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001. note	re: phone numbers (partial) (2 pages)	n.d.	P6/b(6)

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Prevention [Folder 3]

2012-0463-S
rc819

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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b(1) National security classified information [(b)(1) of the FOIA]
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b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Sheet
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John [redacted] [001] Preventiv- benefits

[redacted]

Medicare and You handbook
every single bennie

[redacted]

2. Medicare & you hanbook
2 months before they turn 65

3. Preventive benefit brochure (upon req.)
(tear off card to take to MD)

4. Mammography (w/NCI)

5. Flu

Sandy
~~Kappend~~
Kappert
410 786 6890

6. Osteoporosis

7. Colorectal screening

8. in FFS & you get svcs, Medicare
Summary notice is how
much Medicare paid
on that form there
is a rotating set of
preventives benefit msgs
handled out of Carriers &
FI

Nancy Kahn 410 786 8374
Glen Reidel 410 786 2133

9. AARP
Ann Harvey

billing
statement
hold for
Y2K
changes

contractors
do on their
own
stat
one # →
RDs
any
materials
that
carriers

10. Phil Gambino [P6/(b)(6)]

11. Annual COLA increase

11. on Part B premium billing

12. REACH
regional Ed about
community presentations
Tom Kickham
410 786 6503 [P6/(b)(6)]

13. State Health insurance
Asst Prog
as part of training
in person delivery.

Initiative → the
Healthy Aging Project

Jeff Kang
Katherine Gorton
Rob [P6/(b)(6)]

Your Turn

The following question was asked of the readers of the Journal of Gerontological Nursing:

To what extent are wellness and health promotion strategies available to nursing facility residents (e.g., routine mammograms, nutrition education)?

Wellness and health promotion interventions are not generally available to nursing facility residents. Nursing home residents are not routinely evaluated for even simple preventive strategies. Dietary interventions occur, usually as a response to an actual problem such as skin breakdown or diabetes, and even these are in response to federal regulations requiring a dietary assessment in the presence of specific health problems.

Psychological and social issues are addressed similarly—only after a problem has been documented. Beyond simple podiatry and dentistry services, nursing facility residents are not provided with the readily available preventive and health promotion strategies of which the rest of us can take advantage. On the other hand, millions of Medicare dollars are spent on treatment modalities such as physical, occupational, and speech therapy for nursing facility residents who have developed health problems. Wouldn't it be more effective and efficient to spend some of those dollars preventing health problems and promoting health?

JoAnn Heath, RN, C
Director of Nursing
Dial-a-Nurse
Fort Myers, Florida

As a nurse paralegal working both in the legal industry and in a nursing facility, I find wellness promotion sorely lacking. Yes, we have restorative nursing, but where is massage therapy, where is aromatherapy and simple herbal therapy in health care? Not many of our octogenarians have mammograms and cancer screens. Only recently, has consensual sex been accepted and recognized, as well as AIDS awareness education been taught in skilled nursing homes.

Kathryn Jacobs, LPN, SSA
Nurse Paralegal
Manor Care
Boynter Bead, Florida

> **Education at any level of our lives is good. My elderly residents love to learn.**
>
> *~Sandra Rekkedal, RN*

There is minimal education on specific issues at our facility except what a doctor may visit about with their patients or a nurse may explain about a medication or procedure. Otherwise, the Activities Department has regular exercise and other healthful living sessions.

Ray Poe, BBA
Administrator
Lutheran Homes Society
Muscatine, Iowa

At the nursing facilities where I work, wellness and health promotion strategies are nonexistent. If a lump on a breast was found, it would be treated, but routine mammograms on all female residents are not cost effective. The same is true for nutrition. The residents with poor intake are given supplements. Education on other health topics are not provided. There is too wide a range of mental functioning in a typical nursing home.

Karen A. Knipper, RN, AAS, AS, AA
Registered Nurse
Geneva Care Center
Batavia, Illinois

This question is two-fold. On one hand, we have doctors and families who want routine examinations for their residents. On the other hand, there are those who want nothing done. The bottom line is the effect on the residents, if the outcome of the examinations will be favorable and the treatment within reason. Obviously, a woman of 100 plus years in good health but questionable longevity would not be a candidate for extensive examinations.

Education at any level of our lives is good. My elderly residents love to learn. We have access to several wellness and health promotions if we make the initial contact. No one is searching out the elderly on their own after they are confined to a long-term facility.

Unless, sad to say, money is in the picture.

Sandra Rekkedal, RN
Director of Nursing
Heartland Care Center
Devils Lake, North Dakota

There are no mammograms or prostate examinations. There are no nutrition education for people with special needs, such as diabetes. There are no alternative health care, such as acupressure, acupuncture, chiropractic, or nutritionist. There is excellent assessment for physical, occupational, and speech therapies because reimbursement is available; however, follow up is limited.

Cynthia Ross, MA
Long-Term Care Ombudsman
Northcoast Advocacy Services
Eureka, California

Wellness and health promotion programs have been a part of the health care delivery philosophy since the facility (Pennswood Village) opened in 1981. We have encouraged high-level wellness which accepts a more holistic view of resident responsibility coupled with freedom to choose any of the wellness programs available.

The mean age of the 351 residents is 83.4. The campus is located in lovely Bucks County, Pennsylvania. It has been a developmental process designing the wellness programs. At first, we only had wellness workshops and wellness/health promotions handouts. We did a survey to determine what the residents were interested in and designed the workshops around the results.

From this survey, we have developed a full program that includes:

- A full fitness center staffed by a physical therapist and a personal trainer. More than half of the residents actively and regularly use this center to promote balance, strength, stamina, energy, and to prepare for elective surgery, which helps shorten recovery time. This center is open 6 days a week.
- Geriatric Gyrations is a resident-led program which features gentle stretching and flexibility. This program is held three times a week and is also available on the internal cable television station so residents can participate in their rooms.
- Osteoporosis screening and intervention offers a full range of methods for preventing and/or treating osteoporosis and osteopenia. Of the first 98 residents screened, both men and women, only 7 residents had normal DEXA bone density scans. This particular screening program has great potential for helping older adults live better. Cost-saving implications are great.
- Sigmoidoscopy screening also is part of the program. It is performed on site, and over the past 15 years of performing these screenings, we have found multiple polyps and other lesions which could be taken care of while small.
- Full immunization, nutrition, vision, hearing, dental, and podiatry services are available on site.
- An incontinence center has been available on site for several years and is staffed by a geriatric nurse practitioner. Biofeedback techniques are used to help residents gain better urinary and bowel control.
- Vaginal health care and vaginal estrogen are used to help prevent urinary tract infections, uterine prolapses, vaginal vault prolapses, cystoceles, and rectoceles. We also perform our own pessary care to help keep the older residents comfortable without surgery.
- A wellness/health promotion section is now a part of our main resident library. We also place current health/wellness periodicals in our outpatient waiting room.
- Mammograms and DEXA scans are performed off site.
- A tracking summary of each resident's wellness schedule is kept on the front of each chart. This enables us to send appropriate reminders when tests, such as mammograms, or immunizations are due.
- The facility's swimming and therapeutic pools will be open within the next few years. At present, we have two cooperative ventures with local pools that provide lap swimming and an arthritis program. The facility provides transportation to these pools.
- Alternative/Complementary health care plays a part in our wellness/health promotion program. We offer access to massage, acupuncture, Tai Chi, shiatsu, electromagnetic therapy, and phytotherapy. We have found these to offer great comfort to the residents.
- A Health, Food, and Fitness Fair is held every 2 years. This is a wonderful event offering walking contests, demonstrations of wellness activities such as Tai Chi, samples of nutritious foods, and a variety of fun-related activities.
- An outdoor walking trail is

We have encouraged high-level wellness which accepts a more holistic view of resident responsibility coupled with freedom to choose any of the wellness programs available.

~Sandra G. Crandall, RN, CS, MSN, CRNP

available, and an indoor measured course is also available in case of inclement weather.

We have been very fortunate to have a wellness program. It encourages all of us to live with high-level wellness.

Sandra G. Crandall, RN, CS, MSN, CRNP
Geriatric Nurse Practitioner
Pennswood Village
Newtown, Pennsylvania

I was a Director of Nursing Services for 7 years in facilities in Alaska, Washington state, and Idaho before accepting my current teaching position. I have found routine mammograms are not routine unless the facility has an in-house advanced nurse practitioner who orders and monitors such tests.

However, nutrition education is an everyday priority with HCFA's regulations on weight loss prevention. Interviews with residents to identify personal likes and dislikes and ethnic and cultural preferences are performed by the dietitian on admission and at least every 90 days at the interdisciplinary team conference with the resident and family. At these conferences, the physician's diet order is explained as related to the disease process, what these dietary restrictions hope to attain for the resident in quality of life and longevity, and how individual preferences can be assured especially because of institutional food and the decrease in taste buds. Choices are offered as much as possible regarding time of eating (e.g., early or late breakfast), type (e.g., meat or fish) and preparation of food (e.g., baked, broiled).

At the mandatory inservice education classes for all staff, including CNAs and licenced staff, the dietitian, supported by the director of nursing services, teaches how important liquids are to continence, both bowel and bladder, and also other techniques for feeding assistance for needed calories to prevent weight loss. Sometimes the speech pathologist will show a video of a "cookie swallow," illustrating dysphagia which necessitates different thicknesses of food and liquid. Watching that video makes an indelible impression on staff! Nutrition education is an ongoing process with the residents and the staff who offer them healthy choices.

Nutrition education is an ongoing process with the residents and the staff who offer them healthy choices.
~Maxine M. McCue, RN, MS

Maxine M. McCue, RN, MS
Nursing Instructor
College of Eastern Utah, San Juan Campus
Blanding, Utah

This question was submitted by Mildred O. Hogstel, PhD, RN, C, Gerontological Nursing Consultant, Fort Worth, Texas. Her commentary follows:

It was good to see so many responses to this question. I have been concerned about the apparent lack of wellness and health promotion strategies in nursing facilities for many years. I realize there may be a general focus on various activities (e.g., nutrition, and perhaps health education), but I wondered to what extent regular hypertension, mammogram, colon, and bone density measurement screenings were being performed. Hypertension screening should be relatively easy and inexpensive. The others are now covered by Medicare, and prostate specific antigen screening soon will be.

If nursing facility residents have the same rights as any other citizen on Medicare and if they (or their responsible party) consent to these screenings, they should be made available. These prevention strategies should ultimately save lives and money. Educational programs informing residents of the need and availability of such screenings should be considered. I am encouraged by the excellent wellness program in Pennsylvania described by Ms. Crandall.

United States General Accounting Office

GAO

Report to the Subcommittee on Aging, Committee on Labor and Human Resources, U. S. Senate

October 1989

IN-HOME SERVICES FOR THE ELDERLY

Cost Sharing Expands Range of Services Provided and Population Served

GAO/HRD-90-19

GAO mailed a questionnaire to all state units on aging and all 675 area agencies on aging and also examined in detail certain aspects of cost-sharing programs in three jurisdictions. All 50 states and Washington, D.C., and 73 percent of the area agencies on aging responded.

Results in Brief

A growing number of state and area agencies on aging charge some elderly clients fees for in-home services funded through private and government sources. Typically, agencies use cost sharing for services that have a relatively high cost per client, such as adult day care and homemaker services.

Agencies on aging that responded to GAO's survey had a generally positive attitude toward cost sharing. Whether or not they currently cost-shared, respondents were more likely to favor than oppose amending OAA to authorize the practice specifically. Agencies that cost share indicated that it (1) allows them to serve more elderly clients and broaden the range of services provided and (2) is more likely to reduce than increase the possible welfare stigma associated with agency-provided services.

To preserve their commitment to serving the low-income elderly, cost-sharing agencies have built into the program such protections as sliding fee scales. Indeed, because their incomes are below the minimum at which charges are levied, most clients still receive the cost-shared services free. Among those paying fees, the fees represent a small share of income and cover only a fraction of the cost of providing the service. Eligibility and fees generally are based on self-reporting of income.

Principal Findings

Cost Sharing Extensively Used

Currently, cost sharing for in-home services funded by federal (other than OAA), state, and private sources is used to some extent in 36 states. About a third of the area agencies on aging responding to our survey use cost sharing. Most often, such services as adult day care, home health, and personal care services come under cost sharing. There appears to be little use of it for access services, such as transportation, outreach, and information and referral, or for services traditionally supported through volunteer efforts, such as home-delivered meals and friendly visits. (See pp. 12-15.)

Table 2.1: States With Cost-Sharing Agencies

State	Area agencies within the state (As of May 1988)	Area agencies responding to survey: No. responding	Cost sharing: No.	Cost sharing: Percent
Cost sharing done by area agencies:				
Maine	5	5	6	100
Oregon	18	10	10	100
Utah	12	3	3	100
Washington	13	9	9	100
Kentucky	15	13	12	92
New York	60	43	37	86
Idaho	6	5	4	80
Hawaii	4	4	3	75
Massachusetts	23	16	11	69
Florida	11	10	5	50
Pennsylvania	51	37	18	49
Georgia	18	14	5	36
Nebraska	8	7	2	29
South Carolina	14	11	3	27
Maryland	19	11	3	27
Virginia	25	24	6	25
Wisconsin[a]	7	4	1	25
West Virginia	9	5	1	20
Montana	11	8	1	18
North Carolina	19	12	2	17
New Jersey	22	15	2	13
Oklahoma	11	8	1	13
Tennessee	9	8	1	13
Illinois[a]	13	10	1	10
Kansas	11	10	1	10
Texas	28	20	2	10
California	33	24	2	8
Michigan	14	12	1	8
Ohio	13	12	1	8
Louisiana	48	30	1	3
Cost sharing done only by state agency:				
Connecticut				
Missouri				
North Dakota[b]				
South Dakota[b]				
Rhode Island[b]				
Vermont				

[a]The state unit on aging as well as at least one area agency requires elderly persons to help pay for the in-home services they receive.
[b]Has no area agencies on aging.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

COST SHARING UNDER THE OLDER AMERICANS ACT

JUNE GIBBS BROWN
Inspector General

MAY 1996
OEI-05-95-00170

FINDINGS AND ISSUES

All States collect voluntary contributions and two-thirds of the States make use of cost share programs. States' specific experiences with these practices will affect their readiness to implement Title III cost sharing.

Services cost shared

Thirty-six States reported to us that they have some sort of cost share program for services to elderly people. These programs vary in terms of services cost shared, and in SUA, AAA, and service provider responsibilities for billing, collection, and other procedures. Table 1 alphabetically lists the States which reported to us that they cost share, and the services for which they do this. In-home personal services and adult day care programs are the most commonly reported cost shared services.

Services with voluntary contribution collections

All of the States collect voluntary contributions for some services. As with cost sharing, States vary greatly in their voluntary collection activities. Table 2 alphabetically lists the States and the services for which they collect voluntary contributions. After nutrition services, transportation is the most common service for which voluntary funds are collected.

AAA involvement

In 13 States, all of the AAAs are involved in cost sharing programs and activities. In seven other States, some of the State's AAAs are involved in cost sharing programs, either because AAAs may choose whether to cost share, or because of pilot projects or other special programs within the State.

In 11 States cost sharing for services occurs without any AAA involvement. In these cases the State either contracts directly with local providers, or in a few cases, the cost sharing is conducted through an entirely different State agency. In these cases, the SUA also has no current experience with cost sharing practices.

In terms of conducting cost sharing with Title III funds, current AAA involvement with cost sharing programs will be important because Title III funds are generally funneled out to the local providers through the AAAs. (An exception to this case will be 5 States where the State agency is also the State's only AAA.)

States that Cost Share, By Type of Service

Table 1

	congregate meal	home del. meal	in-home medical	in-home personal	adult day care	transpt.	legal asst.	case mgt.	other
AK	P	P	P	P	CS	P	P	CS	CS (respite)
CA	P	P	P	P	CS	P	P	P	
CT	P	CS	CS	CS	CS	P	P	CS	
DC	P	P	P		P	CS	P	P	P(health promotion+)
GA	P	CS	CS	CS	CS	CS	P	P	
HI	P	P		CS	P	P	P	P	P(escort)
ID	P	P		CS	P	P			
IL	CS			CS	CS	P		P	P(senior companion)
IN	P	CS	CS	CS	CS	CS	P	CS	
KS				CS					
KY	P	CS	P	CS	CS	P	P	P	CS (respite+)
LA	P	CS	P	CS	P	P	P	P	
MA	P	CS	CS	CS	CS	CS	P	P	CS (alzheimer)
MD	P	P	CS	CS	CS	CS	CS	CS	
ME	P	P	CS	CS	CS	P	P	CS	
MN	P	P	CS	CS	CS	CS	P	P	
MO	P	P	CS	CS	P	P	P	P	
ND	?	?	?	?	?	?	?	?	?
NE	?	?	?	?	?	?	?	?	?
NH	P	CS	P	P	CS	P	P	P	
NJ	?	?	?	?	?	?	?	?	?
NM	P	P	P	CS	CS	P	P	CS	CS (respite)
NV	P	P		P	CS	P	P	P	
NY	P	P	P	CS	P	P	P	P	CS (respite+)
OH	P	CS		CS	CS	CS	P	P	
OR	P	P	P	CS	CS	P	P	P	
PA	P	P	CS	CS	CS	CS	P	P	CS (attendant)
RI	P	P	CS	P	CS	CS	P		
SC	P	CS		CS	CS	P	P	P	
SD	P	P	CS	CS	P	P	P		
VA	P	P	CS	CS	P	CS	P	P	
VI	?	?	?	?	?	?	?	?	?
VT	P	P	P	CS	CS	CS	P	P	P(?)
WA	?	?	?	?	?	?	?	?	
WI	?	?	?	?	?	?	?	?	?
WY	P	P		CS	CS	P	P	CS	
TOT	1	9	12	24	21	11	1	7	6

CS = cost sharing for service
P = service provided but not cost shared
If blank, service not provided (with State/local funds)
? = non response to the survey or question
Totals reflect number of States that cost share the service.

QMB

Bill Summary & Status for the 106th Congress

Item 4 of 4

PREVIOUS BILL | NEXT BILL
PREVIOUS BILL:ALL | NEXT BILL:ALL
NEW SEARCH | HOME | HELP

H.R.1455
SPONSOR: Rep McDermott, Jim (introduced 04/15/99)

Jump to: Titles, Status, Committees, Amendments, Cosponsors, Summary

TITLE(S):

- SHORT TITLE(S) AS INTRODUCED:
  QMB Improvement Act of 1999

- OFFICIAL TITLE AS INTRODUCED:
  A bill to amend title XI of the Social Security Act and the Internal Revenue Code of 1986 to establish a mechanism to promote the provision of Medicare cost-sharing assistance to eligible low-income Medicare beneficiaries.

STATUS: Floor Actions

NONE

STATUS: Detailed Legislative Status

House Actions

Apr 15, 99:
Referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.
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STATUS: Congressional Record Page References

04/15/99 Introductory remarks on Measure (CR E681)

COMMITTEE(S):

- COMMITTEE(S) OF REFERRAL:
  House Ways and Means
  House Commerce

AMENDMENT(S):

NONE

COSPONSORS(2):

Rep Stark, Fortney Pete - 04/15/99 Rep Berry, Marion - 04/15/99

SUMMARY:

NONE

HR 1455 IH

106th CONGRESS

1st Session

H. R. 1455

To amend title XI of the Social Security Act and the Internal Revenue Code of 1986 to establish a mechanism to promote the provision of Medicare cost-sharing assistance to eligible low-income Medicare beneficiaries.

IN THE HOUSE OF REPRESENTATIVES

April 15, 1999

Mr. MCDERMOTT (for himself, Mr. STARK, and Mr. BERRY) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To amend title XI of the Social Security Act and the Internal Revenue Code of 1986 to establish a mechanism to promote the provision of Medicare cost-sharing assistance to eligible low-income Medicare beneficiaries.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `QMB Improvement Act of 1999'.

SEC. 2. MECHANISM PROMOTING PROVISION OF MEDICARE COST-SHARING ASSISTANCE TO ELIGIBLE LOW-INCOME MEDICARE BENEFICIARIES.

(a) IN GENERAL- Part A of title XI of the Social Security Act is amended by adding at the end the following:

`PROMOTING PROVISION OF MEDICARE COST-SHARING ASSISTANCE UNDER MEDICAID PROGRAM FOR IDENTIFIED LOW-INCOME MEDICARE BENEFICIARIES

`SEC. 1147. (a) REQUIREMENT FOR DATA MATCH-

`(1) REQUESTING MATCHING INFORMATION- The Commissioner of Social Security shall, not less often than annually beginning with 2001, transmit to the Secretary of the Treasury a list of the names and TINs of Medicare beneficiaries (as defined in section 6103(l)(15) of the Internal Revenue Code of 1986) and request that such Secretary disclose

to the Secretary of Health and Human Services the information described in subparagraph (A) of such section.

`(2) SPECIFICATION OF INCOME LEVELS- The Secretary shall specify--

`(A) the items that will be included in determination of income for purposes of applying this section and section 6103(l)(15)(A)(i) of the Internal Revenue Code of 1986; and

`(B) the levels of such income (based upon a percentage of the Federal poverty guidelines) that individuals may have and qualify for medical assistance under section 1902(a)(10)(E)(i) of the Social Security Act (relating to assistance for Medicare cost-sharing benefits under the Medicaid program).

`(b) NOTICE TO INDIVIDUALS IDENTIFIED-

`(1) INITIAL ELIGIBILITY- The Secretary promptly shall provide for an appropriate notice to each individual identified under subsection (a) who is described in section 6103(l)(15)(A)(i), of the following:

`(A) Subject to subparagraph (B), the individual is deemed eligible for some form of medical assistance for some Medicare cost-sharing under clause (i) or (iii) of section 1902(a)(10)(E), depending on the individual's level of income.

`(B) By accepting such assistance the individual is obligated to notify the Secretary if the individual is not eligible for such assistance due to--

`(i) the individual having tax-exempt income;

`(ii) the individual having countable assets in excess of the maximum permissible assets, if the individual resides in a State that imposes an asset test for such eligibility; or

`(iii) the individual otherwise is not eligible for such assistance.

`(C) If the individual accepts such assistance notwithstanding that the individual is not eligible, the individual is liable to the State for the amount of medical assistance provided (with interest).

`(2) CONTINUED ELIGIBILITY- The Secretary shall provide for an appropriate notice to each individual identified under subsection (a) who is described in section 6103(l)(15)(A)(ii), of the following: `Unless the individual declines coverage or indicates otherwise, the individual will be enrolled for the appropriate assistance with Medicare cost-sharing under the State plan operated under title XIX for the State in which the individual resides.'

`(c) NOTICE TO STATE- In the case of an individual who is identified under this section and resides in a State, the Secretary shall provide for appropriate notice to the State of the individual's eligibility for medical assistance under clause (i) or (iii) of section 1902(a)(10)(E), as the case may be.'.

(b) CONFORMING AMENDMENT TO MEDICAID PROGRAM- Section 1902 of such Act (42 U.S.C. 1396a) is amended by adding at the end the following:

`(aa) A State shall treat an individual who is identified under section 1147(b) as being eligible for medical assistance under clause (i) or (ii) of subsection (a)(10)(E) as being so eligible, until the Secretary notifies the State otherwise, with respect to medical assistance for items and services furnished on or after the date of the notice.'.

(c) AUTHORIZATION OF DISCLOSURE- Section 6103(l) of the Internal Revenue Code of 1986 (relating to disclosure of returns and return information for purposes other than tax administration) is amended by adding at the end the following new paragraph:

`(15) DISCLOSURE OF CERTAIN INFORMATION IN ORDER TO QUALIFY FOR MEDICARE COST-SHARING ASSISTANCE-

`(A) IN GENERAL- The Secretary shall, upon written request from the Commissioner of Social Security, disclose to the Secretary of Health and Human Services, whether with respect to any Medicare beneficiary (as defined in paragraph (12)(E)(i)) identified by the Commissioner--

`(i) there has not been filed an income tax return for the most recent period for which the Secretary has information; or there has been such a return filed and the amount of the gross income (or the sum of such elements of gross income as the Secretary of Health and Human Services may specify) is below such level (or levels) as such Secretary may specify to carry out section 1147(b) of the Social Security Act, treating the number of dependents as the size of the family involved; and

`(ii) whether, for such an individual who qualified for Medicare cost-sharing assistance described in section 1147 at any time in the previous year, the individual is still described in clause (i).

`(B) DISCLOSURE BY HEALTH CARE FINANCING ADMINISTRATION- With respect to information disclosed under subparagraph (A), the Administrator of the Health Care Financing Administration may disclose to the appropriate officials of a State responsible for administration of a State plan under title XIX of the Social Security Act the name, address, and TIN of the preliminary eligibility determination.

`(C) SPECIAL RULES-

`(i) RESTRICTIONS ON DISCLOSURE- Information may be disclosed under this paragraph only for purposes of, and to the extent necessary in, determining the extent to which an individual beneficiary is entitled to medical assistance under a State plan under title XIX of the Social Security Act for some or all Medicare cost-sharing.

`(ii) TIMELY RESPONSES TO REQUESTS- Any request made under subparagraph (A) shall be complied with as soon as possible but in no event later than 60 days after the date the request was made.'.

END

UNITED STATES SENATE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
WASHINGTON, DC 20510-6300

DATE: 5/27/99

TO: Devora 456-5557

FAX NUMBER: David Nexon

FROM:

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NUMBER OF PAGES: 3 (including cover)

MESSAGE:

If you have trouble receiving this fax, please call (202) 224-7675

-revised-

KENNEDY PROPOSAL TO INCLUDE A PROGRAM TO IMPROVE THE HEALTH OF THE ELDERLY IN THE PRESIDENT'S MEDICARE REFORM INITIATIVE

An effective program to improve the health of the elderly should be a part of the Administration's Medicare Reform Initiative. Improving the health of Medicare beneficiaries is a worthy goal in its own right. It may also contribute significantly to reducing Medicare's long-term spending, since healthier senior citizens will use fewer medical services.

A significant part of the program would encourage the elderly to take greater responsibility for their own health. This goal is consistent with one of the President's major themes -- helping the elderly to take care of themselves.

The ability to achieve better health and lower costs through greater use of preventive health services by the elderly is clear. Illnesses due to pneumonia and influenza cost Medicare $3 billion annually. Yet half of all senior citizens are not vaccinated against pneumonia and one-third of all senior citizens do not receive recommended flu shots. Only 28% of elderly women receive mammograms. Eighty-eight percent of the elderly have not received recommended screening for colon cancer.

The large majority of senior citizens are health-conscious and would be interested in taking steps to improve their own health. Experts agree that the potential for better health from exercise, diet, accident prevention and other health promotion and disease prevention activities is great. Too often, however, the elderly lack accurate information to take advantage of these measures.

The elderly also suffer from the gap between "best" practice and "typical" practice in health care:

- Seventy-nine percent of elderly heart attack victims fail to receive indicated treatment with beta blockers following a heart attack--and they suffer a 75% higher death rate as a result.
- A five-fold variation exists in death rates after surgery for coronary artery bypass, depending on the institution and region of the country in which the surgery is performed.
- Strokes attack three million Americans annually--a high proportion of them Medicare enrollees--at a cost of $30 billion a year. Victims receiving new clot-dissolving drugs in the first few hours after a stroke recover more fully and quickly than other patients, but the timely use of this new therapy is far from universal.
- Twenty percent of Medicare beneficiaries have received drugs that should never be prescribed for those over 65. The total cost to Medicare of improper use of prescription drugs is estimated by the GAO to exceed $20 billion annually.

The best managed care plans in the private sector are beginning to address these health quality issues, but fee-for-service Medicare has not made them a priority, despite positive work

done by the PRO program.

The opportunities for better health care and substantial savings are also significant if care can be delivered to beneficiaries with chronic conditions in a more coordinated and effective way. These patients are among the highest-cost users of Medicare services. Diabetics are an extremely high-cost group, but current care for Medicare beneficiaries rarely meets appropriate standards of quality. Up to three-quarters of diabetics do not receive recommended eye examinations, depending on the part of the country in which they live. Up to 90% are not monitored appropriately for glucose control. Such failures lead to unnecessary blindness, amputations, and other severe complications. Several studies have shown that improved medical care for nursing home patients can significantly reduce hospital costs.

A comprehensive proposal to address these issues would have five components:

(1) A HCFA mission statement which includes assuring high quality care and health promotion and disease prevention.

(2) A requirement for HHS, in cooperation with other agencies of the federal government and the private sector, to assist beneficiaries to improve their own health through preventive services and activities such as better diet, exercise, and accident prevention.

(3) Measures to provide more effective and coordinated care to beneficiaries with high-cost chronic illnesses.

(4) Measures to improve the quality of care for senior citizens.

(5) A White House conference on improving the health of senior citizens, to involve the elderly, professional societies, hospitals, community organizations, researchers, and others in addressing these goals.

Date: _____

FAX

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

To: Dcvorsh
Fax:

From: Greg W

Number of Pages (excluding cover): 1

Subject:

65557

Voice Numbers:

Health Division (Front Office)	202/395-4922
Health & Human Services Unit	202/395-4925
Health Programs & Services Branch	202/395-4926
Health Financing Branch	202/395-4930

Fax Numbers:

Health Division (Front Office)	202/395-3910
Health Division (Room 7001)	202/395-7840
Health Division (Room 7002)	202/395-5648

Health Care Financing Administration
Center for Beneficiary Services
Funding Snapshot of FY 1999 Beneficiary Awareness and Education Outreach Activities

Outreach Topic	Total FY 99 Funding	M+C User Fee Funds	Program Mgt. Funds	PRO Funds	BBA Funds	Admin Funds
Education Program: Beneficiary Materials	$48.1M 1/	$33.9M	$14.2M			
Education Program: Toll Free Line	$26M 1/	$26M				
Education Program: Internet	$4.1M 1/	$3.4M	$600K	$100K		
Education Program: Community-Based Outreach	$26.7M 1/	$15.7M	$11M			
Education Program: Program Support Services	$28.5M 1/	$18.7M	$2.2M	$7.6M		
Grassroots Rights and Protections Outreach Project	$1.3M 2/					
Health Promotion: Prevention Projects	$1.39M 3/			$1.39M		
Health Promotion: Maternal Aids Consumer Information	$218K					$218K
Special Nursing Home Initiatives	$2.6M			$2.6M		
Special QMB/SLMB Outreach Projects	$2.8M		$2.8M			
Health Promotion: Video Production	$1M				$1M	
Special Y2K Beneficiary Outreach	$5.4M (Millenium funding source)					
TOTAL	$148.1M					

1/ Reapportionment request for funding amounts pending OMB approval
2/ Funding Source not yet determined--project pending approval
3/ Specific prevention projects are Bone Mass Measurement, Cervical Cancer Prevention, Colorectal Cancer Screening, Diabetes Self-Education Information, and Prostate Cancer Screening

How To Apply For Social Security Retirement Benefits

When To Apply

Generally, we advise people to apply for retirement benefits 3 months before they want their benefits to begin. Even if you have no plans to receive benefits because you plan to continue working, you should still sign-up for Medicare 3 months before age 65.

How To Apply

You can apply by calling our toll-free number, **1-800-772-1213**. Our representatives there can make an appointment for your application to be taken over the telephone or at any convenient Social Security office.

People who are deaf or hard of hearing may call our toll-free "TTY" number, **1-800-325-0778**, between 7 a.m. and 7 p.m. on Monday through Friday.

What You Need

When you apply for benefits, you will need the following information:

- your Social Security number;
- your birth certificate;
- your W-2 forms or self-employment tax return for last year;
- your military discharge papers if you had military service;
- your spouse's birth certificate and Social Security number if he or she is applying for benefits;
- children's birth certificates and Social Security numbers, if applying for children's benefits;
- proof of U.S. citizenship or lawful alien status if you (or a spouse or child is applying for benefits) were not born in the U.S.; and
- the name of your bank and your account number so your benefits can be directly deposited into your account.

You will need to submit original documents or copies certified by the issuing office. You can mail or bring them to Social Security. We will make photocopies and return your documents.

When You Will Receive Benefits

A person who meets all other requirements for entitlement can receive benefits beginning with the first full month he or she is age 62. However, if benefits begin before age 65, they are reduced to account for the longer period over which they will be paid. Choosing the month you start to get benefits is an important decision. Our representatives will be glad to discuss it with you and answer any questions you may have.

Estimating Your Retirement Benefit

PEBES -- Personal Earnings and Benefit Estimate Statement -- shows your Social Security earnings history and how much Social Security taxes you have paid into the program. It also estimates your future benefits and tells you how to qualify for those benefits. The PEBES is a free service of the Social Security Administration.

Some publications online that will give you more information on retirement benefits:

- Retirement
- Social Security: What You Needto Know When You Get Retirement or Survivors Benefits
- How Work Affects Your Benefits
- How Your Retirement Benefit is Figured
- Government Pension Offset
- A Pension from Work Not Covered by Social Security
- Medicare
- Receiving Your Benefits By Direct Deposit
- Social Security: When You'll Get Your Benefit

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Social Security Administration

Medicare

SSA Publication No. 05-10043

June 1996

Why You Should Read This Information

Sooner or later, nearly everyone will be affected by Medicare, the nation's major federal health insurance program. In fact, if you pay taxes, you're already affected by Medicare because a portion of your taxes goes to finance part of the Medicare program.

Even though you're paying into the Medicare program during your working years, and will probably rely on its services in the future, you may not be aware of what benefits the program offers--and what it doesn't offer. The basic information in this booklet will give you an overview of the Medicare program. If you want detailed information or are interested in a specific part of the program, you'll need to get a copy of Your Medicare Handbook, published by the Health Care Financing Administration. The Handbook is mailed to Medicare beneficiaries when they become eligible for the coverage. See Section 7 for information about ordering the Handbook and other publications.

Please Note: This booklet does not list premium amounts, deductibles, coinsurance payments, and other figures that change every year. For the most up-to-date information about these numbers, ask Social Security for a copy of the factsheet Social Security Update (SSA Publication No. 05-10003).

Section 1--What Is Medicare?

Medicare is our country's health insurance program for people age 65 or older, certain people with disabilities who are under 65, and people of any age who have permanent kidney failure. It provides basic protection against the cost of health care, but it doesn't cover all your medical expenses nor the cost of most long-term care. You can choose one of two ways to get benefits under Medicare: the traditional fee-for-service system or the managed care program. To help you decide which way is best for you, read the descriptions in Section 5.

The Health Care Financing Administration is the agency in charge of the Medicare program. But we the people at the Social Security offices help you enroll in the program and give you general Medicare

information.

Medicare Has Two Parts

There are two parts of Medicare. They are:

Hospital Insurance (also called Part A Medicare)--which is financed by a portion of your payroll (FICA) tax that also pays for Social Security; and

Medical Insurance (also called Part B Medicare)--which is partly financed by monthly premiums paid by people who choose to enroll.

You are automatically enrolled in Part B when you become entitled to Part A. However, because you must pay a monthly premium for Part B coverage, you have the option of paying for the coverage or turning it down.

Each part of Medicare covers different kinds of medical costs, has different rules about enrolling, and so on. Because of these differences, the two parts of the Medicare program are described separately in many sections of this booklet.

A Word About Medicaid

Many people think that Medicaid and Medicare are two different names for the same program. Actually, they are two different programs. Medicaid is a state-run program designed primarily to help those with low income and little or no resources. The federal government helps pay for Medicaid, but each state has its own rules about who is eligible and what is covered under Medicaid. Some people qualify for both Medicare and Medicaid. For more information about the Medicaid program, contact your local social service or welfare office.

Section 2--Who Can Get Medicare And How To Sign Up

Hospital Insurance

If You Are 65 or Older

Most people 65 or older are eligible for Medicare hospital insurance (Part A) based on their own--or their spouse's-- employment. You are eligible at 65 if you:

- receive Social Security or railroad retirement benefits, or
- are not getting Social Security or railroad retirement benefits, but you have worked long enough to be eligible for them, or
- would be entitled to Social Security benefits based on your spouse's (or divorced spouse's) work record, and that spouse is at least 62 (your spouse does not have to apply for benefits in order for you to be eligible based on your spouse's work) or,

- worked long enough in a federal, state, or local government job to be insured for Medicare.

If You Are Under 65

Before age 65, you are eligible for Medicare hospital insurance if you:

- have been a Social Security disability beneficiary for 24 months, or
- have worked long enough in a federal, state, or local government job and you meet the requirements of the Social Security disability program.

If you receive a disability annuity from the Railroad Retirement Board, you will be eligible for hospital

insurance after a waiting period. (Contact your railroad retirement office for details.)

Eligibility For Family Members

Under certain conditions, your spouse, divorced spouse, widow or widower, or a dependent parent may be eligible for hospital insurance when he or she turns 65, based on your work record.

Also, disabled widows and widowers under age 65, disabled divorced widows and widowers under 65, and disabled children may be eligible for Medicare, usually after a 24-month qualifying period. (For disabled widows/widowers, previous months of eligibility for Supplemental Security Income (SSI) based on disability may count toward the qualifying period.)

If You Have Kidney Failure

There are special rules for people with permanent kidney failure. Under these rules, you are eligible for hospital insurance at any age if you receive maintenance dialysis or a kidney transplant and:

- you are insured or are getting monthly benefits under Social Security or the railroad retirement system, or
- you have worked long enough in government to be insured for Medicare.

In addition, your spouse or child may be eligible, based on your work record, if she or he receives continuing dialysis for permanent kidney failure or had a kidney transplant, even if no one else in the family is getting Medicare.

If You Do Not Qualify Under These Rules

Certain aged or disabled people who do not qualify for Medicare hospital insurance under these rules may be able to get it by paying a monthly premium.

Medicare Medical Insurance

Almost anyone who is 65 or older or who is under 65 but eligible for hospital insurance can enroll for Medicare medical insurance by paying a monthly premium. You don't need any Social Security or government work credits for this part of Medicare.

Aliens who are 65 or older and are not eligible for hospital insurance must be lawfully admitted permanent residents and must live in the United States for five years before they can enroll for medical insurance.

Help For Low-Income Medicare Beneficiaries

If your income and assets are very limited, you should know about programs that can help save you money. One is the Qualified Medicare Beneficiary or QMB program. The other is the Specified Low-Income Medicare Beneficiary or SLMB program. Both programs are run by the Health Care Financing Administration and the state agency that provides medical assistance under the Medicaid program. They differ in the amount of income that qualifies you for help.

If you qualify for the QMB program, your state will pay your monthly Medicare premiums. You will not have to pay the Medicare deductibles and coinsurance, which can save you a lot more money. If you qualify for the SLMB program, your state will pay only your medical insurance (Part B) monthly premium.

The rules vary from state to state. In general, you may qualify for help from the QMB or SLMB program if:

- your income is limited; and
- your resources do not exceed certain limitations. (Resources are things you own. But some things don't count. For example, the house you live in and some other things, such as a car, may not count.)

Only your state can decide if you qualify for help under the QMB or SLMB program. To find out if you qualify, contact your state or local medical assistance (Medicaid) agency, social service office, or welfare office. For general information, ask Social Security for a copy of the leaflet Medicare: Savings for Qualified Beneficiaries (Publication No. HCFA 02184).

Signing Up For Medicare

If you're already getting Social Security retirement or disability benefits or railroad retirement checks, we'll contact you a few months before you become eligible for Medicare and give you the information you need to sign up.

If you aren't already getting checks, you should contact us about three months before your 65th birthday to sign up for Medicare. You can sign up for Medicare even if you don't plan to retire at 65.

You should contact Social Security about applying for Medicare if:

- you're a disabled widow or widower between 50 and 65 but haven't applied for disability benefits because you're already getting another kind of Social Security benefit;
- you're a government employee and became disabled before 65;
- you, your spouse, or your dependent child has permanent kidney failure;
- you had Medicare medical insurance in the past but dropped the coverage; or
- you turned down Medicare medical insurance when you became entitled to hospital insurance.

Initially, you have seven months to sign up for medical insurance (Medicare Part B). This seven-month period begins three months before your 65th birthday, includes the month you turn 65, and ends three months after that birthday. If you enroll during the first three months of your enrollment period, your medical insurance protection will start with the month you are eligible.

If you enroll during the last four months, your protection will start one to three months after you enroll. If you don't enroll during this initial enrollment period, each year you are given another chance to sign up during a general enrollment period from January 1 through March 31. Your coverage begins the following July. Your monthly premium increases 10 percent for each 12-month period you were eligible but didn't enroll.

If you're 65 or older and don't qualify for Medicare, you can buy Part A coverage, much like private insurance, for a monthly premium. If you want to buy Part A hospital insurance, you must enroll in Part B and pay a monthly premium for that coverage as well. If you wait to buy Part A hospital insurance, the enrollment periods are the same as those for Part B, discussed above.

Section 3--What Medicare Covers

The two parts of Medicare are designed to help pay for different kinds of health care costs. Some kinds of health care aren't covered by Medicare at all. You can get specific information about Medicare costs, deductibles, and coinsurance rates by calling Social Security.

Medicare Hospital Insurance

Medicare hospital insurance can help pay for inpatient care in a hospital or skilled nursing facility following a hospital stay, home health care, and hospice care. Except for home health care, each is subject to a benefit period, which measures your use of services covered by Medicare Part A.

A benefit period starts the day you enter a hospital. It ends when you have been out of the hospital or other facility primarily providing skilled care for 60 days in a row. If you remain in such a facility (other than a hospital), a benefit period ends when you have not received any skilled care there for 60 days in a row. There is no limit to the number of benefit periods for hospital and skilled nursing facility care. But special limits do apply to hospice care. (See Section on Hospice Care.)

Inpatient Hospital Care

If you need inpatient care, hospital insurance helps pay for up to 90 days in any Medicare-participating hospital during each benefit period. Hospital insurance pays for all covered services for the first 60 days, except for a deductible. For days 61 through 90, hospital insurance pays for all covered services except for a daily coinsurance amount. (Coinsurance is the portion of the bill that the beneficiary is required to pay even after the deductible is met.)

If you are out of the hospital for at least 60 days in a row, and then go back in, a new benefit period begins--your 90 days of coverage starts all over again and you pay another deductible.

What if you need more than 90 days of inpatient care during any benefit period? You can use some or all of your reserve days. Reserve days are an extra 60 hospital days you can use if your illness keeps you in the hospital for more than 90 days. You have only 60 reserve days in your lifetime, and you decide when you want to use them. For each reserve day you use, hospital insurance pays for all covered services except for a daily coinsurance amount.

Skilled Nursing Facility Care

If you need inpatient skilled nursing or rehabilitation services after a hospital stay and you meet certain other conditions, hospital insurance helps pay for up to 100 days in a Medicare-participating skilled nursing facility in each benefit period.

Hospital insurance pays for all covered services for the first 20 days. For the next 80 days, it pays for all covered services except for a daily coinsurance amount.

NOTE: It is important to know that Medicare does not pay for custodial care when that is the only kind of care that you need. Custodial care is the type of care many people receive in nursing homes. It is care that could be given by someone who is not medically skilled (for example, help with dressing, walking, or eating).

Home Health Care

If you are confined at home and meet certain other conditions, Medicare can pay the full approved cost of home health visits from a Medicare-participating home health agency. There is no limit to the number of covered visits you can have. If you need one or more of the covered services, then hospital insurance also covers part-time or intermittent services of home health aides, occupational therapy, physical therapy, medical social services, and medical supplies and equipment. A 20-percent copayment applies to covered durable medical equipment (e.g., wheelchairs and hospital beds).

Hospice Care

A hospice program provides pain relief and other support services for terminally ill people. Medicare hospital insurance can help pay for hospice care for terminally ill beneficiaries if the care is provided by a Medicare-certified hospice and certain other conditions are met.

Special benefit periods apply to hospice care. Hospital insurance can pay for hospice care for a maximum of two 90-day periods and one 30-day period and one extension period of indefinite duration when the patient is terminally ill.

Medical Insurance Benefits

Medicare medical insurance helps pay for doctor's services and many medical services and supplies that are not covered by the hospital insurance part of Medicare, such as ambulance services, outpatient hospital care, and X-rays.

Deductible

Each year, before Medicare medical insurance begins paying for covered services, you must meet the annual medical insurance deductible. (A deductible is the amount a beneficiary must pay before Medicare begins paying.) After you meet that deductible, Medicare will generally pay 80 percent of the approved charges for covered services during the rest of the year.

Section 4--What Medicare Does Not Cover

Medicare provides basic health care coverage, but it doesn't pay all of your medical expenses. Here are examples of what Medicare does not pay for:

- custodial care--(This is care that could be given safely and reasonably by a person who is not medically skilled and that is given mainly to help the patient with daily living. Examples include help with walking, bathing, and dressing. Even if you are in a participating hospital or skilled nursing facility, or you are getting care from a participating home health agency, Medicare does not cover the cost of care if it is mainly custodial.)
- most nursing home care
- dental care and dentures
- routine checkups and the tests directly related to these checkups (except that some screening, Pap smears, and mammograms are
- covered)
- most immunization shots (except Part B helps pay for flu and pneumonia shots)
- most prescription drugs
- routine foot care
- services outside the United States
- tests for, and the cost of, eyeglasses or hearing aids and personal comfort items, such as a phone or TV in your hospital room

Section 5--Medicare Options

Medicare beneficiaries may now choose how they'll receive hospital, doctor, and other health care services covered by the program. And, your choice may affect the amount of money you pay for these services. Most people use the traditional fee-for-service delivery system--visiting the hospital or doctor of their choice and paying a fee each time they use a service. But more and more people are turning to health maintenance organizations (HMOs) that feature comprehensive coverage of services offered by a network of health care providers. Medicare coverage is the same under both systems. The differences include how the benefits are delivered, how and when payment is made, and the amount of out-of-pocket expenses required.

Fee-For-Service Systems

Under fee-for-service systems, Medicare pays a set percentage of a beneficiary's hospital, doctor, and other health care expenses, and the beneficiary is responsible for certain deductibles and coinsurance payments (the portion of the bill Medicare does not pay). Most people covered under a fee-for-service Medicare plan also purchase private insurance usually called Medigap or have retiree coverage available from their former employer or union to supplement their Medicare coverage (see Page 16 17).

Health Maintenance Organizations (HMOs)

HMOs that have contracts with the Medicare program must provide all hospital and medical benefits covered by Medicare. However, usually you must obtain services from your HMO's network of health care providers (doctors, hospitals, skilled nursing facilities, for example). In most cases, for services not authorized by your HMO (except emergency services or services urgently required while you are out of the HMO's service area) neither the HMO nor Medicare will pay for these services.

If you enroll in an HMO that has a contract with Medicare, the HMO will receive a monthly payment from Medicare, and you will have to enroll in Medicare Part B and continue to pay your Part B monthly premium. Most HMOs charge a monthly premium for enrollees in addition to a small copayment each time you use a service. Usually, no additional charges are made no matter how many times you visit the doctor, are hospitalized, or use other covered services. HMO members usually do not need a Medigap policy.

Many HMOs that have contracts with the Medicare program also provide benefits beyond those Medicare pays for. These include preventive care, prescription drugs, dental care, hearing aids, and eyeglasses. The benefits may vary by HMO and you'll need to read the individual descriptions to determine which benefits are offered by each.

What If You Think You Need More Insurance?

Traditional fee-for-service Medicare coverage provides basic health care coverage, but it can't pay all of your medical expenses, and it doesn't pay for most long-term care. For this reason, many private insurance companies sell insurance to fill in the gaps in Medicare coverage. This kind of insurance is often called Medigap for short. However, Medigap insurance is not needed if you use an HMO (see section on Health Maintenance Organizations).

The Health Care Financing Administration publishes a booklet with information on supplementing Medicare coverage. It's called Guide To Health Insurance For People With Medicare (Publication No. HCFA 02110) and is available from any Social Security office or by writing to: Medicare Publications, Health Care Financing Administration, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Section 6--What You Should Know If You Have Other Health Insurance

As we've explained, Medicare hospital insurance is free, but you pay a monthly premium for medical insurance. If you already have other health insurance when you become eligible for Medicare, is it worth the monthly premium cost to sign up for Medicare medical insurance?

The answer varies with the individual, and the kind of other health insurance. Although we can't give you yes or no answers, we can offer a few tips that may be helpful when you make your decision.

If You Have A Private Insurance Plan

Get in touch with your insurance agent to see how your private plan fits--or integrates--with Medicare medical insurance. This is especially important if you have family members who are covered under the same policy. And remember, just as Medicare doesn't cover all health services, most private plans don't either. In planning your health insurance coverage, keep in mind that most nursing home care is not covered by Medicare or private health insurance policies. One important word of caution: For your own protection, don't cancel any health insurance you now have until your Medicare coverage actually begins.

If You Have Health Insurance From An Employer Group Health Plan

In this case, there are some special rules you should know about.

If you are age 65 or older and are (a) currently employed or (b) married to an individual of any age who is currently employed, and are covered under a group health plan, you may delay enrolling in Medicare medical insurance (Part B) and enroll during a special enrollment period. The rules allow you to enroll any time while you are covered under the group health plan or during a special eight-month period that begins with the month your group health coverage ends or the month employment ends-- whichever comes first. If you meet the requirements, you may not have to wait for a general enrollment period and you may not have to pay the 10-percent premium surcharge for late enrollment in Medicare. If however, the coverage or employment ends during the last four months of the initial enrollment period and you enroll for Medicare medical insurance during this period, protection will be delayed one to three months.

Group health plans of employers with 20 or more employees are required by law to offer workers who are 65 (or older) the same health benefits that are provided to younger employees. They must also offer the spouses who are 65 (or older)--of workers of any age--the same health benefits given younger spouses.

If you are 65 or older and have current employment or you are 65 or older and are the spouse of a person who has current employment--and you accept the employer's health insurance plan, Medicare will be the secondary payer. This means the employer plan pays first on your hospital and medical bills. If the employer plan does not pay all of your expenses, Medicare may pay secondary benefits.

If you reject the employer's health plan, Medicare will be the primary health insurance payer. The employer is not allowed to offer you Medicare supplemental coverage if you reject his or her health plan.

Remember that when you enroll in Medicare Part B at or after age 65, you will trigger your one-time Medigap open enrollment period.

If you enroll in Part B while you are covered under an employer plan that is the primary payer, you may not need a Medigap policy. Your Medicare Part B will be the secondary payer and your employer will be the primary payer. Later, when you are no longer covered by your employer plan, you may not be able to purchase the Medigap plan of your choice because your Medigap open enrollment period will have expired.

If on the other hand, you delay Part B enrollment until your primary employer plan coverage is about to stop, you will be able to use your open enrollment period to your best advantage. During open enrollment, you may purchase any Medigap plan from any company at its most favorable price for your age group. During this period, you can purchase policies that cover outpatient prescription drugs, which generally are not available outside of the open enrollment period unless you are healthy.

If you are under 65 and disabled, and you are currently employed or are the family member of a person who has current employment and you have health coverage under a large group health plan, Medicare will be the secondary payer. A large group health plan covers employees of an employer or group of employers of which at least one employer has 100 or more workers. If that's the case, you will also have special enrollment period and premium rights that are similar to those for workers 65 or older.

If you are entitled to Medicare because of permanent kidney failure and you have employer group health coverage, Medicare will be the secondary payer for the first 18 months of your Medicare Part A eligibility or entitlement. At the end of the 18-month period, Medicare becomes your primary payer.

If You Have Health Care Protection From Other Plans

If you have coverage under a CHAMPUS or CHAMPVA program, your health benefits may change or end when you become eligible for Medicare. You should contact the Department of Defense or a military health benefits advisor for information before you decide whether or not to enroll in Medicare medical insurance.

If you have health care protection from the Indian Health Service, Department of Veterans Affairs (DVA), or a state medical assistance program, contact the people in those offices to help you decide whether it is to your advantage to have Medicare medical insurance.

Questions?

We've covered a number of difficult rules in this section. If you aren't sure if any apply to you, contact Social Security for help. (But if you aren't sure about the size of the employer group health plan, check with the personnel office or the employer.)

Section 7--Want More Information?

It's difficult to summarize a program as complex as Medicare in a single booklet. If you have other questions about Medicare, please contact Social Security.

You can get more information 24 hours a day by calling Social Security's toll-free number: 1-800-772-1213. You can speak to a service representative between the hours of 7 a.m. and 7 p.m. on business days. Our lines are busiest early in the week and early in the month so, if your business can wait, it's best to call at other times. Whenever you call, have your Social Security number handy.

If you have a touch-tone phone, recorded information and services are available 24 hours a day, including weekends and holidays.

People who are deaf or hard of hearing may call our toll-free TTY number, 1-800-325-0778, between 7 a.m. and 7 p.m. on business days.

The Social Security Administration treats all calls confidentially--whether they're made to our toll-free numbers or to one of our local offices. That's one reason why if you've asked someone to call our office for you to discuss your personal business, you need to be with them when they call so we can verify you want their help. Our representative will ask your permission to discuss your business. We also want to make sure that you receive accurate and courteous service. That's why we have a second Social Security representative monitor some incoming and outgoing telephone calls.

Other Publications Available

The Social Security Administration produces many other publications and factsheets to give you information about other parts of the Social Security program. You can get a free copy of these publications from any Social Security office. Here's a list of some of the publications we have available.

- Social Security: Understanding The Benefits (SSA Publication No. 05-10024)--A brief overview of each of the Social Security programs
- Social Security Retirement Benefits (SSA Publication No.05-10035)--A guide to Social Security retirement benefits
- Social Security Disability Benefits (SSA Publication No. 05-10029)--A guide to Social Security disability benefits
- Social Security Survivors Benefits (SSA Publication No. 05-10084)-- A guide to Social Security survivors benefits
- Social Security SSI Benefits (SSA Publication No. 05-11000)--A guide to the Supplemental Security Income program

All of these publications, including this one, are available in Spanish.

In addition to Your Medicare Handbook, the Health Care Financing Administration publishes several leaflets of particular interest to Medicare beneficiaries. Among them are:

Guide to Health Insurance for People with Medicare (Publication No. HCFA 02110)--A guide to how

private health insurance supplements Medicare and some shopping hints for those looking at private supplements.

Medicare and Managed Care (Publication No. HCFA 02195)--A guide to health maintenance organizations and other types of prepaid plans.

These publications are available from any Social Security office or by writing to Medicare Publications, Health Care Financing Administration, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

You can also access Medicare information from the Health Care Financing Administration Web site at http://www.hcfa.gov.

Social Security Administration
SSA Publication No. 05-10043
June 1996
ICN 460000

Frequently Asked Questions About Glaucoma

Q: What is glaucoma?

Glaucoma refers to a group of eye diseases that have certain common features. These can include an eye pressure too high for the health of the eye, damage to the optic nerve and visual field (sight) loss.

Q: How many people have glaucoma?

It is estimated that **3 million** Americans have glaucoma, and **67 million people** worldwide will have glaucoma by the year 2000. At least half do not know they have it because glaucoma usually has no symptoms (that's why they call it the "sneak thief of sight"). Untreated, glaucoma is a leading cause of irreversible blindness.

Q: How can I tell if I have glaucoma? What are the signs and symptoms?

In most cases, there are no warning signs. In the later stages of the disease, some symptoms may occur. These can include:

- loss of side vision (also called peripheral vision)
- difficulty focusing on close work
- seeing colored rings or halos around lights
- headaches and eye pain
- frequent changes of prescription glasses
- difficulty adjusting eyes to the dark

The **best** way to find out if you have glaucoma is to get**regular** and **complete** eye exams.

Q: Who is at highest risk of developing glaucoma?

Glaucoma can affect all ages, young and old. It is the leading cause of blindness in African Americans. People at greater risk include those:

- over the age of 60
- who are African-American over age 40
- with relatives who have glaucoma

- who have diabetes
- who are very nearsighted

Q: How often should my eyes be checked?

Regular and complete eye exams are important. In general, a check for glaucoma should be done:

- at age 35 and at age 40
- after age 40, every 2-3 years
- after age 60, every 1-2 years
- *if you have any of the risk factors mentioned above, you should get your eyes thoroughly examined every 1-2 years after your 30th birthday.*

Q: Are there different types of glaucoma?

Yes, there are several types of glaucoma. The most common is called primary open-angle glaucoma (POAG). This type of glaucoma accounts for 90% of all cases. Other types include closed-angle glaucoma, congenital glaucoma and normal-tension glaucoma.

Q: Can glaucoma be prevented?

Currently, glaucoma cannot be prevented. Fortunately, with early detection and proper treatment, blindness from glaucoma can usually be prevented. Regular, complete eye exams help monitor changes in your eyesight.

Q: How is glaucoma treated?

Individual treatments will vary from person to person. Treatments include medications (eyedrops and/or pills), laser surgery, standard surgery and drainage implant devices.

Q: Can glaucoma be cured?

A cure for glaucoma is not yet known. The Glaucoma Research Foundation is helping researchers around the world find a cure. Along the way, the search for a cure has brought promising new treatment options that help slow or stop the disease from progressing.

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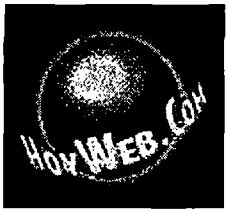

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News: Federal panel endorses counseling as key to quitting smoking

By Braden Goetz, ACA

Public Policy and Information

Individual and group counseling is critical to helping smokers quit, according to new clinical guidelines on smoking cessation interventions recently issued by the Agency for Health Care Policy and Research (AHCPR) and the Centers for Disease Control (CDC).

To develop the new Smoking Cessation Clinical Practice Guidelines, AHCPR and CDC convened an expert panel of 19 physicians and other health care and health education professionals to review and analyze the scientific literature to identify effective, validated treatments and practices. Approximately 300 peer-reviewed articles published between 1975 and 1994 that described randomized, controlled trials using smoking cessation interventions were reviewed and analyzed. The first draft of the guidelines were then reviewed and commented upon by 71 peer reviewers from various disciplines. The panel amended the guidelines to reflect these comments.

The resulting AHCPR/CDC guidelines recommend that, in order to be most effective, smoking cessation interventions should include either individual or group counseling. The content of the counseling, according to the panel, should focus on developing general problem-solving, relapse prevention and stress management skills. Social support provided by a clinician as part of the counseling relationship is also important.

Generally, the panel found that the effectiveness of counseling in promoting smoking cessation was directly related to its intensity and duration. The guidelines recommend four to seven individual or group counseling sessions to be most effective.

The AHCPR/CDC panel declined to endorse any particular mental health discipline to provide smoking cessation counseling, concluding that there was insufficient scientific evidence to recommend one or more disciplines over any other.

In addition to counseling and other psychosocial interventions, the guidelines recommend the use of nicotine patches or gum in helping smokers to quit. Aversive smoking, which involves multiple sessions in which a client smokes intensively to the point of discomfort, was also judged effective with appropriate medical screening and supervision.

The panel found that there was insufficient scientific evidence to support its endorsement of other types of interventions sometimes used to support smoking cessation, including hypnosis, acupuncture and antidepressant drugs.

The AHCPR/CDC expert panel also recommended that:

> All physicians should routinely ask their patients if they smoke and strongly advise any patient who smokes to quit. The panel also recommends that other non-physician health care professionals, including professional counselors, address smoking as part of their encounters with clients. Advice of this kind was found to be effective in promoting smoking cessation. Current research indicates that half of the smokers in the United States have never discussed their smoking with a health care professional. Smokers who have mental or emotional disorders, such as depression or chemical dependence, should be encouraged to quit smoking and treated with the same interventions as other populations. While there is some clinical evidence that smoking cessation may exacerbate some disorders, the panel concluded that any adverse impact is minimal. It also found that there is little evidence that smokers with alcohol or other chemical dependencies relapse to other drug use when they quit smoking. Smoking cessation interventions should be tailored or modified to be appropriate for the racial and ethnic populations with which they are used. Counseling and other smoking cessation treatments should be reimbursed by health insurance and managed care corporations. Counseling and other treatments judged effective by the panel for use with adults should be also be considered for use with children and youth who smoke. Nicotine patches and gum should only be used if the child or adolescent is genuinely dependent on nicotine and is committed to quitting. A separate set of guidelines is being developed to identify effective approaches to preventing smoking among young people.

To assist professional counselors and other health care professionals in helping their clients to quit smoking, AHCPR has developed a free Smoking Cessation Consumer Tools Kit that includes four black-and-white, one-page handouts that address particular concerns of smokers.

The Tools Kit and a copy of the Smoking Cessation Clinical Practice Guidelines can be obtained through the AHCPR Clearinghouse by calling 800-358-9295 or by writing to AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907-8547.

The Smoking Cessation Clinical Practice Guidelines can also be found at CDC's Office of Smoking and Health web site at: http://www.cdc.gov/tobacco.

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Postgraduate Medicine

symposium

Trends in smoking-related diseases

Why smoking cessation is still the best medicine

J. Taylor Hays, MD; Lowell C. Dale, MD; Richard D. Hurt, MD; Ivana T. Croghan, PhD

VOL 104 / NO 6 / DECEMBER 1998 / POSTGRADUATE MEDICINE

This page is best viewed with a browser that supports tables

This is the first of three articles on nicotine dependence

Preview: Although millions of Americans have kicked the habit, the effects of cigarette smoking likely will be around for a long time. What was once regarded as a glamorous habit is now recognized as a health threat and an economic burden. But what headway has been made in the reduction of related morbidity and mortality? The authors of this article review the current epidemiologic data on smoking-related diseases and make an indisputable case for smoking cessation.

As understanding of the mechanisms of many diseases increases, there is a very real hope that many of today's diseases will be preventable in the future through technological advances in molecular and genetic medicine. However, the most important strategy for reducing the chief cause of morbidity and death in the United States--namely, eliminating tobacco use--is often overlooked.

Current statistics are grim. In 1990, cigarette smoking caused an estimated 400,000 deaths (1). The four leading causes of death--heart disease, cancer (especially lung cancer), cerebrovascular disease, and chronic obstructive pulmonary disease (COPD)--are strongly related to smoking. However, despite these disheartening statistics, studies from the last three decades have shown that when people stop smoking, their risk of tobacco-related morbidity and mortality decreases significantly.

The statistical associations between cigarette smoking and specific diseases have not been established on the basis of any randomized, controlled experiments but, rather, on epidemiologic data and observational studies. However, the evidence of a causal association is compelling in light of the consistency of the relationship between smoking and specific diseases, the strength of the association as measured by relative risk, and the presence of a dose-response effect (ie, the risk of disease is directly related to the intensity of exposure to cigarette smoke).

In addition, a temporal relationship exists between exposure to cigarette smoke and the development of related diseases. Typically, there is a latent period of many years between initiation of exposure and development of the target disease, as well as a period of declining risk beginning soon after smoking cessation. Finally, the observed epidemiologic data have biologic plausibility. Experimental data documenting the biologic effects of cigarette smoke fit well with the known pathogenesis of various diseases. In this article, we discuss the relationships between smoking and cardiovascular disease, lung cancer, and COPD.

Cardiovascular disease

Cardiovascular disease continues to be the No. 1 cause of death in the United States, resulting in about 950,000 deaths every year. Ischemic heart disease accounts for the bulk of the mortality, an estimated 500,000 deaths in 1993 (2).

Coronary heart disease

Coronary heart disease is the leading cause of death among men 45 years of age and older. It is a principal cause of premature death among men and accounts for more than 5 million years of potential life lost for all adults (3).

An association between smoking and increased risk of coronary heart disease was first reported in 1940 in an observational study by the Mayo Clinic (4). Subsequently, numerous epidemiologic studies have confirmed a strong and consistent association between cigarette smoking and coronary heart disease morbidity and mortality (table 1) (5-7). In general, the relative risk of death due to coronary heart disease in smokers is two to four times greater than that in persons who have never smoked.

Table 1. Relative risk of coronary heart disease mortality in smokers

Study group	Relative risk Cigarettes per day		
	1-14	15-24	≥25
British male doctors (6)	1.5	1.9	2.3
Nurses' Health Study (7)	2.1	4.2	5.4
American Cancer Society Cancer Prevention Study I (5)	1.3	1.9	2.2

The dose-response effect of smoking has been clearly demonstrated in two important studies. Doll and Peto (6) found that in British male doctors under the age of 45 who smoked 25 or more cigarettes daily, risk of mortality from ischemic heart disease was 15 times higher than in nonsmokers. The dose-response effect also was seen 20 years later in light, moderate, and heavy smokers in the same cohort. In the Nurses' Health Study (7), the relative risk of both fatal and nonfatal coronary heart disease in women ranged from

2.2 in light smokers to 5.4 in those smoking 25 or more cigarettes per day. On the basis of these and other epidemiologic studies, the estimated relative risk of both fatal and nonfatal coronary heart disease is increased roughly twofold in light to moderate smokers and may be 6 to 15 times higher in heavy smokers.

The beneficial effects of smoking cessation have also been reported. Table 2 shows the results of large cohort studies that assessed the time course of the decrease in relative risk of coronary heart disease mortality after smoking cessation. In general, the excess risk among former smokers drops substantially in the first 2 to 3 years (8). Thereafter, the rate of decline decreases so that it takes up to 10 years for former smokers to reach the same risk level as that of persons who have never smoked. The slow decline in all morbidity and mortality due to coronary heart disease is related to reversal of some atherogenic effects of smoking.

Table 2. Relative risk of coronary heart disease mortality after smoking cessation

Smoking status	ACS-CPS II (5)	Nurses' Health Study (8)	Coronary Artery Surgery Study (12)
Currently smoking	2.02	4.0	1.73
Quit smoking for:			
<2 yr	1.57	3.1	1.56
2-10 yr	1.41	2.04	1.37
>10 yr	0.99	1.04	1.28
Never smoked	1.0	1.0	1.0

ACS-CPS II, American Cancer Society Cancer Prevention Study II.

In contrast, the risk of myocardial infarction after smoking cessation declines quickly. Relevant data in both men and women from studies by Rosenberg and associates (9,10) are summarized in figure 1 (not shown). The risk of myocardial infarction diminishes by almost one third after the first year of smoking cessation and reaches the level of persons who have never smoked by the third or fourth year. The rapid decline in myocardial infarction risk is thought to be due to a rapid reversal of hypercoagulability induced by smoking.

Other studies have confirmed that revascularization for coronary heart disease is primarily beneficial in patients who quit smoking. A study by Hasdai and colleagues (11) found that compared with nonsmokers, patients who continued to smoke after percutaneous coronary revascularization had almost twice the risk of death and of Q-wave myocardial infarction. Results from the Coronary Artery Surgery Study (12) also confirm that the benefits of surgical revascularization are nearly negated in patients who continue to smoke. Thus, for smokers with coronary heart disease, the main intervention should be smoking cessation. It not only decreases the overall risk of coronary heart disease morbidity and mortality but also rapidly reduces the risk of myocardial infarction and helps to sustain benefits gained from invasive revascularization procedures.

Cerebrovascular disease

In a meta-analysis by Shinton and Beevers (13), the overall relative risk of stroke associated with smoking was 1.5. The risk of stroke was highest in smokers under age 55, and it diminished with increasing age. The meta-analysis also found a dose-response effect between number of cigarettes smoked and risk of stroke as well as a declining risk after smoking cessation. Strong correlations were noted between smoking and thrombotic stroke, embolic stroke, and subarachnoid hemorrhage. The relative risk of subarachnoid hemorrhage was significantly higher than that of thrombotic stroke (table 3).

Table 3. Relative risk of stroke by subtype in smokers

Study	Relative risk	
	Thromboembolic stroke	Subarachnoid hemorrhage
Meta-analysis (13)	1.92	2.93
Nurses' Health Study (14)	2.7	5.2
British Regional Heart Study (15)	4.0	ND

ND, not determined.

In the Nurses' Health Study (14), increases in relative risk of both thromboembolic stroke and subarachnoid hemorrhage were even more significant. Women who smoked 25 or more cigarettes a day had a relative risk of thromboembolic stroke of 2.7, while their risk of subarachnoid hemorrhage was almost 10 times higher than that in nonsmokers.

A more recent prospective cohort study in middle-aged men (15) found that the risk of stroke was more than four times higher in men who smoked 21 or more cigarettes a day than in those who never smoked. In addition, men who stopped cigarette smoking and switched to cigar or pipe smoking retained a threefold increased risk of stroke. As in other cohort studies, this study found a dose-response effect between cigarette smoking and risk of stroke as well as a declining risk after smoking cessation. The time to maximal risk reduction was about 5 years, after which no further decline in risk was seen.

Other cardiovascular diseases

Other major cardiovascular diseases are strongly associated with cigarette smoking. Prospective cohort studies have consistently shown smoking to be one of the strongest risk factors for development of peripheral vascular disease. Risk of progression of atherosclerotic peripheral vascular disease is also increased among patients who continue to smoke compared with those who quit. Complication rates and risk of amputation are significantly higher among patients with obliterative peripheral vascular disease who continue to smoke. In addition, mortality from abdominal aortic aneurysm in current

smokers is three to five times higher than in persons who have never smoked and is significantly increased compared with the mortality in persons who have stopped smoking.

Thromboangiitis obliterans (Buerger's disease), an inflammatory disease of small arteries and veins, is seen almost exclusively in smokers. It causes significant morbidity among persons in their 30s and 40s. Amputation risk is high in affected patients who continue to smoke. The only effective treatment is smoking cessation.

Smoking is also a significant risk factor for progression of atherosclerosis. The Atherosclerosis Risk in Communities study (16) showed a substantial increase in atherosclerosis progression in patients who smoked compared with those who never smoked and an intermediate progression in former smokers. The progression of atherosclerosis attributable to smoking was more substantial than that due to other cardiovascular risk factors. The risk of progression of atherosclerosis was highest in smokers who had other risk factors, such as hypertension and diabetes mellitus.

The implication from all of the studies regarding cigarette smoking and cardiovascular disease is quite clear. Smoking is the single most important risk factor to modify in patients with established atherosclerotic disease. The benefits of smoking cessation are substantial and rapid. No other intervention for cardiovascular disease is likely to be as cost-effective as smoking cessation.

Lung cancer

Eighty percent to 90% of all lung cancers are directly attributable to cigarette smoking. This attributable risk is far higher than for all other cancers except those of the upper respiratory tract and esophagus. Currently, lung cancer is the most frequently diagnosed major cancer in the world and the most common cause of cancer death in both men and women in the United States.

Before the invention of the manufactured cigarette, lung cancer was an uncommon disease reported only infrequently in the medical literature. However, in the 1940s and 1950s, a dramatic rise occurred in lung cancer deaths among men. This rise in mortality closely paralleled the increased cigarette consumption in the 1920s and 1930s. The latent period between increasing cigarette consumption and rise in lung cancer death rate is due to the fact that carcinogenesis in the respiratory tract is probably a multistep process involving sequential changes, from normal to malignant, in the cells lining the tract.

The death rate due to lung cancer in men appears to have peaked in the late 1980s and has reached a plateau or is edging downward slightly. A similar trend in lung cancer mortality has been noted in women. In 1986, lung cancer exceeded breast cancer as the most common cause of cancer death among women. However, the death rate among women has not reached its peak.

Several other important trends regarding lung cancer should be noted. The relative frequency of adenocarcinoma is increasing, while proportionally fewer cases of squamous cell cancer are being seen. The rise in adenocarcinoma is probably due to changes in smoking behavior since the introduction of filtered cigarettes and those low in tar and nicotine. Deeper and more frequent inhalation delivers carcinogens to the peripheral lung tissues, where adenocarcinoma is preferentially produced (17,18), Small-cell lung cancer is also more likely to be present in current smokers or those who have quit within 10 years than in those who have stopped for more than 10 years.

Smokers have a dramatically increased relative risk of lung cancer compared with persons who have never smoked. The risk estimates vary across studies. However, the American Cancer Society Cancer Prevention Study II, one of the largest cohort studies to date, found

a 21-fold relative risk of lung cancer mortality in men who currently smoked any number of cigarettes a day and a 12-fold increased risk in their female counterparts compared with persons who never smoked (5). Table 4 shows the dose-response effect reflected in the relative risk of lung cancer mortality.

Table 4. Relative risk of lung cancer mortality according to cigarette exposure

Study group	Relative risk	
	Cigarettes per day	
	1-19	≥20
ACS-CPS I (men)*	6.5	13.7
ACS-CPS II (men)*	18.8	26.9
ACS-CPS II (women)	7.3	16.3

ACS-CPS, American Cancer Society Cancer Prevention Study.
*Variations in data from ACS-CPS I and ACS-CPS II are primarily the result of methodological differences in ascertainment of cases and length of follow-up.

Data from US Department of Health and Human Services (5)

Several large cohort studies have also shown a consistent decline in lung cancer mortality risk after smoking cessation (5). After about 15 years of abstinence, the risk of death from lung cancer is reduced 80% to 90% compared with that in current smokers (5). However, the risk never falls to the level of that in persons who have never smoked. These studies also have shown that heavier smokers who quit, regardless of length of abstinence, have a higher relative risk of lung cancer mortality than their lighter-smoker counterparts. According to one study (5), even after 15 years of abstinence, the relative risk of lung cancer mortality in men was more than five times higher than in those who had never smoked; among women, the relative risk was about 2.4 (table 5). Whether former smokers continue to have a gradual reduction in risk is unclear, but they appear to always have a somewhat higher risk than persons who have never smoked.

Table 5. Relative risk of lung cancer mortality after smoking cessation

Time since smoking cessation	Relative risk Cigarettes per day			
	Men		Women	
	1-19	≥20	1-19	≥20
<1 yr	16.8	23.4	3.4	21.1
1-2 yr	16.7	25.3	9.0	18.2
3-5 yr	19.7	20.5	2.5	13.2
6-10 yr	8.6	14.2	1.1	12
11-15 yr	6.3	13.6	1.1	2.9
>15 yr	3.3	5.3	1.6	2.4

Data from US Department of Health and Human Services (5)

Although total years of cigarette smoking also may have some impact, lung cancer mortality continues to be more closely related to the number of cigarettes smoked per day. Other factors, such as depth of inhalation, use of filtered rather than nonfiltered cigarettes, and use of mentholated cigarettes, may affect lung cancer risk. Pipe and cigar smokers who have never smoked cigarettes tend to have lower risks of lung cancer than cigarette smokers.

Environmental exposures to other toxic substances may have some impact on lung cancer risk among smokers as well. The evidence is strongest in smokers who are exposed to asbestos in their environment or to uranium mining. Exposures to urban air pollutants and radon gas are less clearly associated with increased risk of lung cancer among smokers.

Compared with whites, African Americans have a significantly poorer prognosis for any type of lung cancer, although the overall prognosis in all ethnic groups is poor. Racial differences in lung cancer prognosis may be genetically influenced; however, other factors, such as longer delay in diagnosis and characteristics of tobacco exposure (eg, depth of inhalation, length of exposure), may be important. Surgical resection remains the only hope for curative therapy.

Annual screening with a chest film and sputum testing in smokers has not shown benefit in reducing lung cancer mortality. Because smokers with underlying COPD have an increased risk of lung cancer, however, some investigators have argued that screening is probably justified among smokers with early obstructive lung changes. Newer screening

techniques, such as spiral computed tomography of the chest, may prove beneficial in early detection of lung cancer in selected smokers.

The relationship between nutrition and lung cancer risk among smokers also has been studied. Because persons who have a high intake of vegetables rich in beta-carotene have a lower than normal risk of cancer, some investigators have postulated that beta-carotene supplementation may reduce cancer risk. However, a randomized trial of supplementation with beta-carotene and retinyl palmitate in male smokers (19) showed no reduction in risk of lung cancer. In fact, the results raised the possibility that these supplements may actually have harmful effects, because subjects receiving supplementation had a higher incidence of lung cancer than control subjects. Thus, to date, no nutritional supplements have proved beneficial in lung cancer.

COPD

Obstructive airways disease is a group of disorders that includes emphysema, chronic bronchitis, and COPD. In this article, the term "COPD" refers to all of these conditions.

In 1993, COPD was the fourth leading cause of death in the United States, acounting for more than 100,000 deaths yearly. The mortality attributable to COPD has more than tripled since 1970. Mortality and serious morbidity related to COPD occur almost exclusively in smokers.

Numerous observational studies have shown that smokers have significantly higher rates of respiratory symptoms (eg, cough, sputum production, wheezing, shortness of breath) than persons who have never smoked. Smoking cessation reduces the incidence of these symptoms. More important, many of these studies have shown that smoking significantly accelerates the normal age-related rate of decline in lung function. Smoking cessation typically results in a slight improvement in lung function followed by a return to the normal age-related rate of decline. In persons who maintain abstinence, the mortality rate from COPD declines by 50% after 10 years. This finding indicates that the cumulative injury produced by cigarette smoking reverses slowly after smoking cessation.

Two important studies have examined the relationship between smoking cessation and rate of lung function decline among former smokers. The Cardiovascular Health Study (20), a population-based cohort study of more than 5,000 men and women 65 years of age or older, found no detectable difference in lung function between smokers who had quit before age 40 and persons who had never smoked. In smokers who had quit between ages 40 and 60, lung function levels were about equal to those of nonsmokers who were 2.5 to 7.5 years older. Quitting smoking after age 60 was associated with lung function comparable to that of nonsmokers 5.5 to 15 years older, and current smokers had lung function levels equivalent to those of nonsmokers 10 to 20 years older. The study's conclusion is simple: The sooner one quits smoking, the better the preservation of lung function. However, it is never too late to quit, because even smokers who quit after age 60 have significantly better lung function than those who continue to smoke.

The most important longitudinal study of lung function in smokers who have early COPD is the Lung Health Study (21). In this prospective, placebo-controlled clinical trial, subjects were randomly assigned to receive usual medical care or to participate in a smoking cessation program in addition to using an inhaled bronchodilator (ipratropium bromide). At 5-year follow-up, the most important result of the study was that subjects who had quit smoking had significantly better lung function than those who had continued to smoke. A slight improvement in lung function occurred during the first year, with a gradual decline thereafter. However, subjects who continued to smoke had a steady and more rapid than normal loss of lung function during the study. Use of the inhaled bronchodilator had no significant effect on loss of lung function. This study clearly showed that sustained smoking cessation is the best (and possibly only) method for

maintaining and potentially improving lung function in patients with early COPD.

Economic considerations

Despite the obvious economic burden of tobacco-related diseases, only recently has the healthcare industry focused on the economic impact of smoking and the cost-effectiveness of smoking cessation intervention. The Mayo Clinic Nicotine Dependence Center conducted a cost-effectiveness analysis on a cohort of 5,544 consecutive adult patients treated for nicotine dependence from April 1988 to December 1992 (22). The mean age of patients was 47.8 (±13.2) years, and the baseline smoking rate was 25.4 (±12.5) cigarettes a day. At 1 year, the smoking-cessation rate was 22.2%. Treatment of nicotine dependence in this clinical program cost $213.74 for each patient, plus $183.21 for prescription smoking cessation aids, for a total cost of $396.95 per patient. Net years of life gained were computed with use of cessation and relapse rates expected for patients not undergoing intervention. On the basis of these calculations, the estimated cost of this treatment program was $6,828 per net year of life gained.

Compared with the cost-effectiveness of other medical services, $6,828 per net year of life gained by treatment of nicotine dependence is relatively inexpensive. For example, breast cancer screening costs up to $26,800 per year of life gained, treatment of mild to moderate hypertension can cost anywhere from $11,300 to $24,408 per year of life gained, and heart transplantation can cost up to $16,239. The only preventive medical care that is more cost-effective than smoking cessation is use of pneumococcal vaccine in elderly patients, which costs $1,500 per year of life gained.

Conclusion

Mortality attributable to smoking accounts for 20% of all deaths in the United States every year. In addition, smoking is a factor in the four leading causes of death in this country. Physicians see firsthand the devastating impact such diseases have on patients and their families. The knowledge that smoking cessation substantially reduces the morbidity and mortality from tobacco-related disease should compel every physician to intervene by (1) informing patients accurately about the risks of smoking, (2) personalizing the message about the health risks, (3) emphasizing the significant health benefits of smoking cessation, and (4) giving patients a clear and unequivocal message to stop smoking. For patients who are motivated to quit, many new and effective treatment options are available to aid in breaking this deadly addiction.

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UNITED STATES SENATE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
WASHINGTON, DC 20510-6300

DATE: 5/27/99

TO: DeVora

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NUMBER OF PAGES: 4 (including cover)

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-revised-

SPECS FOR SELECTED ASPECTS OF MEDICARE REFORM LEGISLATION

I. Establish HCFA Mission statement for Medicare

In administering the Medicare program, it is the mission of the Health Care Financing Administration to:

(1) Effectively and efficiently administer a program of health insurance coverage for elderly and disabled Medicare beneficiaries in accordance with the requirements of this title;

(2) Assure that health care provided to the elderly and disabled under this title is of the highest quality;

(3) In cooperation with other government agencies and the private sector, carry out programs to promote health, prevent disease, and assure the highest possible functional level for Medicare beneficiaries.

II. More effective delivery of services to beneficiaries with serious and chronic illnesses.

1. The Secretary shall conduct demonstrations to provide higher quality and more cost-effective services to individuals with serious and chronic illnesses.

A. Such demonstrations shall include:

(1) Programs of case management;

(2) Programs of disease management;

(3) Programs to prevent avoidable hospitalizations of nursing home patients;

(4) Such other programs as the Secretary determines offer the possibility of increasing quality of care and reducing costs.

B. Demonstrations under (A) may utilize such techniques as:

(1) Contracts with centers of excellence or other entities or individuals with special expertise in providing quality services ;

(2) Innovative payment techniques, including capitation for all or selected services provided under the demonstration and incentive payments for favorable cost and quality outcomes;

(3) Provision of services not normally covered under this Title, if provision of such services will result in more cost-effective provision of covered services or higher quality care to individuals;

(4) Reduced cost-sharing for beneficiaries participating in such demonstrations.

2. Implementation of effective demonstrations

The Secretary may implement programs to expand successful demonstrations conducted under the authority of (1) on a broader or nationwide basis without prior approval by the Congress if:

o Such implementation will not abridge freedom of choice of provider, except to the degree the beneficiaries voluntarily choose to join a program limiting choice of provider for some or all services. In such case, the Secretary shall implement rules similar to the Medicare plus choice program.

o Such implementation maintains at least the benefits provided in statute without additional premiums or cost-sharing for beneficiaries.

o Such implementation will not prevent providers not participating in the program from continuing to receive payment on the same basis provided in law and regulation.

o The Congress is notified of the Secretary's intent to proceed with such implementation at least six months prior to the commencement of the program.

III. Empowering beneficiaries to more effectively protect and improve their own health

1. The Secretary shall inform beneficiaries of appropriate preventive health services and the benefits of such services, and shall encourage the utilization such services, including services not covered by the Medicare program. To the extent appropriate, information may be targeted on subpopulations of beneficiaries.

2. The Secretary, in cooperation with other agencies of government, the States, and the private sector shall inform Medicare beneficiaries of steps they can take to promote and safeguard their own health, including exercise, diet, accident prevention and such other activities as the Secretary deems appropriate.

3. The Secretary shall enter into grants and contracts with community organizations working with the elderly, organizations representing the elderly, and other appropriate recipients to assist in carrying out the functions described in (1) and (2).

4. The Secretary, in cooperation with the AHCPR, the NIH, academic health centers, professional bodies, and other sources of expertise shall identify areas where treatment of elderly and disabled frequently falls short of the highest professional standards and shall the inform the Medicare beneficiaries of best practices in these areas.

4. The Secretary shall implement a program to provide information to Medicare beneficiaries to reduce the incidence of hospitalization and physician use among Medicare beneficiaries resulting from improper use of prescription and over-the-counter drugs

5. Such programs shall be financed by the Medicare Trust Funds without the requirement for an annual appropriation (similar to PRO program).

IV. Improving quality of care for the elderly and disabled.

1. The Secretary shall promote improvement in care in the areas identified in III-3. In carrying out this responsibility, the Secretary may conduct demonstrations and enter into grants and contracts with academic health centers, professional medical societies, and other appropriate organizations. The Secretary's activities shall include a program to reduce hospitalization and physician services arising from improper use of prescription drugs.

2. Appropriations same as III.

V. White House Conference on Improving the Health of the Elderly

There shall be a White House Conference on improving the health of the elderly. The Conference shall be broadly inclusive of the elderly, those who care for the elderly, researchers and research institutions with an expertise in elderly issues, and other appropriate parties. The goal of the conference shall be to develop a consensus on a program to empower the elderly to protect and improve their own health; to assure that the elderly are provided the highest standard of care, with emphasis on assuring that standard practice is also best practice; to more effectively meet the needs of the elderly through the Medicare program, and to outline a research and demonstration agenda to further these objectives.

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KENNEDY PROPOSAL TO INCLUDE A PROGRAM TO IMPROVE THE HEALTH OF THE ELDERLY IN THE PRESIDENT'S MEDICARE REFORM PROPOSAL

An active, aggressive program to improve the health of the elderly should be a part of the Administration's Medicare reform program. Improving the health of Medicare beneficiaries is a worthy goal in its own right. It may also contribute significantly to reducing Medicare's long-term spending, since healthier seniors use fewer medical services.[1] A significant part of the program would be assisting seniors to take greater responsibility for their own health--a goal which is very consistent with one of the President's major themes, helping the elderly to take care of themselves.

The ability to achieve better health and lower costs through greater use of preventive health services by the elderly is clear. Illnesses due to pneumonia and influenza cost Medicare $3 billion annually, but half of the elderly are not vaccinated against pneumonia and one-third of the elderly do not receive recommended flu shots. Only 28% of elderly female beneficiaries receive mammograms. Eighty-eight percent of the elderly have not received recommended colon cancer screening.

The elderly are generally quite health-conscious and interested in taking steps to improve their own health, and experts agree that the potential for better health from exercise, diet, accident prevention and other health promotion and disease prevention activities is great. Too often, however, the elderly lack the accurate information that would help them take optimal advantage of this opportunity.

There are also substantial deficits in care because of the gap between best practices and typical practice in caring for the elderly. For example, seventy-nine percent of elderly heart attack victims fail to receive indicated treatment with beta blockers following a heart attack--and suffered a 75% higher death rate as a result. There is a five-fold variation in death rates from surgery for coronary artery bypass, depending on the institution and region of the country in which it is performed. Strokes attack three million Americans annually--a high proportion of them Medicare enrollees--at a cost of $30 billion annually. Victims receiving new clot-dissolving drugs in the first few hours after a stroke recover more fully and quickly than other patients, but the timely use of this new therapy is far from universal. Twenty percent of Medicare beneficiaries have received drugs that should never be prescribed for someone over 65, and the total cost to Medicare of improper use of prescription drugs has been estimated by the GAO to exceed $20 billion annually. The best managed care in the private sector is beginning to address these quality issues, but fee-for-service Medicare has not made them a priority, despite some positive work done by the PRO program.

Finally, the opportunities for better health care and program savings are great if care could be delivered to beneficiaries with chronic conditions in a more coordinated and effective way. These patients are among the highest cost users of Medicare services. Diabetics, for example, are an extremely high cost group, but management rarely meets appropriate standards of quality for Medicare beneficiaries. Between three-quarters and one-third of diabetics do not receive recommended eye examinations, depending on the part of the country in which they live.

Between 90% and 30% are not monitored appropriately for glucose control. The result of these failures is unnecessary blindness, amputations, and other complications. Several studies have shown that improved medical care for nursing home patients can significantly reduce hospital costs.

The proposal to address these issues would have five components:

(1) Establish a HCFA mission statement which includes assuring high quality care and health promotion and disease prevention.

(2) Require HHS, in cooperation with other agencies of the government and the private sector, to assist beneficiaries to improve their own health through use of preventive services and activities such as better diet, exercise, and accident prevention.

(3) Establish innovative programs to provide more effective and coordinated care to beneficiaries with high-cost chronic illnesses.

(4) Establish innovative programs to improve the quality of care for senior citizens.

(5) Conduct a White House conference on improving the health of senior citizens to involve the elderly, professional societies, hospitals, community organizations, researchers, and others in addressing these goals.

1. Burton H. Singer and Kenneth Manton, "The Effects of Health Changes on Projections of Health Service Needs for the Elderly Population of the United States," *Proceedings of the National Academy of Sciences*, December 1998. Herbert Pardes, et al., "Effects of Medical Research on Health Care and the Economy;" Manton, "Chronic Disability Trends," January 1, 1999. *Science* Vol. 283, p. 36-37.