Fact Sheet

Improvements to Medicare's Preventive Services under Health Reform

The recently enacted Patient Protection and Affordable Care Act (ACA) will greatly increase the availability of health insurance and broadly impact the delivery of health care in America. This fact sheet looks specifically at how the legislation changes coverage for preventive care services in Medicare.

The ACA makes changes to Medicare coverage for preventive care services. Beginning January 1, 2011, millions of Medicare beneficiaries will be able to access many important preventive services without incurring any cost-sharing obligations. This policy represents an important step in eliminating barriers to preventive services for Medicare beneficiaries.

Current Medicare Preventive Care Coverage

Medicare covers a number of preventive services, with varying levels of beneficiary cost sharing. Currently, cost sharing can take two forms: the annual Part B deductible and standard 20 percent cost sharing. The annual Part B deductible may apply to a service, meaning that a beneficiary would have to pay the full cost up to the annual deductible amount—$155 in 2010. In addition, once the deductible is satisfied, the beneficiary may be required to pay the standard 20 percent coinsurance for Part B services.

New Preventive Service Coverage under Health Reform

Starting January 1, 2011, beneficiaries will have access to the same preventive services, but with no cost sharing for most. The ACA specifies that any Medicare-covered service recommended with a grade A or B by the United States Preventive Services Task Force (USPSTF) for any indication or population must be fully covered by Medicare, with no cost sharing for the patient. The beneficiary will not have to meet the annual Part B deductible before Medicare will pay for the service, nor will the beneficiary have to pay any coinsurance. The appendix describes the rating system and the meaning of different grades for practitioners.

In developing recommendations regarding preventive services, the USPSTF often makes recommendations that are qualified by such criteria as age or health history. For example, the USPSTF has given abdominal aortic aneurysm screening a B-rating *only* for men ages 65 to 75 who have ever smoked.

The ACA does not require the Centers for Medicare and Medicaid Services (CMS)—the federal agency responsible for implementing this provision—to consider the USPSTF qualifying criteria when eliminating cost sharing for A- and B-rated services. It is not clear at this time whether the final regulation will include qualifying criteria or whether CMS will eliminate cost sharing for *all*

Medicare beneficiaries as long as a service has the requisite USPSTF rating. The final regulation is expected to be issued on November 1, 2010.

New Coverage for Wellness Visits and Personalized Prevention Plans

Medicare will continue to cover a Welcome to Medicare physical exam for new beneficiaries within their first year of enrollment in Part B. The Welcome to Medicare exam is free.

In addition to the Welcome to Medicare exam, starting on January 1, 2011, Medicare will cover an annual wellness visit and accompanying personalized prevention plan for all beneficiaries. The visit and personalized prevention plan will be free.

The free personalized prevention plan includes the following:

- A health risk assessment, for which the Department of Health and Human Services is to develop guidelines
- Individual and family medical history
- A list of current providers providing care
- A list of prescription medications
- Height, weight, and body mass index (BMI) or waist circumference measurements
- Blood pressure measurements
- Detection of cognitive impairments
- A screening schedule for appropriate preventive services over the next five to ten years
- A list of risk factors and conditions for which interventions are recommend or under way
- Personalized health advice and referrals as appropriate

In addition, the secretary of the Department of Health and Human Services has the authority to add other elements to the annual wellness visit that he or she deems appropriate.

New enrollees may not receive both the Welcome to Medicare exam and the annual wellness visit during their first 12 months of enrollment. The Welcome to Medicare exam is available during the first 12 months of enrollment, and the annual wellness visit is available each year after that. The two services appear to be similar, though exactly how similar may depend on the guidelines developed for the annual health risk assessment. These guidelines are not due until March 2011.

The ACA does not require Medicare Advantage (MA) plans to offer covered preventive services with no cost sharing. In the future, CMS may require MA plans to do so. In practice, most MA plans already offer Medicare-covered preventive services without cost sharing. Enrollees should check with their plan to confirm cost-sharing requirements for preventive services.

Removing cost sharing for preventive services for which there is strong evidence of benefit to individual health demonstrates Medicare's commitment both to keeping beneficiaries healthy and using evidence to drive coverage decisions.

Appendix
Definitions of USPSTF Ratings

Grade	Definition	Suggestions for Practitioners
A	The USPSTF recommends the service. There is a high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service for an individual patient. There is at least moderate certainty that the net benefit is small.	Offer or provide this service only if other considerations support doing so for an individual patient.
D	The USPSTF recommends against providing the service. There is moderate or high certainty that the service has no net benefit or that the potential harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of the USPSTF recommendation statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harm.

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