osteoporosis is to be aware of the disease and to live a healthy lifestyle. If you think you might be at risk for osteoporosis, talk to your doctor. Ask about the bone density tests available in your area and your prevention and treatment choices.

Resources

National Osteoporosis Foundation
1150 17th Street, NW, Suite 602
Washington, DC 20036-2226
1-800-223-9994

National Resource Center on Osteoporosis and Related Diseases
1-800-624-BONE (2663)
TTY (202) 223-0344

For a list of free publications from the National Institute on Aging (NIA), contact:

NIA Information Center
P.O. Box 8057
Gaithersburg, MD 20898-8057
1-800-222-2225
(1-800-222-4225 TTY)
E-mail: niainfo@access.digex.net

National Institute on Aging



*U. S. Department of Health and Human Services
Public Health Service
National Institutes of Health
1996*

For Immediate Release
June 22, 1998

Contact: HCFA Press Office
(202) 690-6145

MEDICARE EXPANDS COVERAGE FOR BONE DENSITY MEASUREMENT AND DIABETES SELF-MANAGEMENT

Overview: Starting July 1, 1998, Medicare will expand coverage of preventive benefits for beneficiaries at risk for osteoporosis and other bone abnormalities and for people with diabetes. Medical experts agree early detection and management of disease can lead to substantial reductions in life-threatening and serious illness.

The Clinton Administration is committed to making sure Medicare beneficiaries get recommended preventive screening tests. That is why the President worked with Congress to expand the preventive benefits available to Medicare beneficiaries in the Balanced Budget Act of 1997. As of January 1, 1998, Medicare expanded coverage of mammograms, pap smears, and colorectal cancer screening. Today, President Clinton highlighted these exciting preventive tests at the seventh Family Reunion Conference, hosted by Vice President and Mrs. Gore, in Tennessee.

Bone Mass Measurement: The National Osteoporosis Foundation estimates that more than 10 million people in the United States have this disease and another 18 million are at risk for it. As of July 1, 1998, Medicare will cover bone density measurement for beneficiaries at risk for osteoporosis and other bone abnormalities. Through earlier detection of low bone mass and the use of appropriate prevention and treatment measures, the ravaging effects of this disease will be reduced.

Eligible beneficiaries will be able to have their bone mass measured once every two years, or more often, if medically necessary. Doctors will be able to use all of the FDA-approved or cleared bone densitometry and sonometry devices that are currently available in the United States. Beneficiaries should consult with their doctors about whether and when they might need one of these tests.

In the past, bone mass measurement coverage was decided by the many regional contractors that process Medicare claims, resulting in wide variations across the country. The new law makes sure that all beneficiaries who need this testing, no matter where they live, will be covered.

Diabetes Self-Management Benefits: More than 16 million Americans have diabetes and nearly 750,000 new cases are reported every year. Minorities make up a disproportionate share of those suffering from diabetes -- especially African Americans, Native Americans, and Hispanics/Latinos. As of July 1, 1998, more Medicare benefits will be available to diabetics. These newly expanded benefits will help provide people with the skills and resources that most diabetics need to control their diabetes.

Glucose Monitoring for Diabetics: All Medicare beneficiaries with diabetes, whether or not they use insulin, will have coverage for blood glucose monitors and testing strips so they can monitor their own blood glucose levels. Diabetics who keep their blood glucose levels within the normal range reduce the risk of complications, such as blindness and amputations that often are associated with uncontrolled diabetes. In the past, Medicare covered blood glucose monitors and testing strips only for insulin-dependent diabetics.

Diabetes Education: Medicare will cover a wider range of education and training programs to help teach diabetics to control their blood glucose levels. These training programs do not have to be based in hospitals. Physicians and certain other physician practitioners can provide diabetes self-management and training services to their patients if their programs are recognized by the American Diabetes Association. A physician must certify that a patient needs the service under a comprehensive plan of care. In the past, Medicare covered only education and training furnished by hospital-based programs.

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**Qs & As on Bone Density Measurement
(INTERNAL)**

Q. How many more people will be eligible for this expanded benefit?

A. Because virtually all elderly women are at risk of osteoporosis almost all female Medicare beneficiaries would be eligible to receive this benefit. About 21 million women (including disabled and elderly) would be eligible but those beneficiaries with visible signs of osteoporosis are already covered. According to the National Osteoporosis Foundation, 2 million men suffer from osteoporosis and 3.1 million are at risk for the disease.

Q. What is a bone mass measurement?

A. It is a simple, painless test used to measure the density or thickness of the bones, and it should help to determine whether an individual has osteoporosis or is at risk for the disease.

Q. How often will Medicare cover a bone mass test?

A. Once every 2 years, or more frequently if medically necessary.

Q. Which Medicare beneficiaries will be eligible to receive a covered bone mass test?

A. The law identifies five categories of people. These include (1) estrogen-deficient women at clinical risk for osteoporosis, (2) those with vertebral abnormalities, (3) those with primary hyperparathyroidism, (4) those receiving long-term (more than 3 months) steroid therapy, and (5) those being monitored to assess the response to, or efficacy of, an approved osteoporosis drug therapy.

Q. What bone mass measurements are going to be covered under the new Medicare benefit?

A. The benefit will cover all FDA-approved bone mass measurements in clinical use in the United States.

Q. What benefits will the new bone mass measurement provision allow for under Medicare that were not available before enactment?

A. In the past, bone mass measurement coverage was decided by the many contractors that process Medicare claims, resulting in wide variations across the country. The Balanced Budget Act makes sure that all beneficiaries who need this testing, no matter where they live, will be covered.

Q. Should women in menopause seek coverage of a bone mass measurement under the new benefit?

A. Yes, menopause is an estrogen-deficient condition and women should check with their physicians about having the test done.

Q. What is osteoporosis?

A. It is a bone-thinning disease in which bones may become fragile and break. It is estimated that 10 million individuals in the United States have osteoporosis and that another 18 million are at risk for the disease because of a high rate of bone loss.

**Qs and As for Diabetes Self-Management
(INTERNAL)**

Q: What is HCFA doing to implement the blood glucose monitor provision by July 1, 1998?

A: The Balanced Budget Act expanded Medicare coverage to pay for blood glucose monitors and testing strips for all diabetic beneficiaries, whether they take insulin or not, effective July 1, 1998.

Q: What should a beneficiary do in order to have a blood glucose monitor and test strips covered by Medicare?

A: Beneficiaries should ask their doctor if the beneficiary's diabetes could be better controlled by testing their blood glucose. If the physician thinks that better control is necessary the doctor should write a prescription that explains in detail how many times a day or week the beneficiary should test his or her blood sugar and how many test strips the pharmacy or supplier should dispense. The physician will be required to renew this prescription periodically.

Q: I understand that Medicare is not providing the same amount of test strips to non-insulin treated diabetics as insulin treated diabetics can you explain the reasons for this?

A. Medicare will cover the amount that the physician orders. So, these numbers are not limits but will be used as benchmarks to look for potential fraud and abuse in the system. On average medical evidence suggest that the typical non-insulin treated Medicare diabetic beneficiary would use less than 25 test strips per month and the insulin treated Medicare beneficiary would use less than 100 per month. We recognize that there are certain medical conditions that would require the beneficiary to monitor more often, for example, when they are put on a new medication or other medical reasons.

Q: Can you tell us the status of the implementation of the diabetes self-management and training provision?

A: We have a two-phased implementation strategy for diabetes education and training benefits:

By July 1, 1998, HCFA will issue a carrier instruction allowing physicians and certain non-physician practitioners (and services provided incident to their services), who meet the National Diabetes Advisory Board (NDAB) standards to begin providing diabetes self-management training.

HCFA also will develop a Notice of Proposed Rulemaking to enable others who may be eligible to provide diabetes self-management training, and to include quality standards set by the Secretary. It will require a proposed rule with comment period, followed by a final rule. This regulation will identify others who can be reimbursed for this training such as nurse practitioners, physician assistants, clinical nurse specialists, nurse-midwives, clinical psychologists and clinical social workers.

We have taken this two-phased approach because the legislation clearly specifies physicians as eligible to provide diabetes education if they meet NDAB standards. Certain other practitioners are also authorized by law to provide services that would be physician services if they were furnished by a physician.

Q: How does a beneficiary get enrolled in a diabetes self-management and training program?

A: A beneficiary's physician must establish a comprehensive plan of care to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including the self-administration of injectable drugs). Self referral into a program will not be covered.

Q. What are the advantages of a self-management and training program?

A. With better control of their diabetes, beneficiaries will have better health and less medical complications as a result of their diabetes. Diabetes outpatient self-management and training services help beneficiaries manage their diabetes. The program includes education about self-monitoring of blood glucose, diet and exercise, an insulin treatment plan developed specifically for the patient who is insulin dependent, and assistance in developing skills for more effective self-management.

Q: Are all diabetics eligible to attend a self-management training program or only those diabetics who are treated with insulin?

A. Both insulin and non-insulin patients will be eligible to attend a self-management training program as long as they are referred to such a program by the physician who is treating their diabetes.

FOR IMMEDIATE RELEASE
June 22, 1998

Contact:

HCFA Press Office
(202) 690-6145

WWW.MEDICARE.GOV

Official U.S. Government Site for Medicare Information

Overview: President Clinton and Vice President Gore announced www.Medicare.gov the seventh Family Reunion Conference in Tennessee today. Increasing numbers of Medicare beneficiaries use the Internet or have access to it through their families, friends, health care providers, and service organizations. Responding to this growing opportunity to provide beneficiaries with up-to-date information, the Health Care Financing Administration (HCFA), the agency that runs Medicare, has created a new website: www.medicare.gov. Designed with the beneficiary in mind, www.medicare.gov offers a variety of useful and easy-to-read information about Medicare including details of new choices available to them under the Balanced Budget Act.

ONLINE AT WWW.MEDICARE.GOV

HCFA's new website contains the following useful information for Medicare beneficiaries and anyone involved in helping them with their health care decisions:

- **"What is Medicare"** – In this section, visitors can get answers to their questions about Medicare, including eligibility requirements, how to enroll, and how to read a Medicare summary notice.
- **"Managed Care"** – This section is about managed care and new options that will be available in 1999. Visitors can learn more about managed care in general and the Medicare+ Choice options available to Medicare beneficiaries. This includes an extensive question-and-answer section, glossary of terms, and information about how to enroll in and disenroll from a Medicare managed care plan. From this site visitors can also access the "Medicare Compare" database to see what plans and benefits are available where they live.
- **"Who to Contact"** – This section provides state specific contact information, including phone numbers, on a variety of Medicare topics that includes: receiving Medicare, understanding your Medicare bill; Medicare rights, benefits, dealing with complaints and appeals, and managed care.
- **"Publications"** – A variety of publications (in both English and Spanish) are available for visitors to view, print and/or download.

-More-

-2-

- **“Wellness”** – Visitors can learn more about health issues that are of particular concern to them, such as peptic ulcers, pneumonia and the flu, and about new Medicare prevention benefits. This section also includes a calendar of events alerting the user to National Health Observances that are of importance to seniors. Here, seniors can learn about preventing disease or illness, preventive services covered by Medicare and how they can obtain additional information.
- **“Fraud and Abuse”** – This section describes common Medicare rip-offs and teaches visitors how to report suspected fraud in the Medicare system. A *Consumer Fraud Pamphlet* is available for visitors to view and/or print-out.

THE “MEDICARE COMPARE” DATABASE

“Medicare Compare” is HCFA’s new electronic database of information about accredited managed care plans that already serve nearly 6 million Medicare beneficiaries across the country. The database is designed to educate beneficiaries and others about their health care options, so they can make informed health care choices. The information is compiled by HCFA with cooperation from managed care plans, and will be updated on a quarterly basis.

“Medicare Compare” contains the following information:

- Toll-free telephone numbers and website addresses for health plans;
- Service areas listed by state, zip code, and county so beneficiaries can compare services in their own geographic areas;
- Benefit and service packages offered by each plan, including detailed information on premiums, copays/deductibles, and more;
- “Helpful hints” to help users navigate within the database;
- Guest book/E-mail link back to HCFA for users’ comments, questions, and suggestions.

HOW “MEDICARE COMPARE” WORKS

Users can select the level of detail they want to know about the plans, searching either by state, county, or zip code. HCFA will update the database quarterly to provide users with the most timely and complete information.

In addition to viewing the list of Medicare managed care plans in a state, county, or zip code, users can:

- Display side-by-side comparisons of services offered by two health plans;
- Search for a specific type of service such as vision care, podiatry care, or Pap tests.

-More-

-3-

SENIORS SURF THE NET

More and more Medicare beneficiaries and those who will soon be eligible for Medicare use the Internet.

- A Merrill Lynch-sponsored survey conducted in September 1997 shows that 15 percent of those 65 and older use the Internet.
- According to Packard Bell NEC Inc., customers over age 55 accounted for 14 percent of retail purchases of its personal computers in 1997.
- AARP reports that in 1997, 36 percent of Americans between ages 50 and 64 owned a personal computer.

WHO WILL USE THE WEB RESOURCES

While *www.medicare.gov* and "Medicare Compare" are designed especially for Medicare beneficiaries and the people involved in their health care decisions, anyone with access to the Internet can use it. Material in the database may be customized and printed for local and individual needs.

Other primary users will include beneficiary advocacy groups, social and case workers, State Insurance and Assistance Program staff and volunteers, the National Association of Area Agencies on Aging network and its staff, federal and state organizations, and health care providers.

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**WWW.MEDICARE.GOV
FREQUENTLY ASKED QUESTIONS
(INTERNAL)**

Q. What is www.medicare.gov?

A. www.medicare.gov is the official U.S. Government Internet site for Medicare information. It is designed to meet the consumer information needs of Medicare beneficiaries. It offers a variety of useful and easy to read information about Medicare.

Q. Who will use www.medicare.gov?

A. While www.Medicare.Gov and the information include there are designed especially for Medicare beneficiaries and the people involved in their health care decisions, anyone with access to the Internet can use it. Material in the database may be customized and printed for local and individual needs.

Other primary users will include:

- beneficiary advocacy groups
- social and case workers
- State Insurance Advisory Program staff and volunteers
- staff in the National Association of Area Agencies on Aging network
- federal and state organizations
- health care providers

Q. Why use www.medicare.gov?

A. Increasing numbers of Medicare beneficiaries use the Internet or have access to it through their families, friends, health care providers and service organizations. Responding to this growing opportunity to provide beneficiaries with up-to-date information, the Health Care Financing Administration (HCFA), the agency that runs Medicare, has created this new web site. Beneficiaries can use the site to access various kinds of Medicare information.

Q. What kind of information can visitors find on the Internet site?

A. www.Medicare.Gov contains the following useful information for Medicare and anyone involved in helping them with their health care decisions:

- ◆ **“What is Medicare”** - In this section, visitors can get answers to their questions about Medicare, including eligibility requirements, how to enroll and how to read a Medicare summary notice.

- ◆ **“Managed Care”** - This section is about Managed Care and the new options that will be available to beneficiaries in 1999. Visitors can learn more about managed care and the Medicare + Choice options available to beneficiaries. This includes an extensive question and answer section, glossary of terms, and information about how to enroll in and disenroll from a Medicare managed care plan. From this site, visitors can also access the Medicare Compare database to see what plans and benefits are available where they live.

- ◆ **“Who to Contact”** - This section provides state specific contact information, including phone numbers on a variety of Medicare topics broken down into five broad categories:
 - Your Medicare Bill
 - Getting Medicare, other health insurance, other benefits
 - Complaints, appeals and other Medicare rights
 - Your health plan choices
 - Railroad Retirement Board

- ◆ **“Publications”** - A variety of publications (in both English and Spanish) are available for visitors to view, print and/or download.

- ◆ **“Wellness”** - Visitors can learn more about health issues that are of particular concern to them, such as peptic ulcers, pneumonia and the flu and about new Medicare prevention benefits. This section also includes a calendar of events alerting the user to National Health Observances that are of importance to seniors. Here, seniors can learn about preventing disease or illness, preventive services covered by Medicare and how they can obtain additional information.

- ◆ **“Fraud and Abuse”** - This section describes common Medicare rip-offs and tells visitors how to report suspected fraud in the Medicare system. A *Consumer Fraud Pamphlet* is available for visitors to view and/or print out.

Q. How can visitors access the site?

A. Visitors can visit their local library, school, home or any computer with access to the Internet. Visitors can use Netscape or Internet Explorer and any web browser or search engine will work. Type in <http://www.medicare.gov> to access the home page. The site can be accessed 24 hours a day, 7 days a week.

Q.: Is the site worthwhile? How many seniors actually use the Internet?

A. More and more, Medicare beneficiaries and those who will soon be eligible for Medicare use the Internet. The following research indicates Internet access growth:

- A Merrill Lynch sponsored survey conducted in September 1997 shows that 15 percent of those 65 and older use the Internet.

- According to Packard Bell NEC inc., customers over age 55 accounted for 14 percent of retail purchases of its personal computers in 1997.

AARP reports that in 1997, 36 percent of Americans between ages 50 and 64 own a personal computer.

Q. What is the Medicare Compare database?

A. Medicare Compare is HCFA's new electronic database of information about accredited managed care plans that are available to 26 million Medicare beneficiaries across the country. Currently 6 million Medicare beneficiaries are members of managed care plans. The database is designed to educate beneficiaries (and others including beneficiaries' family members, advocates and social workers) about their health care options so they can make informed health care choices. The information is compiled by HCFA with cooperation from managed care plans and will be updated on a quarterly basis.

Q. What kind of information does the Medicare Compare database contain?

A. The Medicare Compare database contains the following information:

- Toll-free telephone numbers and web site addresses for health plans.
- Service areas listed by state, zip code and county so beneficiaries can compare services in their own geographic areas.
- Benefit and service packaged offered by each plan including detailed information on premiums, copays/deductibles and more.
- Helpful hints to help users navigate within the database.
- Guest book/E-mail link back to HCFA for users comments, questions and suggestions.

Q. How do visitors use Medicare Compare?

A. Users can select the level of detail they want to know about the plans, searching either by state, county or zip code. (While the database contains a broad range of information on the plans, certain areas of interest to Medicare beneficiaries may not be documented.) HCFA will update the database quarterly to provide users with the most timely and complete information. In addition to viewing the list of Medicare managed care plans in a state, county or zip code, users can:

- Display side-by-side comparisons of services offered by two health plans
- Search for a specific type of service such as vision care, podiatry care or Pap tests.

Q. What are future plans for the site?

A. Future plans include the development of additional consumer information resources targeted to meet the immediate and ongoing needs of Medicare beneficiaries and those who work with them. We will develop the additional resources in response to market research and to ongoing surveillance of customer service needs.

Q. Are there plans to include more plan comparison information on the web site in the future?

A. Yes. Plan information will be updated at least quarterly to reflect new plans that are available to Medicare beneficiaries. In addition, there are plans to expand the comparison information to include new information as it becomes available. The first expansion will include quality and satisfaction information in late Fall 1998. Quality information will be obtained from 1996 data reported on measures that comprise the Health Plan Employer Data and Information Set (HEDIS). These data are reported by health plans that contract with Medicare, and will be useful in comparing health plans. Satisfaction information will be obtained from 1997 data reported by Medicare beneficiaries from questions that comprise the Consumer Assessment of Health Plans Survey (CAHPS). Finally, disenrollment rates will be available on the web site in late spring of 1999.

Guide to Child Care & Medicaid: Partners for Healthy Children

This guide is designed to improve childrens' health by encouraging enrollment in Medicaid and the new Children's Health Insurance Program, known as CHIP. It explains Medicaid and CHIP benefits and activities so that child care programs, referral agencies, and other health professionals can determine when children are eligible and how to help them enroll. They can also use it to learn how to establish linkages with these programs so they can make sure children they serve are getting the health care coverage and services they need and deserve.

The *Child Care and Medicaid Guide* has been produced through a collaboration between the Health Care Financing Administration (HCFA), which runs Medicaid in partnership with states, and the Administration on Children and Families (ACF). It is one of many cooperative efforts between these two federal agencies to link child care with health care. The guide is a tool to help child care programs, referral agencies, and other health care professionals facilitate enrollment of children in CHIP as well as Medicaid. On the June 22, 1998, the guide will be distributed at the seventh Family Reunion Conference, hosted by Vice President and Mrs. Gore, in Tennessee. The guide includes:

- outreach activities that child care programs can perform to enroll eligible children into Medicaid and be compensated for, such as assisting families in completing Medicaid applications and obtaining services, informing families about Medicaid through brochures or other promotional materials, and assisting the Medicaid agency in fulfilling the outreach objectives of the Medicaid program;
- examples of children's programs, local health departments, and various community-based organizations that have working linkages with Medicaid programs and that are successfully identifying and enrolling children who are eligible;
- a description of BBA provisions designed to increase children's health care coverage through Medicaid;
- an explanation of the Early and Periodic Screening, Diagnosis and Treatment program within Medicaid, and of related activities that child care programs can perform, such as making referrals, scheduling appointments and transportation, and conducting case management;
- a chart of state Medicaid eligibility criteria for pregnant women, infants and children; and
- each State's Maternal and Child Health toll-free number, which can provide more information about available health care resources.

Questions and Answers

Q. What is the intended audience for this Child Care and Medicaid Guide?

A. This guide is for child care program administrators and child care organizations interested in establishing linkages with Medicaid and other public health insurance programs.

Q. What are the purposes of this guide?

A. This guide provides the basis for understanding the dynamics of the Medicaid program and Early Periodic Screening, Diagnostic and Treatment (EPSDT), Medicaid's comprehensive child health component. EPSDT provides integral health services to beneficiaries under age 21, including: a comprehensive history and physical; immunizations; health education and counseling services; and examinations, services and treatment for vision, dental and hearing. Furthermore, this guide will help child care programs and child care resource and referral agencies understand the pivotal role they can play in identifying children who are eligible, but not enrolled in Medicaid or CHIP, and providing their families/caretakers with information and understanding about the importance of using available health insurance programs to provide their children access to health care services and improved health status.

INTERAGENCY CHILDREN'S HEALTH OUTREACH TASKFORCE

On August 5, 1997, President Clinton signed the Children's Health Insurance Program into law. As part of his continuing commitment to improving children's health, he brought together federal departments that have regular contact with low income families. The resulting Children's Health Outreach Taskforce is working to find more and better ways to reach out to uninsured children. It has developed an approach that involves: 1) educating families about their eligibility; 2) educating Federal, state, and grantee personnel about children's health outreach; and 3) coordinating outreach efforts across departments and with the private sector. Particular attention will be given to minority and special needs children with unique access problems and to the coordination of eligibility.

Upon receiving the Children's Health Outreach Taskforce Report on June 22, 1998, President Clinton issued an Executive Memorandum that directs eight Federal agencies to implement over 150 initiatives to help enroll the millions of uninsured children eligible for but not enrolled in health insurance programs. President Clinton issued the Executive Memorandum at the seventh Family Reunion Conference, hosted by Vice President and Mrs. Gore, in Tennessee.

Background

- In a February 18, 1998 Executive Memorandum, the President asked eight federal departments to work together to develop ways to educate families and enroll children in Medicaid and the new Children's Health Insurance Program, known as CHIP.
- The Interagency Children's Health Outreach Taskforce is led by the Department of Health and Human Services and includes other departments and agencies that serve children who are potentially eligible for Medicaid or CHIP. These include the Departments of Treasury, Agriculture, Labor, Education, Housing and Urban Development, Interior and the Social Security Administration. Taskforce members also have networks of private sector counterparts who can be involved and educated in children's health insurance outreach.

The taskforce proposed more than 150 single-event and ongoing activities intended to assure that the effects of the children's health outreach efforts are not temporary. Proposed activities fall into three broad efforts:

Educating families about potential eligibility for health insurance.

Efforts to help families learn about eligibility include:

- a national toll-free number for referral for child health outreach;
- informational materials in plain language and application forms available from federal and state agencies and other sources; and
- coordinating program enrollment across agencies so applicants for one program will learn when they or their children may be eligible for Medicaid or CHIP.

Educating government workers about children's health outreach.

All Taskforce departments will educate their own workers about the health insurance options for children by:

- informing clearinghouses and technical assistance centers, providers and eligibility workers about eligibility and access to Medicaid and CHIP;
- distributing newsletters to keep federal and state employees informed of developments in children's health outreach activities;
- educating grantees and potential grantees about the Medicaid and Children's Health Insurance programs;
- convening regional interagency taskforces for children's health outreach; and
- Secretarial letters to federal workers.

Coordinating efforts across departments and agencies and with private sector groups.

The taskforce is also working to coordinate efforts to achieve essential ongoing communication across departments about Medicaid and CHIP outreach, including:

- developing models to link school lunch program applications with Medicaid and CHIP applications;
- engaging major national associations, advocacy groups and other private organizations in outreach;
- linking Internet sites; and
- publishing the "Child Care and Medicaid: Partners for Healthy Children" guide which will be available soon to assist child care programs in getting eligible individuals enrolled in Medicaid and CHIP.

Other Areas in Need of Special Attention.

The task force has identified other areas that need and receive special attention, as well, ensure optimal use of Medicaid and CHIP coverage.

Special attention for minority and special needs children. Particular attention will be given to minority and special needs children with unique access problems, and to eligibility coordination across programs. Taskforce subgroups on minorities, special needs, and eligibility have been established to address these concerns.

Eliminating barriers in the eligibility and application processes. An eligibility subgroup also is looking at the programs to make the eligibility and application processes less confusing and cumbersome for beneficiaries, including finding ways to consolidate eligibility and application forms across programs.

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**CHIP : Questions and Answers
(INTERNAL)**

Q. Why wasn't such an outreach effort undertaken earlier?

- A. Outreach is not new. However, children's health insurance outreach efforts have not been as successful as they could be for a variety of reasons. Specifically, there has not been a well coordinated interagency effort to produce an awareness of the available child health care options among individuals and agencies who come into regular contact with low-income families.

In partnership with the President, governors, major foundations, children's and provider groups recognize the need to pursue a more aggressive outreach strategy that includes identifying and promoting outreach models that work; engaging a broader set of participants nationwide; and advertising these programs through the mass media in the same way that a private business does.

Q. Why haven't these eligible but uninsured kids been enrolled?

- A. Many of the children who may be eligible for Medicaid or CHIP are difficult to reach. Special needs populations and minorities often face sociocultural and linguistic barriers and low literacy. In addition, they may live in isolated areas or have homeless or transient living situations that make it difficult for them to be found and enrolled. For these same reasons, many of the individuals in these groups tend to be uninsured. Cross-agency subgroups of the taskforce are currently developing group-specific recommendations to deal with such problems.

Other reasons for eligible children not being enrolled were found in barriers created by the eligibility and application processes of various programs, such as lengthy or confusing application processes. An eligibility subgroup is looking at major social programs to identify, issues in coordination of program eligibility and effective models of federal and state collaboration.

Q. How will the Federal government make certain that the Federal agency activities set forth in the report will be implemented on a timely basis?

- A. The Children's Health Initiative Leadership Board of the Department of Health and Human Services, which includes representatives from all DHHS components, will be expanded to include principals from the other taskforce agencies. The plan is for it to monitor the status of each activity on a quarterly basis.

Q. How will the national toll-free number work?

A. When a call is received, it will be transferred to the appropriate state number based on the area code from which the call is made. State staff will then provide the caller with program and enrollment information for that state.

Q. What is the intended audience for the Child Care and Medicaid Guide?

A. Child care program administrators and child health organizations are the intended audience. These individuals can use the guide in establishing linkages with Medicaid and other state health insurance programs.

Q. What are the purposes of this guide?

A. This guide provides basic information about the workings of the Medicaid program and Early Periodic Screening, Diagnostic and Treatment (EPSDT), Medicaid's comprehensive child health care component. EPSDT provides integral health services to beneficiaries under age 21, including: a comprehensive history and physical; immunizations; health education and counseling services; and examinations, services and treatment for vision, dental and hearing. Furthermore, the guide also will help child care programs and child care resource and referral agencies understand their role in identifying children who are eligible, but not enrolled in Medicaid or CHIP, and providing their families with information about the importance of using available health insurance programs to care for their children.

Mammography file
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: January 5, 1995 

FROM: Bruce C. Vladeck
Administrator, Health Care Financing Administration

SUBJECT: Mammography for Medicare Beneficiaries

TO: Hillary Rodham Clinton
First Lady, White House

Chris Jennings asked me to drop you a note about Medicare's coverage of mammograms.

The Medicare benefit for screening mammography for women age 65 and older is set at one test every two years. Our interval for screening is consistent with that in the HSA and is supported by a variety of organizations including both the National Cancer Institute and the American Geriatric Society. There are no limits on the frequency of diagnostic mammograms other than the usual requirement that they be medically necessary.

Our real problem with the Medicare benefit is underuse. Our latest figures show that fewer than 30% of all elderly women on Medicare have a claim submitted for a mammogram, diagnostic or screening, in any given year. Rates for African American women and those poor enough to be eligible for Medicaid are even lower. I am enclosing a chart which summarizes the data.

Later this spring we plan to launch a major initiative to increase the use of screening mammograms by Medicare beneficiaries. Using consumer information material prepared by the National Cancer Institute and various outside organizations, we will contact a wide variety of beneficiary groups to remind them that Medicare does pay for mammograms and that women do not outgrow the need for this test.

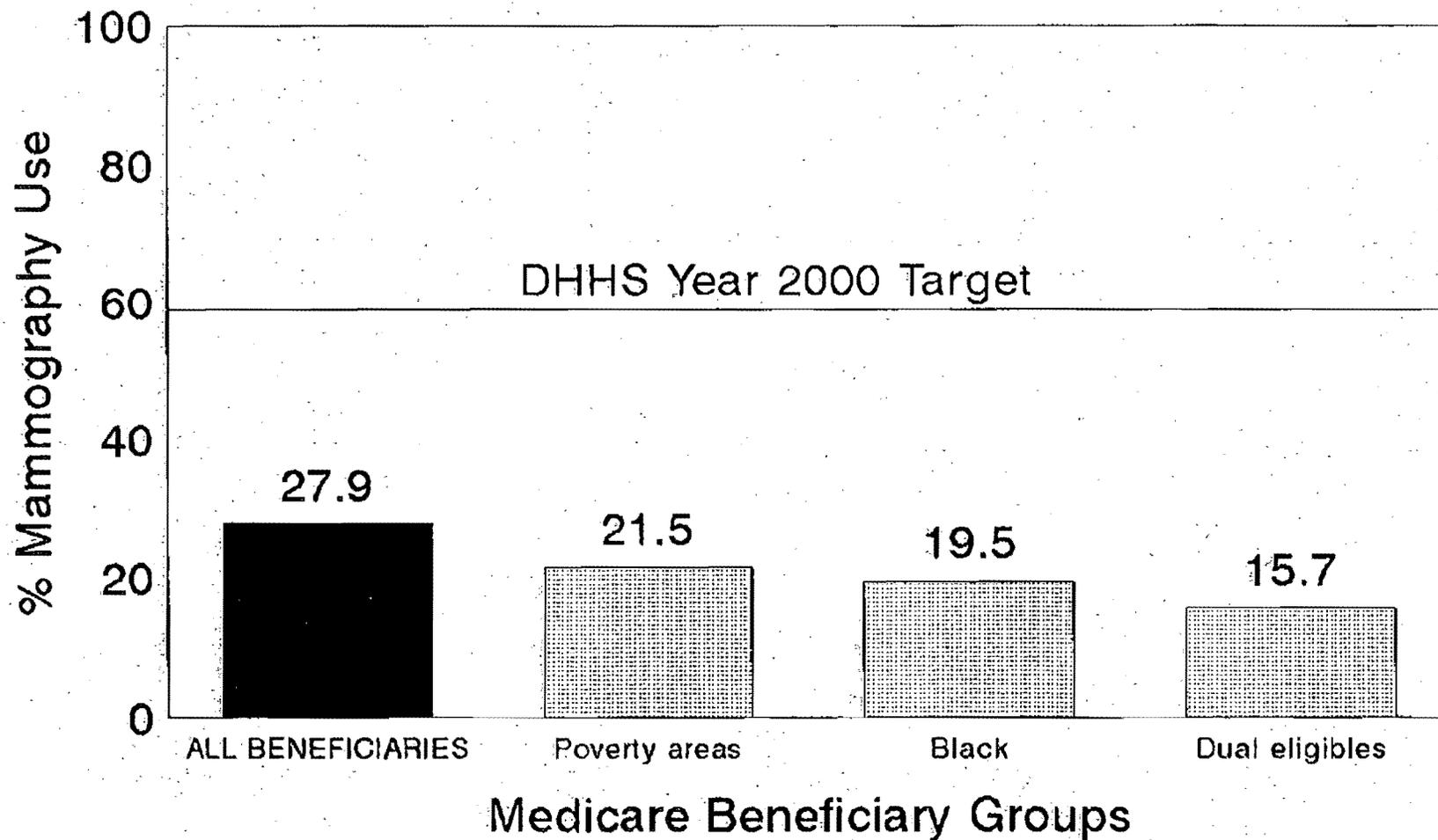
As part of this initiative, we will contact physicians both through professional societies and our Carriers and Intermediaries. Our aim will be to be sure that physicians serving Medicare beneficiaries are informed about the availability of the screening benefit and that they understand the importance of distinguishing between diagnostic and screening tests in the billing process. Carriers will also be reminded that properly coded diagnostic mammograms should not be denied on the basis of frequency screens intended only for screening procedures.

I am very excited about this initiative which can, if successful, make a real difference to the health of our beneficiaries. We are still in the early planning phases and would be very appreciative if you could be directly involved.

If you have any further questions, please feel free to contact me.

The woman who wrote you about her cancer should have no trouble having her follow up mammograms paid for by Medicare every six months. I think it might be a nice touch if you mention the low use of the service in your response and urge her to remind her friends to obtain mammograms.

Annual Mammography Use By Medicare Beneficiaries: 1991 (Percent By Group)



Notes: The DHHS Year 2000 target is for women 50 years of age and over.

Dual eligibles are entitled to both Medicare and Medicaid.

Source: Medicare Part B claims and enrollment database: 1991

Differences Between H.R. 15 (Thomas Bill) and Administration Proposals for Preventive Medicare Services

Mammography

- * The Administration's bill would cover annual screening mammograms for all women age 40-49. H.R. 15 introduces no change from the current law which covers mammograms every two years for all women age 40-49 (or annual if high risk).
- * 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

- * The Administration's bill expands coverage for both blood glucose monitors and testing strips. H.R. 15 expands coverage only for testing strips.
- * The Administration's bill would reduce payment for testing strips by 10 percent. H.R. 15 does not include a payment reduction.
- * 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 time frames set by the Secretary, and defines an eligible provider as a physician or other entity designated by the Secretary.
- * H.R. 15 includes the establishment of outcome measures by the Secretary in order to evaluate improvement in the health status of diabetic beneficiaries. Based on these outcome measures, the Secretary will periodically recommend coverage modifications to Congress. The Administration bill does not include outcome measures.

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 ever 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 PSA blood test would be paid for under clinical diagnostic lab test free schedules. 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.

Colorectal Screening

- * There are many differences between the Administration's bill and H.R. 15 in the areas of fecult-occult blood, flexible sigmoidoscopy, colonoscopy, and other procedures of colorectal screenings.
- * Specifically, for barium enema, the Administration's bill would cover individuals over age 51, every 5 years (every 4 years for high risk individuals). H.R. 15 provides coverage only if the Secretary finds, within 2 years, that the procedure is the appropriate alternative to flexible sigmoidoscopy or colonoscopy. If covered, the Secretary will set frequency consistent with other colorectal screening tests. Payment limits (including nonpar physician charges) are consistent with limits under Part B for diagnostic barium enemas.

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.

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- 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
<p>Screening Mammography</p>	<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>
<p>Pap Smears</p>	<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 screening pelvic exam. <p><u>Cost-sharing</u> Must pay deductible + co-insurance for pelvic exam (but not for pap smear lab test).</p>	<p>No provision</p>	<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>

Differences Between H.R. 15 (Thomas Bill) and Administration Proposals for Preventive Medicare Services

Mammography

- * The Administration's bill would cover annual screening mammograms for all women age 40-49. H.R. 15 introduces no change from the current law which covers mammograms every two years for all women age 40-49 (or annual if high risk).
- * 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

- * The Administration's bill expands coverage for both blood glucose monitors and testing strips. H.R. 15 expands coverage only for testing strips.
- * The Administration's bill would reduce payment for testing strips by 10 percent. H.R. 15 does not include a payment reduction.
- * 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 time frames set by the Secretary, and defines an eligible provider as a physician or other entity designated by the Secretary.
- * H.R. 15 includes the establishment of outcome measures by the Secretary in order to evaluate improvement in the health status of diabetic beneficiaries. Based on these outcome measures, the Secretary will periodically recommend coverage modifications to Congress. The Administration bill does not include outcome measures.

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 ever 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 PSA blood test would be paid for under clinical diagnostic lab test free schedules. 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.

Colorectal Screening

- * There are many differences between the Administration's bill and H.R. 15 in the areas of fecult-occult blood, flexible sigmoidoscopy, colonoscopy, and other procedures of colorectal screenings.
- * Specifically, for barium enema, the Administration's bill would cover individuals over age 51, every 5 years (every 4 years for high risk individuals). H.R. 15 provides coverage only if the Secretary finds, within 2 years, that the procedure is the appropriate alternative to flexible sigmoidoscopy or colonoscopy. If covered, the Secretary will set frequency consistent with other colorectal screening tests. Payment limits (including nonpar phys'n charges) are consistent with limits under Part B for diagnostic barium enemas.

Comparison Between H.R. 15 (Thomas Bill) and Administration Proposals for Preventive Medicare Services

Major Differences:

Mammography

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- * The Administration's bill would cover annual screening mammograms for all women age 40-49. *H.R. 15 introduces no change in the current law, which covers mammograms every 2 yrs for all women age 40-49*
- * 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. *(or annual if high risk)*

Diabetes

- * The Administration's bill expands coverage for both blood glucose monitors and testing strips. H.R. 15 expands coverage only for testing strips. *? where?*
- * The Administration's bill would reduce payment for testing strips by 10 percent. H.R. 15 does not include a payment reduction.
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payments

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

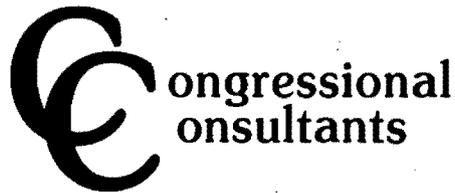
Vaccines

?
where

- * 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.

Colorectal Screening

- * There are many differences between the Admin Bill & H.R. 15 in ~~the~~ the areas of fecult-occult blood, flexible sigmoidoscopy, colonoscopy & other procedures of colorectal screening.
- = Specifically in the ^{procedure} area of barium enema, H.R. 15 ~~covers~~ provides for coverage only if the Secretary finds ^{(within 2 years) that} this procedure to be the appropriate alternative to flex sigmoidoscopy or colonoscopy. If covered.



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October 22, 1996

Chris Jennings
Special Assistant to the President for Health Policy
Old Executive Office Building
Washington, D.C. 20500

Dear Mr. ^{Chris}Jennings:

Thanks for meeting with National Osteoporosis Foundation Executive Director Sandra Raymond, Bente Cooney and myself on updating the Medicare Carriers Manual on diagnostic testing for bone mass measurement.

Enclosed please find a copy of an article from CDC's *Morbidity and Mortality Weekly Report* entitled "Incidence and Costs to Medicare of Fractures Among Medicare Beneficiaries Aged >65 Years - United States, July 1991-June 1992," which strengthens the argument for updating the Carriers Manual now.

The first paragraph of the article summarizes the findings:

- * An estimated 850,000 fractures occur annually in the U.S. among persons aged 65 and older.
- * Osteoporosis is a major cause of these fractures.
- * Approximately 25 million persons may be at increased risk for fractures because of low bone mass.
- * During 1986-1995, annual medical care costs for fractures among older adults ranged from \$7 billion to \$10 billion in 1986 and to \$13.8 billion in 1995.
- * **Excess costs to Medicare for the ten incident fracture types analyzed in this study represent 3% of all Medicare costs for 1992.**
- * With a concomitant increase in the proportion of the U.S. population at risk for age-related fractures, excess costs to Medicare for fracture treatment are likely to increase steadily.

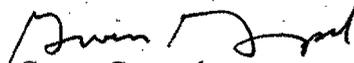
Given the enormous and increasing cost to Medicare from fractures due to osteoporosis it would appear that a very compelling case can be made for updating the Carrier Manual instructions now on bone mass measurement diagnostic testing. The 1984 manual instructions do not reflect the current technologies nor do they provide the carriers with guidelines on who should receive the diagnostic tests. Appropriate FDA approved technologies exist to measure bone mass and FDA approved treatments are available to increase bone mass and thereby reduce the risk of fractures.

The National Osteoporosis Foundation has developed clinical guidelines for measuring bone mass which will be sent to Steven Sheingold, Director, Technology and Special Analysis Staff.

In light of this CDC article and the availability of clinical guidelines, we would urge you to contact Kathleen Buto about updating the Carrier Manual instructions on Medicare reimbursement for diagnostic bone mass measurement.

Please let us know what you plan to do by contacting Gwen Gampel at the above address.

Sincerely,



Gwen Gampel

Representing the National Osteoporosis Foundation

Enclosure

CC: Steven Sheingold

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

- 877 Incidence and Costs to Medicare of Fractures Among Medicare Beneficiaries Aged ≥65 Years
- 983 Ten Leading Nationally Notifiable Infectious Diseases — U.S.
- 884 Hunting-Associated Injuries and Wearing "Hunter" Orange Clothing — New York, 1989–1995
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**Incidence and Costs to Medicare of Fractures
Among Medicare Beneficiaries Aged ≥65 Years —
United States, July 1991–June 1992**

An estimated 850,000 fractures occur annually in the United States among persons aged ≥65 years (1,2). Osteoporosis, an age-associated condition resulting in decreased bone density, is a major cause of these fractures, which typically result from a fall to the floor (2); approximately 25 million persons may be at increased risk for fracture because of low bone mass (3). During 1986–1995, annual medical-care costs for fractures among older adults ranged from \$7 billion to \$10 billion in 1986 (4) to \$13.8 billion in 1995 (5). To determine more accurately the incidence of fractures at 10 anatomical sites among persons aged ≥65 years during July 1991–June 1992 and to estimate the excess costs to Medicare of these fractures during the 1-year period following the fracture, claims data were analyzed for a 5% systematic sample (n=1,288,618) of Medicare beneficiaries. This report summarizes the findings, which indicate that excess costs to Medicare for the 10 incident fracture types represent 3% of all Medicare costs for 1992.

Medicare is a national health insurance program that includes coverage for persons aged ≥65 years, and the Medicare dataset comprises claims for 97% of persons in this age group (6). Medicare data include claims from inpatient hospitals, physicians/suppliers, outpatient-care facilities, skilled-nursing facilities (SNF), home-health agencies, and hospice care. Claims files for hospital inpatient services, outpatient hospitals, and physicians' services were reviewed to identify persons with a single fracture at one of 10 sites: ankle, nonankle tibia-fibula, patella, nonhip femur, hip, pelvis, distal forearm (wrist), nonwrist radius-ulna, shaft-distal humerus, and proximal humerus. These persons were identified through use of algorithms employing fracture diagnosis codes from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM), and current procedure codes indicating a particular treatment for fracture (6,7).

Denominators used to compute incidence rates were obtained from the annual Medicare denominator files that include demographic and entitlement information for the beneficiary population. Incidence rates were age-adjusted by 5-year age groups to the 1990 U.S. population aged ≥65 years. Fracture incidence was analyzed by race because previous studies have documented race-specific differences in age-related fractures. The race categories (black, white, and other/unknown) included in this

Fractures — Continued

analysis reflect categories coded in the Medicare dataset. Data were excluded for persons with incomplete information (i.e., health-maintenance organization enrollees, Railroad Retirement Board enrollees, non-U.S. residents, and persons without continuous part A and part B coverage), with bone cancer, or with evidence of previous fracture (i.e., prevalent fractures).

Costs to Medicare were determined for the 10 types of incident fractures by using claims data listing the amount reimbursed by Medicare (including per diem adjustments for inpatient and SNF care) (8). Two types of costs were calculated for three specific time intervals pre- and post-fracture: the 6-month baseline before fracture, an initial 12-week episode of care (i.e., the usual healing time for a simple fracture), and a 40-week follow-up period. Mean costs to Medicare per person per day were computed for each of the 10 fracture sites, and excess costs per person were determined by comparing costs during the initial episode and follow-up periods to baseline costs for the 6-month period before fracture. Excess costs for each fracture site were extrapolated to the entire population that met the criteria for inclusion in this analysis.

Incidence Rates

From July 1991 through June 1992, a total of 26,785 single fractures at the 10 sites were identified among the 1,288,618 Medicare beneficiaries in the 5% sample (Table 1). Hip fracture occurred most frequently (incidence rate: 73.9 per 10,000 population), followed by fracture of the wrist (37.8) and of the proximal humerus (21.8). The incidence rate was lowest for fracture of the patella (5.5). Sex-specific rates were higher for women than for men for all fracture sites and for all races; race-specific rates were higher for whites than for blacks and other/unknown races for all fracture sites; for most fracture sites, rates were highest for white women and lowest for blacks.

Cost of Fractures

From July 1991 through June 1992, the mean daily cost to Medicare for a beneficiary was greatest during the initial 12-week period following a fracture; the daily costs were highest for persons with a fracture of the hip (\$191.50) and of the lower femur (\$153.98) (Table 2). Mean daily costs were lower during the 40-week follow-up period; however, for most fracture sites, these costs were higher than mean daily costs during the 6-month baseline preceding the fracture. Total excess costs to Medicare for a person during the year following a fracture ranged from \$2564 following wrist fracture to \$15,294 following hip fracture. The total excess cost to Medicare for the 10 fracture sites among beneficiaries aged ≥ 65 years meeting inclusionary criteria was \$4.2 billion; \$2.9 billion (69%) of this excess was associated with hip fracture (Table 3).

Reported by: JA Baron, MD, Dept of Medicine, and Dept of Community and Family Medicine, J Barrett, MSc, Dept of Community and Family Medicine, Dartmouth Medical School, Hanover, New Hampshire. M Berger, MD, Merck & Co., Inc., West Point, Pennsylvania. Prevention Effectiveness Activity, Div of Prevention Research and Analytic Methods (proposed), Epidemiology Program Office; Div of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The overall national incidence of fractures cannot be readily estimated because many types of fractures are treated in outpatient settings, which are not linked to integrated databases (3). For Medicare beneficiaries aged ≥ 65 years, however, the Medicare dataset provides a means for estimating the occurrence and costs of fractures among nearly the entire population, and for fracture types not previously

TABLE 1. Incidence rate* of fractures among Medicare beneficiaries aged ≥65 years, by fracture site, race,† and sex — United States, July 1991–June 1992‡

Characteristic	Ankle (n=2432)		Nonankle tibia-fibula (n=978)		Patella (n=712)		Nonhip femur (n=924)		Hip (n=10,189)	
	Rate	(95% CI)	Rate	(95% CI)	Rate	(95% CI)	Rate	(95% CI)	Rate	(95% CI)
Race										
White	18.2	(18.4–20.1)	7.5	(7.0–8.1)	5.6	(5.1–6.1)	8.9	(8.3–7.4)	77.4	(75.8–79.0)
Black	15.8	(13.2–18.4)	7.0	(5.3–8.8)	3.8	(2.3–4.9)	8.8	(5.1–8.5)	37.0	(33.2–40.9)
Other/Unknown	17.6	(13.3–22.0)	4.1	(1.9–8.3)	4.5	(2.3–6.7)	4.5	(2.1–6.9)	54.8	(45.2–63.3)
Sex										
Male	10.2	(9.2–11.2)	3.7	(3.1–4.3)	2.5	(2.0–3.0)	2.8	(2.4–3.4)	48.0	(45.8–50.0)
Female	24.6	(23.6–26.0)	9.5	(8.8–10.3)	7.4	(6.7–8.0)	8.8	(8.2–9.5)	88.0	(88.0–90.1)
Total	18.9	(19.1–19.7)	7.4	(6.8–7.9)	5.5	(5.0–5.9)	6.8	(6.3–7.3)	73.9	(72.4–75.4)

Characteristic	Pelvis (n=1769)		Distal forearm (wrist) (n=4980)		Non-wrist radius-ulna (n=1100)		Shaft distal humerus (n=631)		Proximal humerus (n=2908)	
	Rate	(95% CI)	Rate	(95% CI)	Rate	(95% CI)	Rate	(95% CI)	Rate	(95% CI)
Race										
White	13.7	(13.0–14.4)	39.6	(38.4–40.8)	8.8	(8.2–9.4)	6.5	(6.0–7.0)	22.9	(22.0–23.8)
Black	5.3	(3.8–6.8)	17.3	(14.6–20.0)	3.2	(2.0–4.4)	3.7	(2.4–5.0)	7.6	(5.8–9.4)
Other/Unknown	11.3	(7.5–15.2)	33.5	(27.2–39.8)	7.2	(4.3–10.1)	6.3	(2.7–9.0)	22.7	(17.4–27.9)
Sex										
Male	5.1	(4.4–5.8)	11.7	(10.7–12.7)	3.7	(3.1–4.3)	3.2	(2.7–3.8)	9.5	(8.5–10.4)
Female	17.3	(16.3–18.2)	54.0	(52.4–55.7)	11.4	(10.6–12.2)	8.1	(7.4–8.7)	29.2	(28.0–30.4)
Total	13.0	(12.4–13.7)	37.6	(36.7–38.8)	8.4	(7.8–8.9)	8.2	(5.8–6.7)	21.8	(20.9–22.6)

* Per 10,000 Medicare beneficiaries. Age-adjusted by 5-year age groups to the 1990 U.S. population aged ≥65 years.
 † The race categories (black, white, and other/unknown) included in this analysis reflect categories coded in the Medicare dataset.
 ‡ Data were analyzed for a 5% systematic sample (n=1,288,618) of Medicare beneficiaries. Data were excluded for persons with incomplete information (i.e., health-maintenance organization enrollees, Railroad Retirement Board enrollees, non-U.S. residents, and persons without continuous part A and part B coverage), with bone cancer, or with evidence of previous fracture (i.e., prevalent fractures).
 § Confidence interval.

TABLE 2. Estimated mean daily costs and estimated total excess costs to Medicare* per person for beneficiaries aged ≥65 years with an incident fracture, by fracture site — United States, July 1991–June 1992†

Type of Cost/ Time period	Ankle (n=2247)	Nonankle tibia-fibula (n=809)	Patella (n=505)	Nonhip femur (n=752)	Hip (n=9249)	Pelvis (n=1522)	Distal forearm (wrist) (n=4405)	Nonwrist radius-ulna (n=968)	Shift distal humerus (n=636)	Proximal humerus (n=2477)
Mean daily cost										
Baseline										
18 mos pre-fracture	\$ 9.14	\$ 12.84	\$ 10.47	\$ 20.43	\$ 18.16	\$ 18.37	\$ 9.00	\$ 9.43	\$ 12.26	\$ 12.22
12 wks post-fracture	47.71	82.01	64.00	163.98	191.60	93.62	27.88	38.60	66.88	57.13
13–52 wks post-fracture	13.37	17.98	15.15	20.52	18.17	16.89	12.48	13.18	16.53	16.38
Total excess cost										
12 wks post-fracture	3,240.00	5,811.00	3,856.00	11,218.00	14,729.00	8,321.00	1,584.00	2,450.00	4,596.00	3,352.00
13–52 wks post-fracture	1,188.00	1,438.00	1,316.00	25.00	665.00	-414.00 [‡]	979.00	1,054.00	1,227.00	1,163.00
Total excess costs 0–52 wks post-fracture										
	\$4,328.00	\$7,249.00	\$4,972.00	\$11,242.00	\$15,294.00	\$5,907.00	\$2,564.00	\$3,504.00	\$5,814.00	\$4,515.00

* Medicare costs are the amounts the program paid institutions (inpatient hospitals, outpatient hospitals, skilled-nursing facilities, home-health agencies, and hospices) or providers (physicians/suppliers). These costs include costs for fractures plus excess costs of complications or comorbid conditions. Excess costs were calculated by subtracting baseline costs from post-fracture costs.

† Data were analyzed for a 5% systematic sample (n=1,289,818) of Medicare beneficiaries. Data were excluded for persons with incomplete information (i.e., health-maintenance organization enrollees, Railroad Retirement Board enrollees, non-U.S. residents, and persons without continuous part A and part B coverage), with bone cancer, or with evidence of previous fracture (i.e., prevalent fractures). The sample size for each type of fracture in this table is lower than in Table 1 because of the exclusion of persons with fewer than 6 months of data before the fracture.

‡ Negative excess costs during the 40-week follow-up period may be the result of a high proportion of deaths among persons with a pelvis fracture.

TABLE 3. Estimated total excess costs to Medicare* for beneficiaries aged ≥65 years who met the inclusionary criteria and had an incident fracture, by fracture site — United States, July 1991–June 1992†

Time period	Ankle	Nonankle tibia-fibula	Patella	Non-hip femur	Hip	Pelvis	Distal forearm (wrist)	Nonwrist radius-ulna	Shaft distal humerus	Proximal humerus	Total
12 wks post-fracture	148	94	44	169	2,752	193	140	43	59	166	3,808
13–52 wks post-fracture	54	23	18	0	108	-13‡	86	18	16	58	384
Total excess costs 0–52 wks post-fracture	189	117	59	169	2,858	180	228	61	74	224	4,167†

* In millions of dollars. Medicare costs are the amounts the program paid institutions (inpatient hospitals, outpatient hospitals, skilled-nursing facilities, home-health agencies, and hospices) or providers (physicians/suppliers). These costs include costs for fractures plus excess costs of complications or comorbid conditions. Excess costs were calculated by subtracting baseline costs from post-fracture costs.

† Data were analyzed for a 5% systematic sample (n=1,288,818) of Medicare beneficiaries. Data were excluded for persons with incomplete information (i.e., health-maintenance organization enrollees, Railroad Retirement Board enrollees, non-U.S. residents, and persons without continuous part A and part B coverage), with bone cancer, or with evidence of previous fracture (i.e., prevalent fractures).

‡ Negative excess costs during the 40-week follow-up period may be the result of a high proportion of deaths among persons with a pelvis fracture.

† The row total differs from the column total because of rounding.

Fractures — Continued

characterized. The race- and sex-specific fracture incidence rates in this report reflect known differences in bone density between the sexes and among racial groups. For example, women have lower peak bone density and lose bone more rapidly than men; similarly, whites have lower bone mass and may lose bone more rapidly than blacks (2). These findings also highlight the increased risk among older women—particularly white women—for fractures later in life.

The total excess costs to Medicare for all fracture sites combined (\$4.2 billion) represent 3% of the total annual federal outlay for the Medicare program for 1992 (\$138.3 billion) (7). However, the excess costs to Medicare described in this report represent only part of the total costs of health care for fractures among the elderly; these excess costs omit beneficiary deductibles, copayments, and other out-of-pocket expenses (8) and estimates for persons excluded from the study. The number of persons aged ≥ 65 years is projected to increase from 32.0 million to 51.5 million during 1990–2020; with a concomitant increase in the proportion of the U.S. population at risk for age-related fractures, excess costs to Medicare for fracture treatment are likely to increase steadily. Future estimates of the cost impact of fractures also must consider these additional costs to the health-care system and social costs related to functional impairment and disability resulting from fractures.

The findings in this report include cost estimates to Medicare for several fracture types for which specific costs have not previously been characterized. Vertebral compressions, which are among the more common fractures among older persons, were not included in this study because onset often is gradual and painless; in addition, because there are no uniform diagnostic criteria for vertebral compressions, these fractures are likely to be underreported.

The findings in this report emphasize the need for further characterization of modifiable risk factors for fractures at specific sites and improved interventions for fracture prevention. Strategies for primary prevention of fractures optimally should include maximizing bone density during adolescence and young adulthood through measures such as promoting a calcium-rich diet and physical activity, and later in life, by reducing falls. Current efforts for primary prevention, which have especially been directed toward perimenopausal white women, include promotion of adequate dietary intake of calcium, regular weight-bearing physical activity, avoidance of smoking and excess alcohol consumption, and elimination of host and environmental causes of falls (e.g., poor balance or household obstacles, respectively) (2,9,10). Strength and balance training also may effectively reduce the incidence of falls and subsequent fractures among older adults (9). Strategies for secondary prevention for high-risk postmenopausal women include bone-density screening; hormone-replacement therapy; or for women with low bone density, the use of agents that retard bone resorption (9). Reduction of fractures among the elderly requires increased awareness among the public and health-care providers about this problem, therapies, and modifiable risk factors.

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Fractures — Continued

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