subject to regular on-site inspections. Those that fall into the waived or physician microscopy categories are already exempt. Low-volume labs are generally thought to be those that perform fewer than 2,000 tests annually.

Under the current proposal, backed by top Health and Human Service (HHS) officials, labs that pass an inspection could waive their next one. However, no labs would be able to waive two inspections in a row.

The law, which took effect last September, requires all labs to be surveyed every two years to make sure they are in compliance with CLIA regulations. By law, CLIA was to have been entirely user fee-funded through charges for registration, certification, and compliance. The Health Care Financing Administration (HCFA) was to use this money to pay all CLIA's overhead. But federal officials have said that CLIA fees proved insufficient to meet the program's operating expenses, requiring HCFA to underwrite the development and implementation costs.

Federal officials are meeting with key members of Congress to discuss the proposed CLIA changes. HCFA hopes to make these changes administratively to avoid a legislative battle with members of Congress who oppose an easing of the rules.

FROM: *American Medical* News. August 9, 1993.

Cost Savings and Health Benefits Prompts Medicare Coverage of Influenza Vaccine

A four-year congressionally mandated demonstration project has demonstrated health and economic benefits of influenza vaccination and has prompted coverage for influenza vaccine for all Medicare beneficiaries. In the last year alone of the Medicare Influenza Vaccine Demonstration, overall influenza vaccination levels almost exceeded the national health objective for the year 2000 of 60% vaccine coverage among noninstitutionalized persons ≥65 years.

Case-control studies of vaccine effectiveness in preventing hospitalization for pneumonia were conducted during the demonstration. These studies estimated that influenza vaccine was 31% to 45% effective in preventing hospitalization for any pneumonia during the 1989-90, 1990-91, and 1991-92 influenza season.

The results of the cost-effectiveness analysis varied because of the variability of influenza from season to season in causing disease outcomes and the difficulty of attributing these outcomes to influenza. Nonetheless, provision of influenza vaccine was cost-effective for Medicare and may be cost-saving, depending on the effectiveness of the vaccine in reducing pneumonia hospitalizations and deaths and the level of vaccine coverage.

The demonstration project's success in vaccine delivery resulted from focused interventions to overcome common barriers to adult vaccination, including the absence of a comprehensive vaccine delivery system, limited reimbursement mechanisms, and lack of vaccination programs where adults congregate.

FROM: Final results: Medicare influenza vaccine demonstration-selected states, 19881992. *MMWR* 1993;42:601-604.

AIDS Rates Increases Are Greater Among Women

Reported AIDS cases among women in 1992 continued to increase at a faster rate than among men, and for the first time, more than half the cases among women were the result of heterosexual contact. From 1991 to 1992, the increase in reported cases among women was 9.8%, compared to 2.4% for men. Although the proportionate increase in cases attributed to heterosexual contact was greater for men than for women in 1992 (26.3% versus 11.5%), women accounted for a majority of the persons infected through heterosexual contact (59.4%). For the second consecutive year, the number of reported cases among homosexual/bisexual men decreased during 1992.

The CDC stated that "the steady increase in heterosexually acquired AIDS cases among men and women underscores the need to improve understanding of the factors that influence the adoption of safer sexual practices ... and how these factors vary in different population subgroups." The CDC also commented that because injecting drug users and men who have sex with men continue to account for 80.5% of the cases, prevention efforts targeting these populations must remain a priority and interventions targeting persons at increased risk for heterosexual transmission must be strengthened.

FROM: Update: AIDS, United States, 1992. *MMWR* 1993;42:547-551,557.