

GAO

Testimony

Before the Subcommittee on Health,  
Committee on Energy and Commerce,  
House of Representatives

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# MEDICARE PREVENTIVE SERVICES

## Most Beneficiaries Receive Some but Not All Recommended Services

Statement of Janet Heinrich  
Director, Health Care—Public Health Issues





Highlights of [GAO-04-1004T](#), a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

### Why GAO Did This Study

Preventive care depends on identifying health risks and on taking steps to control these risks. In contrast, Medicare, the federal health program insuring almost 35 million beneficiaries age 65 or older, was established largely to help pay beneficiaries' health care costs when they became ill or injured. Congress has broadened Medicare coverage over time to include specific preventive services, such as flu shots and certain cancer-screening tests, and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added coverage for several preventive services, including a one-time preventive care examination for new enrollees, which will start in 2005.

GAO's work, done before MMA, included analyzing data from four national health surveys to examine the extent to which Medicare beneficiaries received preventive services through physician visits. GAO also interviewed officials from the Centers for Medicare & Medicaid Services (CMS) and other experts and reviewed the results of past demonstrations and studies to assess expected benefits and limits of different delivery options for preventive care, including a one-time preventive care examination.

[www.gao.gov/cgi-bin/getrpt?GAO-04-1004T](http://www.gao.gov/cgi-bin/getrpt?GAO-04-1004T).

To view the full product, including the scope and methodology, click on the link above. For more information, contact Janet Heinrich on 202-512-7119.

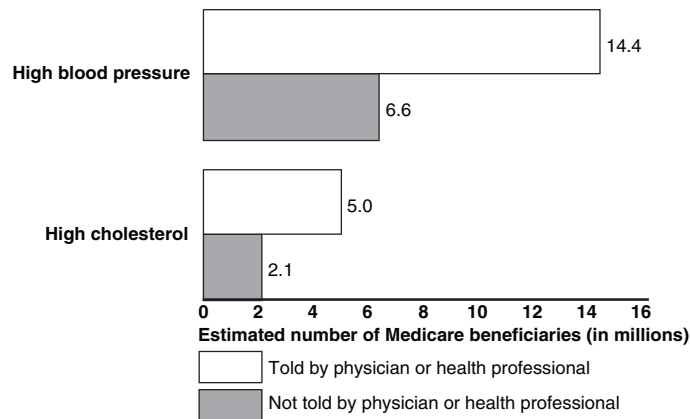
## MEDICARE PREVENTIVE CARE

### Most Beneficiaries Receive Some but Not All Recommended Services

#### What GAO Found

Most Medicare beneficiaries receive some but not all recommended preventive services. Our analysis of year 2000 data shows that nearly 9 in 10 Medicare beneficiaries visited a physician at least once that year; beneficiaries made, on average, six visits or more within the year. Still, many did not receive recommended preventive services, such as flu or pneumonia vaccinations. Moreover, many are apparently unaware that they may have conditions, such as high cholesterol, that preventive services are meant to detect. In one 1999–2000 nationally representative survey where people were physically examined and asked a series of questions, nearly one-third of people age 65 or older whom the survey found to have high cholesterol measurements said they had not before been told by a physician or other health professional that they had high cholesterol. Projected nationally, this percentage translates into about 2.1 million people who may have had high cholesterol without knowing it.

**Estimated Number of Medicare Beneficiaries Age 65 or Older Who Were Aware or Unaware That They Might Have High Blood Pressure or High Cholesterol, 1999–2000**



Source: CDC's National Health and Nutrition Examination survey.

A one-time preventive care examination may help orient new beneficiaries to Medicare and provide further opportunity for beneficiaries to receive some preventive services. Covering a one-time preventive care examination does not ensure, however, that beneficiaries will receive the recommended preventive services they need over the long term or consistently improve health or lower costs. CMS is exploring an alternative that would provide beneficiaries with systematic health risk assessments by means other than visits to physicians. A key component of this early effort involves the coupling of risk assessments with follow-up interventions, such as referrals for follow-up care.

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss seniors' health and the preventive care benefits in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Overall preventive care depends heavily on identifying health risks associated with the onset or progression of disease and on taking steps to reduce or mitigate these risks. The Medicare program, in contrast, was established largely to help pay beneficiaries' health care costs when they became ill or injured. Over time, however, Congress has broadened Medicare coverage to include specific preventive services, such as immunizations for influenza and pneumonia and screening tests for certain cancers, that aim to keep an illness or condition from developing or becoming more serious. Most recently, in passing the MMA, Congress added coverage, to start in 2005, for a one-time preventive care examination for new enrollees and for selected other preventive services.<sup>1</sup>

As these new benefits are implemented under MMA, you have inquired about lessons learned from previous research on delivery options for preventive services. Since 2002, we have done a series of reports for Congress that examines the delivery of preventive care services to Medicare beneficiaries. My statement today summarizes some relevant findings from our work done before MMA, specifically:

- the extent to which Medicare beneficiaries receive preventive services through physician visits, and
- some of the expected benefits and limitations of delivering services through a one-time preventive care examination, including discussion of another delivery option being explored by the Centers for Medicare & Medicaid Services (CMS).

My testimony today is based on reports and testimony we have issued since 2002.<sup>2</sup> Our work for these products included a synthesis of

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<sup>1</sup>Pub. L. No. 108-173, 117 Stat. 2066.

<sup>2</sup>See U.S. General Accounting Office, *Medicare: Beneficiary Use of Clinical Preventive Services*, [GAO-02-422](#) (Washington, D.C.: April 2002); *Medicare: Use of Preventive Services Is Growing but Varies Widely*, [GAO-02-777T](#) (Washington, D.C.: May 23, 2002); and *Medicare: Most Beneficiaries Receive Some but Not All Recommended Preventive Services*, [GAO-03-958](#) (Washington, D.C.: September 2003).

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information on preventive care received by people age 65 or older<sup>3</sup> from four nationally representative health surveys;<sup>4</sup> a review of the results of past related research demonstrations and congressionally mandated studies; and interviews with Department of Health and Human Services (HHS) and CMS officials and other experts. This work allows us to discuss the benefits and limitations of the delivery of preventive services through a one-time examination. This body of work was conducted from August 2001 through August 2003 in accordance with generally accepted government auditing standards. In July 2004, we updated information on recommended preventive services and on the status of a CMS effort to explore another delivery option.

In summary, although they typically visit a physician several times during a year, most Medicare beneficiaries receive some but not all recommended preventive services. Our analysis of year 2000 data shows that nearly 9 in 10 Medicare beneficiaries visited a physician at least once that year, and beneficiaries made an average of six visits or more within the year. Despite these opportunities, many beneficiaries did not receive recommended preventive services. In 2000, for example, about 30 percent of Medicare beneficiaries did not receive an influenza vaccination, and 37 percent had never had a pneumonia vaccination as recommended under current guidelines for people age 65 or older. Moreover, many Medicare beneficiaries are apparently unaware that they may have conditions that preventive services are meant to detect. For example, in one 1999–2000 nationally representative survey during which people received physical examinations, nearly one-third of people age 65 or older whom the survey

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<sup>3</sup>We focused this work on the people covered by Medicare who are 65 or older—about 86 percent of the entire Medicare population. Besides this age group, Medicare also covered about 5.8 million disabled persons younger than age 65, whom our work did not include. Throughout this testimony, except where otherwise noted, we use the term “Medicare beneficiaries” to refer only to those beneficiaries age 65 or older.

<sup>4</sup>The Centers for Disease Control and Prevention’s (CDC) Behavioral Risk Factor Surveillance System asks a range of health questions over the telephone, including if respondents received a “routine checkup” within the past year. CMS’s Medicare Current Beneficiary Survey collects self-reported data, including whether respondents have received influenza or pneumonia immunizations. CDC’s National Health and Nutrition Examination Survey (NHANES) collects data on health conditions by means of both comprehensive health examinations and interviews, where patients self-report information, including whether a physician or other health professional has ever told them that they have a given health condition. Unlike the other surveys, which take a sample of the population, CDC’s National Ambulatory Medical Care Survey samples physician practices, collecting detailed information about office visits, including the major reason for the visit and which preventive services were ordered or provided.

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found to have high cholesterol measurements said they had not previously been told by a physician or other health professional that they had high cholesterol. Projected nationally, this percentage translates into 2.1 million people age 65 or older who may have had high cholesterol without knowing it.

A one-time preventive care examination may provide an opportunity for beneficiaries to receive some preventive services while orienting new beneficiaries to Medicare. But covering an initial examination does not ensure that beneficiaries receive the recommended preventive services they need. The results of a CMS demonstration conducted in the late 1980s and early 1990s indicated that offering Medicare beneficiaries packages of broad-based preventive services slightly improved the use of some services, such as immunizations and cancer screenings, but did not consistently improve health or lower costs. CMS is exploring an alternative for Medicare preventive care that, by means other than a physician's examination, would provide systematic health risk assessments to Medicare beneficiaries. A key component of this demonstration, which is still in development, is to address concerns that to be effective, risk assessments must be coupled with follow-up interventions, such as referrals for follow-up care.

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## Background

Preventive health care can extend lives and promote well-being among our nation's seniors. Medicare now covers a number of preventive services, including immunizations, such as hepatitis B and influenza, and cancer screenings, such as Pap smears and colonoscopies. Not all beneficiaries, however, avail themselves of covered preventive services. Some beneficiaries may simply choose not to use these services, but others may be unaware that the services are available or covered by Medicare. Further, for some beneficiaries, certain services may not be warranted or may be of limited value. Appropriate preventive care depends on an individual's age and particular health risks, not simply on the results of a standard battery of tests.

To evaluate preventive care for different age and risk groups, HHS in 1984 established the U.S. Preventive Services Task Force, a panel of private-sector experts. The task force recommends certain screening, immunization, and counseling services for people age 65 or older. Medicare covers some, but not all, of these services (see table 1).

**Table 1: Preventive Services Recommended by the U.S. Preventive Services Task Force or Covered by Medicare as of August 2003**

<b>Service</b>	<b>Task force recommendation for age 65+</b>	<b>Year first covered by Medicare as preventive service</b>	<b>Medicare cost-sharing requirements<sup>a</sup></b>
<b>Immunization</b>			
Pneumococcal	Recommends	1981	None
Hepatitis B	No recommendation	1984	Copayment after deductible
Influenza	Recommends	1993	None
Tetanus-diphtheria (Td) boosters	Recommends	Not covered <sup>b</sup>	N/A
Varicella	Recommends	Not covered <sup>b</sup>	N/A
<b>Screening</b>			
Cervical cancer: Pap smear	Recommends against <sup>c</sup>	1990	Copayment with no deductible <sup>d</sup>
Breast cancer: mammography	Recommends <sup>e</sup>	1991	Copayment with no deductible
Vaginal cancer: pelvic exam	Not evaluated	1998	Copayment with no deductible <sup>d</sup>
Colorectal cancer: fecal-occult blood test <sup>f</sup>	Strongly recommends	1998	No copayment or deductible
Colorectal cancer: flexible sigmoidoscopy or colonoscopy <sup>g</sup>	Strongly recommends	1998	Copayment after deductible <sup>h</sup>
Osteoporosis: bone mass measurement	Recommends (women only)	1998	Copayment after deductible
Prostate cancer: prostate-specific antigen test and/or digital rectal examination	Insufficient evidence to recommend for or against	2000	Copayment after deductible <sup>d</sup>
Glaucoma	Insufficient evidence to recommend for or against	2002	Copayment after deductible
Vision impairment	Recommends	Not covered	N/A
Hearing impairment	Recommends	Not covered	N/A
Height, weight, and blood pressure	Recommends	Not covered	N/A
Cholesterol measurement	Strongly recommends	Not covered	N/A
Problem drinking	Recommends	Not covered	N/A
Depression	Recommends	Not covered	N/A
<b>Counseling</b>			
Smoking cessation, injury prevention, dental health	Recommends	Not covered	N/A
Aspirin for primary prevention of cardiovascular events	Strongly recommends	Not covered	N/A

Source: U.S. [GAO-03-958](#) and U.S. Preventive Services Task Force, *Guide to Clinical Preventive Services*, 2nd ed. (Washington, D.C.: 1996) and related updates. According to a task force official, since our 2003 report was issued, the task force has also recommended diabetes screening for people age 65 or older at risk of this disease.

<sup>a</sup>Applicable Medicare cost-sharing requirements generally include a 20 percent copayment after a \$100 per year deductible. Specifically, each year, beneficiaries are responsible for 100 percent of the payment amount until those payments equal a specified deductible amount, \$100 in 2003. 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. 42 U.S.C. § 1395(a)(1) (2000).

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<sup>b</sup>Although the tetanus-diphtheria (Td) and varicella (chickenpox) booster vaccinations are not covered under Medicare as “preventive” services, these treatments might be covered under Medicare if necessary to a beneficiary’s medical treatment. Medicare provides coverage for medical treatment and services that are “reasonable and necessary for the diagnosis or treatment of an illness or injury,” provided that the services or products used are “safe and effective” and not merely “experimental.” 42 U.S.C. § 1395(a)(1)(A) (2000).

<sup>c</sup>The task force recommends against routinely screening women older than 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.

<sup>d</sup>The costs of the laboratory test portion of these services are not subject to a copayment or deductible. The beneficiary is subject to a deductible, copayment, or both for physician services only.

<sup>e</sup>The task force recommends screening mammography, with or without a clinical breast examination, every 1–2 years for women age 40 and older.

<sup>f</sup>Data are insufficient to determine which strategy is best to balance benefits against potential harm or cost-effectiveness. Barium enemas are covered as an alternative if a physician determines that their screening value is equal to or greater than sigmoidoscopy or colonoscopy.

<sup>g</sup>The copayment has increased from 20 to 25 percent for services provided in an ambulatory surgical center.

Medicare’s fee-for-service program<sup>5</sup> does not cover regular periodic examinations, where clinicians might assess an individual’s health risk and provide needed preventive services. Beneficiaries could and still can, however, receive some of these services during office visits for other health issues.

In late 2003, MMA added coverage under Medicare for a one-time “initial preventive physician evaluation” if performed within 6 months after an individual’s enrollment under Part B of the program.<sup>6</sup> Covered services under the examination include measurement of height, weight, and blood pressure; an electrocardiogram; and education, counseling, and referral services for screenings and other preventive services covered by Medicare. MMA also added coverage for various screening tests to identify

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<sup>5</sup>“Fee-for-service” is the Medicare arrangement sometimes referred to as the original Medicare plan. Under this option, Medicare pays a health care practitioner for each visit or procedure received by a patient, and a beneficiary can visit any hospital, physician, or health care provider who accepts Medicare patients. Medicare pays a set percentage of the expenses, and the beneficiary is responsible for certain deductibles and coinsurance payments—the portion of the bill that Medicare does not pay. Our September 2003 report indicated that about 84 percent of Medicare enrollees were in the fee-for-service program.

<sup>6</sup>The Medicare Program is divided into three parts. Part A provides hospital insurance coverage, and Part B provides coverage for supplemental medical insurance benefits, such as the preventive health care services discussed above. Part C requires managed care plans participating in the Medicare + Choice program to provide all the basic benefits covered under Parts A and B.

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cardiovascular disease (and related abnormalities) in “elevated risk” beneficiaries and diabetes in “at risk” beneficiaries.<sup>7</sup> The new coverage applies to services provided on or after January 1, 2005.

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## Most Beneficiaries Receive Some but Not All Recommended Preventive Services

Nationally representative survey data show that Medicare beneficiaries visit physicians often and that most report receiving “routine checkups.” These data do not show, however, which specific services were delivered during those “checkups.” Despite the frequency of visits, many Medicare beneficiaries do not receive the full range of recommended preventive services. Data also show that many beneficiaries may not know about their risk for health conditions that preventive care is meant to detect.

From 2000 survey data and U. S. Bureau of the Census estimates of people age 65 or older, we estimated that beneficiaries visited a physician at least six times that year, on average, mainly for illnesses or medical conditions. Only about 1 in 10 visits occurred when beneficiaries were well (see fig. 1).<sup>8</sup>

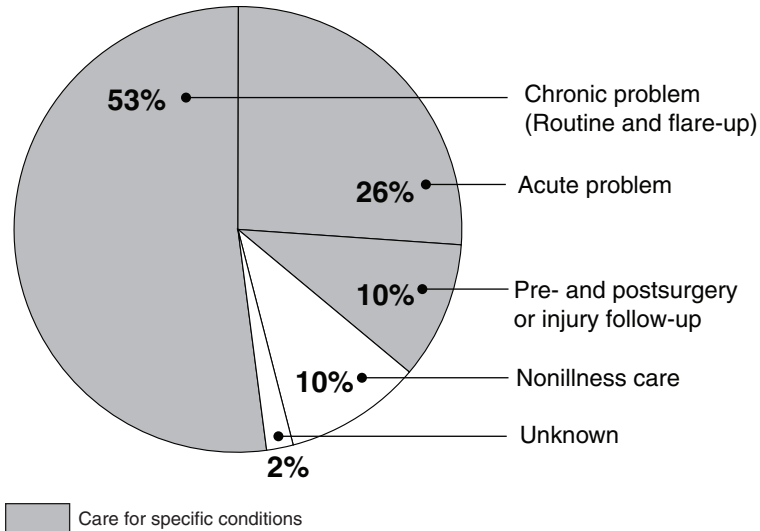
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<sup>7</sup>The new preventive care services requirements appear at Pub. L. No. 108-27, §§ 611–613, 117 Stat. 2303-2306 (adding sections 1861(s)(2)(W), (X), and (Y) to SSA) (to be codified at 42 U.S.C. §§ 1395x(s)(2)(W), (X), and (Y).)

<sup>8</sup>Because Medicare’s fee-for-service program covers some preventive services, such as immunizations and certain cancer screening tests, it is possible that some of the nonillness visits in 2000 were to obtain such services. In addition, some fee-for-service beneficiaries may be paying for nonillness examinations through other means, such as employer-provided or other supplemental insurance. According to CMS’s Medicare Current Beneficiary Survey, in the year 2000 about 41 percent of Medicare fee-for-service beneficiaries had insurance from former employers to supplement their basic Medicare benefit.



**Figure 1: Major Reasons for Physician Visits by Medicare Beneficiaries in the Fee-for-Service Program, 2000**



Source: CDC's National Ambulatory Medicare Care Survey, 2000.

Note: Numbers do not add to 100 percent because of rounding. The survey defined an "acute problem" as a condition or illness of sudden or recent onset, a "chronic problem" as a preexisting long-term or recurring condition or illness, and "nonillness care" as a general health maintenance examination or routine periodic examination of a presumably healthy person. For chronic problems, the survey reported results separately for "routine chronic problems" and for "chronic problem flare-ups." We combined these results in this figure.

Even though the majority of visits to physicians were to treat illness or health conditions, most Medicare beneficiaries reported receiving what they considered to be "routine checkups." In CDC's 2000 Behavioral Risk Factor Surveillance System Survey, for example, 93 percent of respondents age 65 or older reported that they had received a "routine checkup" within the previous 2 years.<sup>9</sup> This survey did not, however, provide information on which specific services were delivered during those checkups. Data from another survey, enumerating services provided during office visits, indicated that Medicare beneficiaries do receive some preventive services during visits when they are ill or being treated for a health condition.

<sup>9</sup>In 2000, data from CMS's Medicare Current Beneficiary Survey also showed that 88 percent of Medicare beneficiaries reported that they visited a physician at least once that year.

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Despite how often Medicare beneficiaries visit physicians, relatively few beneficiaries receive the full range of recommended preventive services covered by Medicare. As we reported in 2002, for example, although 91 percent of female Medicare beneficiaries in our analysis received at least one preventive service, only 10 percent were screened for cervical, breast, and colon cancer and were also immunized against influenza and pneumonia.<sup>10</sup> Our analysis of additional data for our 2003 report showed that many Medicare beneficiaries still did not receive certain recommended preventive services. The task force recommends, for example, that all people age 65 or older receive an annual influenza vaccination and at least one pneumonia vaccination. According to data from CMS's Medicare Current Beneficiary Survey of 2000, however, about 30 percent of Medicare beneficiaries did not receive an influenza vaccination, and 37 percent had never had a pneumonia vaccination.

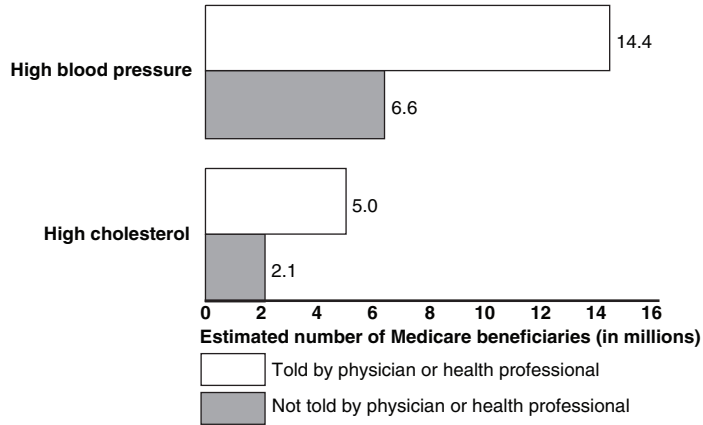
Many Medicare beneficiaries may not know that they are at risk for health conditions that preventive care could detect—strong evidence that they may not be receiving the full range of recommended preventive services.<sup>11</sup> For example, data from CDC's NHANES for 1999–2000 show that, of beneficiaries participating in this nationally representative survey who, as part of the survey, had a physical examination and were found to have elevated blood pressure readings at that time, 32 percent reported that no physician or other health professional had told them about the condition before. On the basis of this survey, we estimate that, during the period when the survey was conducted, 21 million Medicare beneficiaries may have been at risk for high blood pressure, and an estimated 6.6 million of them may have been unaware of this risk. Similarly, 32 percent of those found by the survey to have a high cholesterol level reported that no one had told them that they had high cholesterol. Projected nationally, this percentage translates into 2.1 million Medicare beneficiaries who may have had high cholesterol without knowing it (see fig. 2).

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<sup>10</sup>In January 2003, the U.S. Preventive Services Task Force released new recommendations for the use of Pap smears to screen for cervical cancer. The task force now “recommends against screening women 65 or older who have had adequate recent screenings with normal Pap smears and are not otherwise at increased risk for cervical cancer.”

<sup>11</sup>The source of data for this statement was CDC's NHANES of 1999–2000. This survey oversampled; that is, it included a larger number of persons age 60 and older in the sample, providing for a sample size that enabled us to focus our analysis specifically on the Medicare-age population for selected conditions.

**Figure 2: Estimated Number of Medicare Beneficiaries Age 65 or Older Who Were Aware or Unaware That They Might Have High Blood Pressure or High Cholesterol, 1999–2000**



Source: CDC's National Health and Nutrition Examination survey.

Note: CDC's NHANES measured blood pressure three or four times during its 1-day physical examination. For our analysis, we calculated the average of the blood pressure measurements and applied CDC's definition of high blood pressure: that is, a patient's having an average systolic blood pressure equal to or greater than 140, or an average diastolic blood pressure equal to or greater than 90, or a patient who reported taking hypertension medication. CDC defined high cholesterol as a total cholesterol level equal to or greater than 240.

## An Initial Examination May Improve Preventive Care, but Follow-up Is Also Key

A one-time initial preventive care examination covered by Medicare may offer opportunity to deliver some preventive services but alone is not enough to ensure better health among beneficiaries. Information from a CMS demonstration and from other related studies shows that ensuring receipt of follow-up care will be important to improving beneficiaries' health. A proposed CMS demonstration, currently in design, will explore another preventive care delivery option and examine the value of linking beneficiaries to needed follow-up services.<sup>12</sup>

As proponents of a one-time "Welcome to Medicare" examination told us, such an examination could be a means to better ensure that health care providers have enough time to identify individual Medicare beneficiaries' health risks and provide preventive services appropriate for their risks. It could be used to orient new beneficiaries to Medicare and encourage them to make informed choices about providers and plans. Nevertheless, a one-

<sup>12</sup>We confirmed in July 2004 that this CMS demonstration was still in the design phase.

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time examination does not ensure delivery of the full range of preventive services. Primary care physicians typically cannot provide services such as mammography screenings for breast cancer or colonoscopies for colon cancer, because these services usually require specialists.

It also is uncertain whether a one-time or periodic examination would be an effective way to improve beneficiaries' health. For example, one previous CMS initiative that included preventive health care visits ended with mixed results. In the late 1980s and early 1990s, the agency conducted a congressionally mandated demonstration to test varied health promotion and disease prevention services, such as free preventive visits, health risk assessment, and behavior counseling, to see if they would increase use of preventive services, improve health, or lower health care expenditures for Medicare beneficiaries.<sup>13</sup> The agency's final report, published in 1998, concluded that the demonstration services were marginally effective in raising the use of some simple disease-prevention measures, such as immunizations and cancer screenings, but did not consistently improve beneficiary health or reduce the use of hospital or skilled nursing services.<sup>14</sup> The report tempered these results by pointing out that the relatively brief period during which the services were provided (roughly 2 years) and the limited number of follow-ups and beneficiary contacts with providers (one to two) may have been inadequate to achieve measurable outcomes.

Determining how to better ensure adequate follow-up once health risks are identified is a concern that a new CMS project aims to evaluate. CMS is exploring an alternative for Medicare preventive care that would provide systematic health risk assessments to fee-for-service beneficiaries through a means other than examination by a physician. In the late 1990s, the agency commissioned the RAND Corporation to evaluate the potential effectiveness of health risk assessment programs. Such programs collect information from individuals; identify their risk factors; and refer the individuals to at least one intervention to promote health, sustain function,

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<sup>13</sup>The Consolidated Omnibus Budget Reconciliation Act of 1985 directed CMS (then known as the Health Care Financing Administration) to conduct a 4-year demonstration (*see* Pub. L. No. 99-272, § 9314, 100 Stat. 82, 194-196 (1986)), which was extended for an additional year by the Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4164, 104 Stat. 1388, 1388-100.

<sup>14</sup>Donna E. Shalala, *Medicare Prevention Demonstration: Final Report*, RC 87-172 (Washington, D.C.: Department of Health and Human Services, 1998).

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or prevent disease.<sup>15</sup> The study concluded that health risk assessment programs have increased beneficial behavior (particularly exercise) and improved physiological variables (particularly diastolic blood pressure and weight) and general health.<sup>16</sup> In addition, the study stated that to be effective, risk assessment questionnaires must be coupled with follow-up interventions, such as referrals to appropriate services. The study recommended that CMS conduct a demonstration to test cost-effectiveness and other aspects of the health risk assessment approach for Medicare beneficiaries.

Following through on the study's findings, CMS has begun designing a demonstration project focused on Medicare fee-for-service beneficiaries, called the Medicare Senior Risk Reduction Program, to identify health risks and follow up with preventive services provided by means other than examinations by physicians. The program will use a beneficiary-focused health risk assessment questionnaire to assess health risks, such as lifestyle behaviors, and use of clinical preventive and screening services. The program will test different approaches to administering health risk assessments, creating feedback reports, and providing follow-up services, such as referring beneficiaries to health-promoting community services including physical activity and social support groups. According to project researchers, the program will tailor preventive interventions to individual risks; track patient risks and health over time; and provide beneficiaries with self-management tools and information, health behavior advice, and end-of-life counseling where appropriate. The design phase had not been finalized as of last week and, according to a CMS official, still required approval from HHS and the Office of Management and Budget.<sup>17</sup>

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<sup>15</sup>A typical health risk assessment obtains information on demographic characteristics (e.g., sex, age); lifestyle (e.g., smoking, exercise, alcohol consumption, diet); personal health history; and family health history. In some cases, physiological data (e.g., height, weight, blood pressure, cholesterol levels) are also obtained, as well as a patient's status regarding cancer screens and immunizations.

<sup>16</sup>Southern California Evidence-Based Practice Center/RAND, *Health Risk Appraisals and Medicare* (Baltimore: Centers for Medicare & Medicaid Services, 2001). RAND identified 267 articles, unpublished reports, and conference presentations, of which 27 contained data that project staff deemed necessary to be included as evidence of the effectiveness of health risk assessments.

<sup>17</sup>The demonstration's final cost was uncertain at the time our report was completed in September 2003. CMS was spending approximately \$1 million on the developmental work.

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## Concluding Observations

Current data indicate that many opportunities exist for Medicare beneficiaries to receive preventive care, but many beneficiaries nonetheless fail to receive the full range of recommended services. Although some beneficiaries may not choose to seek these services, others may not be aware that these services are available and covered by Medicare. Our work shows that more needs to be done to deliver preventive services to those beneficiaries who need them, because many people may have a health condition that preventive services can easily diagnose, and yet they may not know that they have this condition.

A one-time preventive care examination will add a dedicated opportunity for delivering preventive care and could help reduce the gap in the preventive services that Medicare beneficiaries receive. At the same time, it is not a panacea. Ensuring that beneficiaries receive needed services and follow-up care is likely to remain a challenge.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of this Committee may have.

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## Contact and Acknowledgments

For future contacts regarding this testimony, please call Janet Heinrich at (202) 512-7119. Katherine Iritani, Matt Byer, Ellen W. Chu, Lisa Lusk, and Behn Miller Kelly also made key contributions to this testimony.

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