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MEDICARE

Use of Preventive Services is Growing but Varies Widely

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today as you review existing preventive health care services offered in the Medicare program and consider proposals for expanding these benefits. At your Subcommittee's request, we have been examining several issues related to preventive services and have prepared a report that is being released today.¹ My statement today highlights some of the key aspects of that report.

Preventive health care services, such as flu shots and cancer screenings, can extend lives and promote the well-being of our nation's seniors. Medicare now covers 10 preventive services—3 types of immunizations and 7 types of screening—and legislation has been introduced to cover additional services.² However, not all beneficiaries avail themselves of Medicare's preventive services. Some beneficiaries may simply choose not to use them, but others may be unaware that these services are available or covered by Medicare.

You asked us to examine two questions regarding preventive services for older Americans:

- To what extent are Medicare beneficiaries using covered preventive services?
- What actions have the Centers for Medicare and Medicaid services (CMS), which administers Medicare, taken to increase beneficiaries' use of preventive services?

Our data on the extent to which beneficiaries are using covered services are taken primarily from a survey conducted by the Centers for Disease Control and Prevention (CDC), another agency that like CMS is within the Department of Health and Human Services. The survey collects information on the use of several preventive services covered under Medicare, including immunizations for influenza and pneumococcal disease, and screening for breast, cervical, and colon cancer.

In summary, although use of Medicare covered preventive services is growing, it varies from service to service and by state, ethnic group, income, and level of

¹U.S. General Accounting Office, *Medicare: Beneficiary Use of Clinical Preventive Services*, [GAO-02-422](#) (Washington, D.C.: April 12, 2002).

²A bill introduced last year proposes adding visual acuity, hearing impairment, cholesterol, and hypertension screenings as well as expanding the eligibility of individuals for bone density screenings. See H.R. 2058, 107th Cong. § 203 (2001).

education. For example, in 1999, 75 percent of women had been screened within the previous 2 years for breast cancer, compared with 55 percent of beneficiaries who had ever been immunized against pneumonia. However, even for a widely used preventive service such as breast cancer screening, state-by-state usage rates ranged from 66 to 86 percent. Among ethnic groups, differences were greatest for immunizations. For example, 1999 data show that about 57 percent of whites and 54 percent of “other” ethnic groups had been immunized against pneumonia, compared to about 37 percent of African Americans and Hispanics.³ Among income and educational groups, variation was greatest for cancer screening.

To help ensure that preventive services are being delivered to those beneficiaries who need them, CMS sponsors activities—called “interventions”—aimed at increasing use. CMS currently funds interventions aimed at increasing the use of three services—breast cancer screening and immunizations against flu and pneumonia—in each state. CMS also pays for interventions that focus on increasing use of services by minorities and low-income beneficiaries who have low usage rates. The techniques being used in some of these interventions, such as allowing nurses or other nonphysician medical personnel to administer vaccinations with a physician’s standing order, have been found effective in the past. CMS is evaluating the effectiveness of current efforts and expects to have the evaluation results later in 2002.

Types of Services Covered

When the Medicare program was established in 1965, it only covered health care services for the diagnosis or treatment of illness or injury. Preventive services did not fall into either of these categories and, consequently, were not covered. Since 1980, the Congress has amended the Medicare law several times to add coverage for certain preventive services for different age and risk groups within the Medicare population. These services include three types of immunizations—pneumococcal disease, hepatitis B, and influenza. Screening for five types of cancer—cervical, vaginal, breast, colorectal, and prostate—are also covered, as well as screening for osteoporosis and glaucoma. Except for flu and pneumonia immunizations, and laboratory tests, Medicare requires some cost-sharing by beneficiaries. Most beneficiaries have additional insurance, which may cover most, if not all, of these cost-sharing requirements.⁴

³“Other” ethnic groups include survey respondents who reported an ethnicity other than African American, Hispanic, or white.

⁴U.S. General Accounting Office, *Medigap Insurance: Plans Are Widely Available but Have Limited Benefits and May Have High Costs*, [GAO-01-941](#) (Washington, D.C.: July 31, 2001).

For a number of reasons, not all Medicare beneficiaries are likely to use these services. For some beneficiaries, certain services may not be warranted or may be of limited value. Screening women for cervical cancer is an example. Survey data show that 44 percent of women age 65 and over have had hysterectomies—an operation that usually includes removing the cervix.⁵ For these women, researchers state that cervical cancer screening may not be necessary unless they have a prior history of cervical cancer.⁶ Also, patients with terminal illnesses or of advanced age may decide to forgo services because of the limited benefits preventive services would offer. Research has shown, for example, that the benefits of cancer screening services, such as for prostate, breast, and colon cancer, can take 10 years or more to materialize. Finally, the controversy over the effectiveness of some services, such as mammography and prostate cancer screening, may add to the difficulty in further improving screening rates for these services.

To help determine which preventive services are beneficial among various patient populations, the U.S. Department of Health and Human Services established a panel of experts in 1984, called the U.S. Preventive Services Task Force. The task force identifies and systematically evaluates the available evidence to determine the effectiveness of preventive services for different age and risk groups, and then makes recommendations as to their use. Task force recommendations were first published in the Guide to Clinical Preventive Services in 1989, and are periodically updated as new evidence becomes available. These recommendations are for screening, immunizations, and counseling services that are specific for each age group, including people 65 and older. See table 1 for the task force recommendations for various preventive services including those currently covered by Medicare.

⁵Data are from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), 2000.

⁶CDC researchers report that among the general population, over 80 percent of hysterectomies are performed for noncancerous conditions such as fibroids and endometriosis.

Table 1: Preventive Services Covered by Medicare or Recommended by the Task Force

Service	Task force recommendation for age 65+	Year first covered by Medicare as preventive service	Medicare cost-sharing requirements^a
Immunizations			
Pneumococcal	Recommended	1981	None
Hepatitis B	No recommendation	1984	Copayment after deductible
Influenza	Recommended	1993	None
Tetanus-diphtheria (Td) boosters	Recommended	Not covered	N/A
Screening			
Cervical cancer—pap smear	Recommended ^b	1990	Copayment with no deductible ^c
Breast cancer—mammography	Recommended ^d	1991	Copayment with no deductible
Vaginal cancer—pelvic exam	No recommendation	1998	Copayment with no deductible ^c
Colorectal cancer—fecal-occult blood test	Recommended	1998	No copayment or deductible
Colorectal cancer—sigmoidoscopy	Recommended	1998	Copayment after deductible ^e
Colorectal cancer—colonoscopy	No recommendation	1998	Copayment after deductible ^e
Osteoporosis—bone mass measurement	No recommendation	1998	Copayment after deductible
Prostate cancer—prostate- specific antigen test and/or digital rectal examination	Not recommended	2000	Copayment after deductible ^c
Glaucoma	No recommendation	2002	Copayment after deductible
Vision impairment	Recommended	Not covered	N/A
Hearing impairment	Recommended	Not covered	N/A
Height, weight, and blood pressure	Recommended	Not covered	N/A
Cholesterol measurement	Recommended	Not covered	N/A
Problem drinking	Recommended	Not covered	N/A
Counseling			
Diet and exercise, smoking cessation, injury prevention, and dental health	Recommended ^f	Not covered	N/A
Postmenopausal hormone prophylaxis	Recommended	Not covered	N/A
Aspirin for primary prevention of cardiovascular events	Recommended	Not covered	N/A

^aApplicable Medicare cost-sharing requirements generally include a 20 percent copayment after a \$100 per year deductible. Each year, beneficiaries are responsible for 100 percent of the payment amount until those payments equal a specified deductible amount, \$100 in 2002. Thereafter, beneficiaries are responsible for a copayment that is usually 20 percent of the Medicare approved amount. For certain tests, the copayment may be higher. See 42 U.S.C. § 1395(a)(1).

^bThe task force found insufficient evidence to recommend for or against an upper age limit for pap testing, but recommendations can be made on other grounds to discontinue regular testing after age 65 in women who have had regular previous screenings in which the smears have been consistently normal.

^cThe costs of the laboratory test portion of these services are not subject to copayment or deductible. The beneficiary is subject to a deductible and/or copayment for physician services only.

⁴The task force recommends routine screening for breast cancer every 1 to 2 years, with mammography alone or along with an annual clinical breast examination, for women aged 50 to 69. The task force found insufficient evidence to recommend for or against routine mammography or clinical breast examination for women aged 40 to 49 or aged 70 and older.

⁵The copayment is increased from 20 to 25 percent for services rendered in an ambulatory surgical center.

⁶The task force recommends these counseling services on the basis of the proven benefits of modifying harmful or risky behaviors. However, the effectiveness of clinician counseling to change these behaviors has not been adequately evaluated.

Source: U.S. General Accounting Office, Medicare: Beneficiary Use of Clinical Preventive Services, GAO-02-422 (Washington, D.C.: Apr. 12, 2002) and U.S. Preventive Services Task Force, Guide to Clinical Preventive Services, 2nd ed. (Washington, DC, 1996) and related updates.

As table 1 shows, Medicare explicitly covers many, but not all, of the preventive services recommended by the task force. However, beneficiaries may receive some of the preventive services not explicitly covered by Medicare. For example, even though blood pressure and cholesterol screening are not explicitly covered under Medicare, in 1999, nearly 98 percent of seniors reported that they had had their blood pressure checked within the last 2 years, and more than 88 percent of seniors reported having their cholesterol checked within the prior 5 years.⁷ Other task force recommended services—such as counseling intended to change a patient’s unhealthy or risky behaviors—may also be occurring during office visits.⁸ Determining the extent to which these preventive counseling services occur is difficult, in part, because the content of such services is not well defined. It is also interesting to note that the task force recommends these counseling services on the basis of the proven benefits of a good diet, daily physical activity, smoking cessation, avoiding household injuries such as falls, and avoiding dental caries (tooth decay) and periodontal (gum and bone) disease. However, the effectiveness of clinician counseling to actually change these patient behaviors has not been established.

⁷Survey data are from the CDC’s BRFSS 1999.

⁸Counseling women regarding hormone replacement therapy, and all beneficiaries regarding the use of aspirin for the prevention of cardiovascular events is not necessarily intended to change behavior. Rather, it is intended to provide the patient current information on both the potential benefits and risks of these therapies. The task force recommends that the decision to undertake these therapies should be based on patient risk factors for disease and a clear understanding of the probable benefits and risks of these therapies.

Use of Preventive Services is Growing but Varies Widely

Use of preventive services offered under Medicare has increased over time. For example, in 1995, 38 percent of beneficiaries had been immunized against pneumonia, compared with 55 percent in 1999. Similarly, the use of mammograms at recommended intervals had increased from 66 percent in 1995 to 75 percent in 1999. While these examples show that use of preventive services generally is increasing, they also show variation in use by service. Beneficiaries received screenings for breast and cervical cancer at higher rates than they did immunizations against flu and pneumococcal disease. Of the services for which data are available, colorectal screening rates were the lowest, with 25 percent of the beneficiaries receiving a recommended fecal occult blood test within the past year, and 40 percent receiving a recommended colonoscopy or sigmoidoscopy procedure within the last 5 years.

Relatively few beneficiaries receive multiple services. While 1999 utilization data show progress in improving receipt of preventive services, and in some cases relatively high rates of use for individual services, a small number of beneficiaries access most of the services. For example, although 91 percent of female Medicare beneficiaries received at least 1 preventive service, only 10 percent of female beneficiaries were screened for cervical, breast, and colon cancer, and immunized against both flu and pneumonia.

Although national rates provide an overall picture of current use, they mask substantial differences in how seniors living in different states use some services. For example, the national breast cancer screening rate for Medicare beneficiaries was 75 percent in 1999, but rates for individual states ranged from a low of 66 percent to a high of 86 percent. Individual states also ranged from 27 percent to 46 percent in the extent to which beneficiaries receiving a colonoscopy or sigmoidoscopy for cancer screening.

Usage rates also varied based by beneficiary, income, and education. Among ethnicity groups, the biggest differences occurred in use of immunization services. For example, 1999 data show that about 57 percent of whites and 54 percent of “other” ethnic groups were immunized against pneumonia, compared to about 37 percent of African Americans and Hispanics. Similarly, about 70 percent of whites and “other” ethnic groups received flu shots during the year compared to 49 percent of African Americans. Beneficiaries with higher incomes and levels of education tend to use preventive services more than those at lower levels.

Efforts Under Way to Increase Use of Some Preventive Services

CMS has conducted a variety of efforts to increase the use of preventive services. These include identifying which approaches work best and sponsoring specific initiatives to apply these approaches in every state.

Studies Identify Effective Methods to Increase Use of Services

To identify how best to increase use of preventive services needed by the Medicare population, CMS sponsors reviews of studies that examine various kinds of interventions used in the past.⁹ Among the CMS-sponsored reviews was one that examined the effectiveness of various interventions for flu and pneumonia immunizations and screenings for breast, cervical, and colon cancer.¹⁰ This evaluation, which consolidated evidence from more than 200 prior studies, concluded that no specific intervention was consistently most effective for all services and settings.

While no one approach appears to work in all situations, the CMS evaluation concluded that system changes and financial incentives were the most consistent at producing the largest increase in the use of preventive services.

- **System changes.** These interventions change the way a health system operates so that patients are more likely to receive services. For example, standing orders may be implemented in nursing homes to allow nurses or other nonphysician medical personnel to administer immunizations.
- **Incentives.** These interventions include gifts or vouchers to patients for free services. Medicare allows providers to use this type of approach only in limited circumstances.¹¹ For example, in order to encourage the use of preventive services, providers may forgo some compensation by waiving coinsurance and deductible payments for Medicare preventive services. In addition, other types of incentives—such as free transportation or gift certificates—are also allowed so long as the incentive is not disproportionately large in relationship to the value of the preventive service.

⁹CMS also conducts a variety of health promotion activities to educate beneficiaries about the benefits of preventive services and to encourage their use. These include the publication of brochures on certain covered services and media campaigns.

¹⁰Health Care Financing Administration, *Evidence Report and Evidence-Based Recommendations: Interventions that Increase the Utilization of Medicare-Funded Preventive Services for Persons Age 65 and Older*, Publication No. HCFA-02151 (Prepared by Southern California Evidence-based Practice Center/RAND, 1999).

¹¹Under regulations that became effective on April 26, 2000, Medicare providers may offer certain incentives for preventive services. Under no circumstances may cash or instruments convertible to cash be used. See 42 CFR § 1003.101.

Other interventions found to be effective—though to a lesser degree than the categories above—are reminder systems and education programs.

- **Reminders.** These interventions include approaches to (1) remind physicians to provide the preventive service as part of services performed during a medical visit or (2) generate notices to patients that it is time to make an appointment for the service. Studies show that reminders to either physicians or patients can effectively improve rates for cancer screening. However, if a computerized information system is present in a medical office, computerized provider reminders are consistently more cost-effective than notifying the patient directly. Patient reminders that are personalized or signed by the patient’s physician are more effective than generic reminders.
- **Education.** These interventions include pamphlets, classes, or public events providing information for physicians or beneficiaries on coverage, benefits, and time frames for services. The review found that while the effect of patient education is significant, it has the least effect of any of these types of interventions.

CMS Is Sponsoring Efforts to Increase Use of Services

CMS contracts with 37 Quality Improvement Organizations (QIOs), each responsible for monitoring and improving the quality of care for Medicare beneficiaries in one or more states, in the District of Columbia, or in U.S. territories.¹² QIO activities currently aim to increase use of three Medicare preventive services—immunizations against flu and pneumonia and screening for breast cancer.

QIOs are using various methods of increasing the use of these preventive services. For example, they are developing reminder systems, such as chart stickers or computer-based alerts, that remind physicians to contact patients on a timely basis for breast cancer screening. QIOs are also conducting activities to educate patients and providers on the importance of flu and pneumonia shots. CMS has taken steps to evaluate the success of these efforts. CMS officials explained that the contracts with the QIO organizations are “performance based” and provide financial incentives as a reward for superior outcomes. CMS officials expect information on the results by the summer of 2002.

¹²CMS formerly referred to this program as the Peer Review Organization program. During the course of our review CMS began referring to these entities as Quality Improvement Organizations. CMS officials told us that CMS plans to formalize the name change in a future *Federal Register* notice.

CMS plans to expand these efforts by QIOs. While the current efforts include only 3 of the preventive services covered by Medicare, CMS is also planning to include requirements for the QIOs to increase the use of screening services for osteoporosis, colorectal, and prostate cancer in future QIO contracts. CMS is not currently planning to include QIO contract requirements for the remaining preventive services covered by Medicare—hepatitis B immunizations or screenings for glaucoma and vaginal cancer.

Other specific efforts have been started to increase use of preventive services by minorities and low-income Medicare beneficiaries in each state. CMS-funded research on successful interventions for the general Medicare population 65 and older concluded that evidence was insufficient to determine how best to increase use of services by minority and low-income seniors. To address this lack of information, CMS has tasked each QIO to undertake a project aimed at increasing the use of a preventive service in a given population. For example, the QIO may work with community organizations, such as African American churches, in order to convince more women to receive mammograms. CMS expects to publish a summary of QIO efforts to increase services for minorities and low-income seniors after the spring of 2002.

Finally, other studies or projects that CMS has under way aim to identify barriers and increase use of services by certain Medicare populations. For example, the Congress directed CMS to conduct a demonstration project to, among other things, develop and evaluate methods to eliminate disparities in cancer prevention screening measures.¹³ These demonstration projects are in the planning stages. A report evaluating the cost-effectiveness of the demonstration projects, the quality of preventive services provided, and beneficiary and health care provider satisfaction is due to the Congress in 2004.

Concluding Observations

Medicare beneficiaries are making more use of preventive services than ever before, but there is still room for improvement. While most preventive services are used by a majority of beneficiaries, few beneficiaries receive multiple services. Also, disparities exist in the rates that beneficiaries of different ethnic groups, income and education levels use Medicare covered preventive services. CMS has activities underway that have the potential to increase usage of

¹³See the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106-554, Appendix F, § 122, 114 Stat. 2763, 2763A-476 *classified* to 42 U.S.C. § 1395b-1 nt.

preventive services. However, the full effect of these activities will not be known for quite some time.

As the Subcommittee and Congress consider broadening Medicare's coverage of preventive services, it is important to recognize the difficulty of translating some preventive service recommendations into covered benefits. For example, inclusion of behavioral counseling services may be beneficial, but reaching consensus on common definitions of these services remains a major challenge. Establishing Medicare coverage for some screening activities such as blood pressure and cholesterol screening may not be necessary since most beneficiaries already receive these services. Nevertheless, we believe that it is important to regularly review Medicare's coverage of preventive services as information on the effectiveness of such services becomes available. It is also important to continue to explore new approaches to encourage beneficiaries to avail themselves of the preventive services Medicare covers.

This concludes my prepared statement, Mr. Chairman. I will be happy to respond to any questions that you or Members of the Subcommittee may have.

Contacts and Acknowledgements

For future contacts regarding this testimony, please call Janet Heinrich, Director, Health Care—Public Health Issues, at (202) 512-7119, or Frank Pasquier at (206) 287-4861. Other individuals who made key contributions include Matthew Byer, Behn Miller, and Stan Stenersen.