



## Focus on Prevention: Medicare Wellness Visits

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**New Report from The Department of Health and Human Services Shows More than 150,000 Seniors and People with Disabilities Have Benefited from the New Annual Wellness Visit in 2011**

### **From the healthcare.gov Implementation Center:**

The Affordable Care Act brings new benefits and savings to millions of people covered by Medicare in 2011. At the forefront of these improvements is prevention. As of January 1, 2011, Medicare beneficiaries no longer have to pay a deductible, co-insurance, or copayment for many preventive services covered by Medicare as well as recommended services newly covered by the program.

These services include certain cancer screenings such as mammograms and colonoscopies as well as a new annual wellness visit. During the annual wellness visit, doctors and beneficiaries can develop and/or update a personalized prevention plan that takes into account medical and family history, detection of any cognitive impairment, potential (risk factors) for depression, and review of the individual's functional ability and level of safety. Doctors can also furnish personalized health advice and referrals, as appropriate, to education or preventive counseling services and programs.

The annual wellness visit and other recommended services are free of charge, when obtained by a participating health care professional, for all seniors and people with disabilities enrolled in the Medicare part B program.

The Affordable Care Act is already helping Medicare beneficiaries access preventive services and lowering costs:

- 1. More than 150,000 Medicare beneficiaries have already received an annual wellness visit:** Use of the new Medicare annual wellness visit has been high, with 151,764 beneficiaries having received one between January 1 and February 23, 2011. Counting weekends, this means that an average of nearly 2,800 seniors and people with disabilities per day accessed this important new benefit. When obtained from a participating health care professional, this visit is free of charge – beneficiaries do not pay a deductible, copayment or co-insurance. This means real savings for seniors since an annual wellness visit in a physician's office can cost just over \$160 for the first visit and \$105 for a subsequent annual wellness visit. It also means better health, quality of life, and potentially lower Medicare costs due to a decrease in preventable illnesses over time.
- 2. Many more beneficiaries will receive access to and save on preventive benefits as a result:** Medicare deductible and co-insurance will be waived for many preventive services covered by the program. Beneficiary savings result from new coverage and reduced cost sharing. Medicare also has the ability to cover additional services if they have been given an "A" or "B" recommendation by the United States Preventive Services Task Force (USPSTF).

- 3. Expanded Medicare prevention lowers premiums for employers, states, and people with Medigap:** New Medicare coverage for the annual wellness visit and prevention services will lower the cost for employers that sponsor retiree coverage, states that fill in Medicare's coverage gaps, and seniors that purchase Medigap coverage.

## **BACKGROUND**

### **Value of Prevention for Seniors**

The obesity epidemic and growing levels of preventable diseases and chronic conditions contribute greatly to the high costs of health care. One study estimates that almost 80% of all health care spending in the United States can be attributed to potentially preventable chronic illnesses such as cancer and diabetes.<sup>[11]</sup> In fact, the costs of treating cancer alone totaled \$93 billion in 2008.<sup>[12]</sup> The cost of preventable diseases is particularly high for Medicare, which in 2011 will provide health care coverage to 49 million seniors and people with disabilities.<sup>[13]</sup> Studies have found that chronic diseases, such as diabetes, arthritis, hypertension, and kidney disease, account for an increasing share of Medicare's costs.<sup>[14]</sup>

The use of physician-recommended preventive services increases the chance that these diseases will be identified in their early stages, treated, managed, and, in some cases, cured. Proven preventive services could improve the quality and length of the lives of seniors as well as reduce costs of medical care. For example, immunizing those over age 65 against pneumococcal disease has been found to be particularly cost-effective, but pneumococcal vaccines are still underutilized.<sup>[15]</sup> Approximately 40,000 Americans die each year due to pneumococcal infections, with the highest rate among seniors. Yet, only 58% of Americans over 65 have received the vaccination. One study estimates that if all seniors received this vaccine, health care costs could be reduced by nearly \$1 billion per year.

As another example, over the next 25 years, management of diseases such as hypertension among seniors could reduce health care spending by as much as \$890 billion while simultaneously decreasing mortality rates. Similarly, eliminating diabetes could increase lifespan, enhance quality of life, and save nearly \$250 billion.<sup>[16]</sup>

However, Americans use preventive services at about half the recommended rate.<sup>[17]</sup> And Medicare beneficiaries are not much different. In 2008, approximately 43% of female Medicare beneficiaries did not receive a mammogram.<sup>[18]</sup> These statistics become even more dramatic when considered in the context of race and ethnicity. Current data indicate that Hispanic and non-Hispanic Black Medicare beneficiaries experience lower rates of colorectal cancer screening, compared to non-Hispanic Whites.<sup>[19]</sup> Some of this disparity may result from cost sharing requirements, or the amount a person must pay at the point of service. The presence of copayments reduces the likelihood that preventive services will be used and may discourage individuals from seeking care that could improve health outcomes. One study found that the rate of women getting a mammogram went up as much as 9% when cost sharing was removed.<sup>[110]</sup> Cost sharing requirements have larger effects on utilization for lower-income beneficiaries than for those with more resources.

### **Gaps in Coverage in Medicare**

Prior to enactment of the Affordable Care Act, Medicare covered some recommended preventive services, and many of the services covered had cost sharing (see Table 1). For example, while Medicare covered colorectal

cancer screening, and exempted the cost of such care from the deductible, the 20% co-insurance could have been as much as \$160 in 2010. And, despite the cost that tobacco use and its resulting illnesses impose on Medicare, Medicare did not pay the costs for tobacco cessation or counseling until after beneficiaries met their deductible, which was \$155 in 2010. Even if the beneficiaries had met this deductible, they still paid a 20% share of this service as co-insurance.

Prior to enactment of the Affordable Care Act, after an initial “Welcome to Medicare” visit that focused on wellness and prevention, Medicare did not pay for any further wellness or prevention doctor visits. The “Welcome to Medicare” visit is now covered without cost sharing during the first 12 months of Part B coverage. This one-time exam pays physicians to review beneficiaries’ health as well as offer education and counseling about preventive services and other care. In addition, Medicare now covers an annual wellness visit. The average Medicare payment for the initial annual wellness visit is \$160 and \$105 for a subsequent annual wellness visit in 2011.

**Table 1. Examples of Medicare Coverage of Recommended Preventive Services Prior to the 2011 Implementation of the Affordable Care Act**

| <b>20% Co-insurance Prior to 2011 (deductible waived)</b> | <b>20% Co-insurance and Deductible Prior to 2011</b>         |
|---|--|
| Breast Cancer Screening                                   | Bone Mass Measurement  |
| Cervical Cancer/Screening (Pap Tests/ Pelvic Exam)        | Hepatitis B (HBV) vaccine (plus administration)              |
| Colorectal Cancer Screening                               | Medical Nutrition Therapy (MNT)                              |
| Initial Examination (IPPE)                                | Smoking and Tobacco Use Cessation Counseling <sup>[11]</sup> |

**Affordable Care Act’s Expansion of Medicare’s Coverage of Prevention**

The Affordable Care Act makes important preventive services more accessible to Medicare beneficiaries. For recommended preventive services like mammograms, colonoscopies and bone density measurements, the Medicare part B deductibles and co-insurance will be waived if the services are covered by the program.

This benefit also applies to the Medicare annual wellness visit; beneficiaries who access that benefit will not pay co-insurance.<sup>[12]</sup> Due to the Affordable Care Act, seniors now have access to these important visits without the burden of cost sharing. This change represents savings for seniors as well as better health, quality of life, and potentially lower Medicare costs due to a decrease in preventable illnesses over time.

During the annual wellness visit, doctors and beneficiaries can develop and/or update a personalized prevention plan that takes into account medical and family history, detection of any cognitive impairment, potential (risk factors) for depression, and review of the individual’s functional ability and level of safety, along with the furnishing of personalized health advice and referral, as appropriate, to education or preventive counseling services or programs.

## Early Results

According to claims filed by physicians as of February 23, 2011, more than 150,000 Medicare beneficiaries have already had an annual wellness visit, newly covered with no cost sharing thanks to the Affordable Care Act. Counting weekends, this means that, per day, an average of nearly 2,800 seniors and people with disabilities accessed this important new benefit.

Starting this year, Medicare now covers recommended preventive services at no charge to beneficiaries if obtained from qualified and participating practitioners, or, in other words, with no deductible or cost sharing. The program will track the use of preventive services. With the financial barrier to care eliminated, the use of these services should increase.

In addition to improving the use of preventive services and increasing savings for beneficiaries, Medicare's new prevention enhancements will lead to lower premiums for employers who now fill this gap in coverage. The same is true with states that fill in Medicare's benefit gaps and cost sharing for low-income seniors through Medicaid. Lastly, many seniors buy Medigap insurance to cover Medicare's cost sharing: with Medicare now paying for annual wellness visits and recommended preventive services cost sharing, Medigap premiums should be lower.

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<sup>[1]</sup> Anderson, Gerard, and Jane Horvath (2004). "The growing burden of chronic disease in America." *Public Health Reports* 119(3): 263–70.

<sup>[2]</sup> American Cancer Society. *Cancer Facts & Figures 2009*. Atlanta, GA. 2009. [http://www.cancer.org/docroot/MIT/content/MIT\\_3\\_2X\\_Costs\\_of\\_Cancer.asp](http://www.cancer.org/docroot/MIT/content/MIT_3_2X_Costs_of_Cancer.asp)

<sup>[3]</sup> Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

<sup>[4]</sup> Chronic Conditions Account For Rise In Medicare Spending From 1987 To 2006 by [Kenneth E. Thorpe](#), [Lydia L. Ogden](#) and [Katya Galactionova](#) *Health Affairs* 2/23/10

<sup>[5]</sup> Michael V. Maciosek and others, "Priorities Among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis," *American Journal of Preventive Medicine*, vol. 31, no. 1 (July 2006), pp. 52–61.

<sup>[6]</sup> Dana P. Goldman, David M. Cutler, Baoping Shang, and Geoffrey F. Joyce. "The Value of Elderly Disease Prevention" *Forum for Health Economics & Policy* biomedical\_research (2006).

<sup>[7]</sup> McGlynn, E.A., S.M. Asch, J. Adams, J. Keeseey, J. Hicks, A. DeCristofaro, and E.A. Kerr. "The Quality of Health Care Delivered to Adults in the United States." *The New England Journal of Medicine*, vol. 348, no. 26, June 26, 2003: 2635–2645.

<sup>[8]</sup> Kaiser Family Foundation. *Medicare Chartbook, Fourth Edition*. Kaiser Family Foundation, 2010.

<sup>[9]</sup> Chyke Doubeni, Adeyinka Laiyemo, Carrie Klabunde, Angela Young, Terry Field, Robert Fletcher, "Racial and Ethnic Trends of Colorectal Cancer Screening Among Medicare Enrollees." *American Journal of Preventive Medicine*, Vol. 38, No. 2 (February 2010), pp. 184-191.

<sup>[10]</sup> Solanki G., Halpin Schauffler, H., Miller, L.S. "The Direct and Indirect Effects of Cost-Sharing on the Use of Preventive Services," *Health Services Research*, vol. 34, no. 6, February 2000, pp. 1331-1350.

<sup>[11]</sup> Includes up to 8 face-to-face visits in a 12-month period but only if the beneficiary is diagnosed with an illness caused or complicated by tobacco use, or takes a medicine that is affected by tobacco. There is a 20% copayment, the Part B deductible applies, and if in a hospital outpatient setting, the hospital copayment applies.

<sup>[12]</sup> The co-insurance represents the beneficiary's share of the payment to the provider or supplier for furnished services. Co-insurance generally refers to a percentage (for example, 20%) of the Medicare payment rate for which the beneficiary is liable and is applicable under the PFS, while copayment generally refers to an established amount that the beneficiary must pay that is not necessarily related to a particular percentage of the Medicare payment, and is applicable under the hospital Outpatient Prospective Payment System (OPPS).