



---

# Issue Brief

---

Understanding Medicare's Preventive Services

August 2006



## Issue Brief

# Understanding Medicare's Preventive Services

August 2006

### Introduction

This report highlights the preventive care services and demonstration projects provided by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers these programs. The CMS wants to draw attention to preventive services and the “prevention gap,” the difference between the number of beneficiaries who could take advantage of preventive benefits and those who actually do. It is believed that many Medicare beneficiaries are not utilizing the services that, combined with intervention, could prevent or postpone the onset of more serious illnesses, manage early complications and ultimately control costs.

### Preventive Services

A beneficiary must be in Part B to receive preventive services or to participate in demonstration projects. In contrast to Part A (Hospital Insurance), which covers most services received in a hospital, Part B (Supplemental Medical Insurance) provides coverage for doctor and other outpatient medical services.<sup>1</sup> Although enrollment in Part B is voluntary, most Medicare beneficiaries participate.

Provisions in the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 expanded Medicare Part B coverage for several preventive services and demonstrations. Recent expansions in preventive services within the past two years include: a “Welcome to Medicare” physical exam for new enrollees; blood screening for cardiovascular

**Table 1. Medicare Preventive Services, Coverage Frequency And Co-Pays**

Service	Coverage Frequency	Purpose	Beneficiary Co-Pay and Deductible *
<b>Shots</b>	Pneumococcal	Prevent pneumonia	No
	Flu	Prevent flu virus	No
	Hepatitis B, if at risk	Protection from getting Hepatitis B	Yes
<b>Exams</b>	Pelvic Exam	Check for cervical, vaginal and breast cancers	Co-pay but no deductible
	Pap Test Clinical Breast Exam		
<b>Screenings</b>	Welcome to Medicare physical	One-time review of health status; counseling/referrals	Yes
	Colorectal Cancer	Find precancerous or early growths	Co-pay only as of 1/1/07
	Prostate Cancer	Find prostate cancer	Depends on test
	Mammogram	Check for breast cancer	Co-pay only
	Cardiovascular	Prevent heart attack/stroke	No
	Diabetes 1 for those at risk	Check for diabetes onset	No
	Glaucoma 1 for those at risk	Find eye disease glaucoma	Yes
	Abdominal aortic aneurysms (available 1/1/07)	Ultrasound to confirm aneurysm presence	Pending
	Diabetes services & supplies	Test strips/lancets for monitoring	Yes
	Bone mass measurement	Determine bone fracture risk	Yes
<b>Other</b>	Medical nutrition therapy	Prevent/reduce diabetes or kidney disease complications	Yes
	Smoking cessation counseling	Reduce smoking-related diseases	Yes

\* Co-payment/co-insurance for a beneficiary is 20 percent of the Medicare-approved amount. Some preventive benefits are also subject to a Part B annual deductible which is \$124 in 2006.

risk factors such as high cholesterol; diabetes screening and self-management training; and smoking and tobacco use cessation counseling. Abdominal aortic aneurysm ultrasound tests will be available January 1, 2007.

Table 1 provides a snapshot of preventive tests and services available under Medicare. Some of the tests are cost-free or are not considered as part of the deductible; others require a co-payment of 20 percent of the Medicare-approved amount.

### Low Utilization of Preventive Services

Approximately half of Medicare beneficiaries are not taking advantage of the preventive services available to them. See Table 2. The rate is even lower for some of the screenings and some groups. Medicare began covering preventive services in 1981 with the pneumococcal vaccination. Despite 25 years of coverage, pneumococcal pneumonia vaccination rates are less than optimal: 65 percent overall with only 38.5 percent of African Americans and 30.2 percent of Hispanics reporting ever receiving it.

According to CMS, only 2 percent of eligible beneficiaries have taken the introductory physical since it first became available as a benefit in January 2005. Colorectal cancer is the second leading cause of cancer death but only 31 percent of the Medicare population have had a colorectal cancer screening test. Nearly two-thirds (64 percent) of older women do not obtain a regular pap smear and pelvic exam and over four in 10 avoid having an annual mammograms. Although 65 percent of all prostate cancers occur in men age 65 and older, nearly half of older men (46 percent) do not get prostate cancer screening. Heart disease is the leading cause of death yet nearly one in five beneficiaries do not get cardiovascular screening.

**Table 2. Utilization Rates of Key Medicare Preventive Services**

Service	Medical Condition	Utilization Rate
Colorectal screening	Colon cancer	31%
Pap test and pelvic exam	Cervical and vaginal cancer	36 %
PSA blood test	Prostate cancer	54 %
Mammography	Breast cancer	55 %
Pneumococcal vaccine	Pneumonia	65%
Flu vaccine	Annual flu	68%
Cardiovascular screening	Heart disease	83%

Source: Centers for Medicare & Medicaid Services

One of the reasons why Medicare beneficiaries don't utilize preventive services to a greater degree may be due to a mindset among older health care consumers that medical services exist for the treatment of illnesses, not for when one is in apparent good health. Another explanation may be related to the variations in cost. Many of the services require a 20 percent

co-insurance and are subject to the deductible while others are free. Establishment of a standard cost-sharing policy would likely encourage more Medicare beneficiaries to take advantage of these benefits. Other reasons for low utilization may be due to lack of transportation to the doctor particularly in suburban and rural areas; and insufficient information, both in English and other languages, about the availability and advantages of preventive health care.

### **Recently-Covered Preventive Services**

The **Welcome to Medicare physical exam** includes obtaining a medical history, height, weight, and blood pressure measurements, vision test, an electrocardiogram, and education, counseling, and referrals related to other preventive benefits covered by Medicare. The exam, however, is a one-time only benefit and must be performed within 6 months of initial coverage under Part B. Cost for the beneficiary is 20 percent of the Medicare-approved amount after meeting the annual Part B deductible (\$124 for 2006).

The **cardiovascular screening** includes cholesterol testing and other blood fat measurements for the purpose of identifying beneficiaries at increased risk of developing heart disease or stroke. The screening is covered once every five years. There is no charge for the screening—no co-payment and it is not subject to the deductible.

The **diabetes screening, supplies and self-management training** is targeted to those at risk for the disease. This includes those with high blood pressure, high cholesterol, obesity, or a history of high blood sugar. The screening and supplies consist of a glucose test, glucose monitors, test strips, and lancets. The self-management training must be requested by a doctor. By identifying and treating diabetes early, CMS estimates that the development of severe vision loss can be reduced by 50-60 percent and kidney failure can be reduced by 30-70 percent. Depending on test results, one or two screenings a year are covered. The screening test is free—there is no deductible required nor a co-payment. However, the supplies and training charges for beneficiaries are 20 percent of the Medicare-approved amount after the deductible.

The **smoking and tobacco use cessation counseling** was initiated by CMS in March 2005. By helping beneficiaries to quit smoking, their risk of complications and death from other diseases such as heart, lung and cerebrovascular diseases and multiple cancers could be significantly reduced. Medicare will cover 2 quit attempts per year and up to 8 intermediate or intensive counseling sessions. Cost for the beneficiary is 20 percent of the Medicare-approved amount after meeting the annual Part B deductible.

The **abdominal aortic aneurysm screening** benefit, authorized by the 2005 Deficit Reduction Act, begins January 1, 2007. The abdominal aorta is a large blood vessel that supplies blood to the abdomen, pelvis, and legs. When an aneurysm occurs, the blood vessel becomes

abnormally large or balloons outward. Aneurysms can develop over years and often have no symptoms. If an abdominal aneurysm ruptures, survival rate is less than 50 percent. Men over age 50 who are or have been smokers are at high risk. Ultrasound screening helps detect an aneurysm before it ruptures and can be surgically repaired, if necessary.

## **Long-Standing Preventive Services**

**Cervical and Vaginal Cancer Screening** provides for Pap tests and pelvic exams to check for cervical and vaginal cancers. The pelvic exam includes a clinical breast exam to check for breast cancer. Medicare covers all three once every 24 months for most women; every 12 months for high-risk women. There is a 20 percent co-payment but the screening is not subject to the Part B deductible.

**Mammograms** screen for breast cancer, the second leading cause of cancer death in women in the United States. Medicare covers an annual mammogram for Medicare beneficiaries over age 40.<sup>2</sup> There is no co-payment nor is it subject to the deductible.

**Bone mass measurements** determine whether a person is at risk for bone fractures, generally because of osteoporosis, a disease in which bones become weak. Medicare covers the test every 24 months for those at risk. There is a 20 percent co-payment after the deductible.

**Colorectal cancer screenings** help find pre-cancerous polyps or growths in the colon so they can be removed before they become cancerous. There are four possible tests: the fecal occult blood test; flexible sigmoidoscopy; screening colonoscopy; and barium enema. Medicare covers the fecal occult blood test for all Medicare beneficiaries over age 50 annually. For beneficiaries at high risk of colorectal cancer, Medicare covers the flexible sigmoidoscopy every 48 months, and the screening colonoscopy and the barium enema every 24 months. For those at low risk, Medicare covers the flexible sigmoidoscopy and screening colonoscopy once every 10 years and the barium enema every four years. There is no cost to the beneficiary for the fecal occult blood test but co-payments and the deductible apply to the other tests.

**Prostate cancer screening** consists of two tests: one that tests the amount of Prostate Specific Antigen (PSA) in the blood and a digital rectal exam. Medicare covers both every 12 months. There is a co-payment and deductible for the rectal exam but not for the PSA test.

**Glaucoma tests** can reveal the existence of this eye disease, which is caused by high pressure in the eye and can lead to blindness. Medicare covers glaucoma tests every 12 months for those in one of the high risk groups which includes Medicare beneficiaries with diabetes mellitus, a family history of glaucoma, African Americans age 50 and over, and Hispanics age 65 and over. There is a 20 percent co-payment and the deductible applies.

Medicare covers **flu, pneumococcal, and Hepatitis B shots**. All three infections can be life threatening for older persons. Usually only one pneumococcal shot is needed in a lifetime but flu shots are generally needed every year. Medicare covers both without a co-pay or deductible. Three Hepatitis B shots are needed for complete protection for at risk beneficiaries including those with hemophilia, end-stage renal disease or a condition that lowers resistance to infection. There is a 20 percent co-payment after the deductible for the Hepatitis B shots.

**Medical nutrition therapy** is provided by a dietitian or nutritionist for Medicare beneficiaries diagnosed with diabetes or a renal disease to prevent further complications. It requires a physician's referral. Medicare covers up to 3 hours of one-on-one counseling in the first year and 2 hours in subsequent years. There is a 20 percent co-payment and deductible.

**My.Medicare.gov website.** CMS has created a new prevention and other services website (without the "www") where beneficiaries may create their own personalized file. After signing up with the information on their Medicare card, beneficiaries will receive a password in the mail from CMS. Once logged in, they are able to access information on preventive services under the Preventive Services icon. They will also be able to view their own preventive services record, e.g., their Part B deductible status, the date they last received a preventive service and the date when eligible for the service again. There will be links to publications, on-line forms, services and doctors in their area. They may view messages from CMS and will also have access to "health coaches" and 24-hour chat hotlines to help them know what to ask their doctors, advice on taking medications, and even help with preparing living wills.

## **Demonstration Projects**

Demonstration projects are usually initiated, either through Congressional mandate or administrative directive, to test possible improvements in coverage and quality of care or payment alternatives.<sup>3</sup> They are typically targeted to a specific group and/or offered only in a specific geographical area. The results of demonstrations have led to many of the primarily beneficial changes in Medicare over the years. The current demonstrations that directly target beneficiaries are described below.

**The Cancer Prevention and Treatment Demonstration for Racial and Ethnic Minorities** was authorized by the Benefits Protection and Improvement Act in 2000. The aim is to reduce or eliminate health care disparities through screening, diagnosis and treatment and promote collaboration with community-based organizations. Medical centers in 7 states<sup>4</sup> will provide services from July 2006 to June 2010 to a target population of 7,000 American Indian, Asian American/Pacific Islander, Hispanic American, and African American beneficiaries.

**The Medicare Management Performance Demonstration** authorized by MMA has a goal to improve quality and coordination of care for chronically ill Medicare beneficiaries and promote information technology in 800 small and medium-sized physician practices in four states—Arkansas, California, Massachusetts, and Utah. The 3-year project begins in 2006.

**The Low Vision Rehabilitation Demonstration** targets beneficiaries with moderate and severe visual impairment who are difficult to reach. Participants will receive up to 9 hours of vision rehabilitation services over a 90-day period including services provided in the patient's home. The project runs from April 2006-March 2011 in six sites: Atlanta, Georgia; Kansas; New Hampshire; New York City; North Carolina; and Washington State.

**The Rhode Island Flu Pilot Project** tests the ability of this state to respond to a pandemic by increasing influenza immunization rates, assuring adequate vaccine supply, and testing the vaccine procurement and distribution infrastructure. The project will be in effect through the 2007-2008 flu season.

### **For More Information**

Call 1-800-MEDICARE

Visit the CMS prevention information website

- Go to [www.medicare.gov/spotlights.asp](http://www.medicare.gov/spotlights.asp)
- Scroll down and click on "Preventive Services Start Now!"
- Click on links to descriptions of various services
- Link to Publication 10110, "Guide to Medicare's Preventive Services"

To enroll in Medicare's personalized online service for Medicare beneficiaries

- Go to [My.Medicare.gov](http://My.Medicare.gov)
- Have your Medicare Identification Number available
- Follow directions for registration process

This report was researched and written by Dianna M. Porter, director for policy. This is a publication of the Alliance for Retired Americans Educational Fund (ARAEF), the research and education branch of the Alliance for Retired Americans. ARAEF is a 501(c)(3) organization that focuses primarily on retiree issues. Permission to reproduce all or part of this report is given with following credit line: Reprinted [or excerpted] with permission of the Alliance for Retired Americans Educational Fund.

---

<sup>1</sup> Part A is paid for by taxes on payroll earnings. There is an annual deductible and some limits on hospital coverage depending on length of stay. Part B is paid for by premiums and general revenues. Additionally, there is an annual deductible and beneficiaries usually pay a co-insurance of 20 percent for most services. The law requires that Part B premiums account for 25 percent of Part B expenditures.

---

<sup>2</sup> Those who receive Social Security or Railroad Retirement disability benefits for at least 2 years, and most persons with end-stage renal disease, are eligible for Medicare. Approximately 15 percent of Medicare beneficiaries of all ages have coverage based on disability.

<sup>3</sup> The MMA requires a disturbing demonstration to be launched in 2010 as the “comparative cost adjustment “ or “premium support/voucher” project that will require the Medicare program to compete with private managed care plans in six geographical areas affecting approximately 7 million beneficiaries. Premiums will likely be higher and varied for these beneficiaries.

<sup>4</sup> The demonstration sites are: Montana; Utah; Molokai, Hawaii; Harris County and Houston, Texas; Newark, New Jersey; Baltimore, Maryland; and Wayne, Oakland, and Macomb counties, Michigan.