



Understanding the New Health Care Law

From Families USA • March 2011

An Advocate's Guide to the New Preventive Services Benefit in Medicare

This fact sheet is a troubleshooting guide for advocates who are assisting beneficiaries as they navigate the new coverage of preventive services in Medicare. A companion fact sheet, *Medicare's New Preventive Care Benefit: What It Means for You*, written especially for Medicare consumers, explains how the new benefit works and what is covered. It's available online at <http://familiesusa2.org/assets/pdfs/health-reform/Consumer-Guide-Medicare-Preventive-Care-Benefit.pdf>. For more information on the new annual wellness visit that is covered under Medicare, see our companion fact sheet, *An Advocates' Guide to the New Annual Wellness Visit Benefit in Medicare*, available online at <http://familiesusa2.org/assets/pdfs/health-reform/Advocate-Guide-Medicare-Wellness-Visit.pdf>.

What Are Preventive Services?

The term "preventive services" refers to health screenings, vaccinations, and counseling services. Screenings include, for example, blood tests to check a person's cholesterol level. Vaccinations include the annual flu shot. Counseling services include talking with a doctor or other health care provider about such things as how to stop smoking. These services can help prevent illness from occurring, or they can help determine if a person is at risk for certain conditions, such as heart disease, so that he or she can take steps to prevent these conditions.

How the New Preventive Benefit Works and What It Means for Beneficiaries

Medicare has provided seniors and people with disabilities with health coverage for more than 40 years. Until recently, however, Medicare coverage was aimed primarily at treating beneficiaries' illnesses, injuries, and other conditions after people were already affected, rather than emphasizing preventive care to keep people healthy in the first place.

Under the Affordable Care Act, the health care law that was enacted in March 2010, Medicare coverage of preventive services will improve significantly. While Medicare previously provided some coverage for preventive services, beneficiaries often had to pay out of pocket for these services. Beginning on January 1, 2011, most preventive services for those with Medicare are free (in most circumstances). If a beneficiary sees a health care provider who accepts Medicare assignment (that is, the provider accepts Medicare's payment as payment in full), the beneficiary will not have any cost-sharing for the covered preventive services. However, if the beneficiary sees a health care provider who does not accept Medicare assignment or does not accept Medicare at all, the beneficiary may have to pay for preventive services.

This benefit is available to all people who are enrolled in original Medicare. The Centers for Medicare and Medicaid Services (CMS), the agency that runs the Medicare program, has proposed requiring Medicare Advantage plans to cover preventive services for free as well. However, it has not yet finalized the regulations that would make this a requirement. These regulations should be finalized in April 2011. In the meantime, beneficiaries should check with their Medicare Advantage plan to determine whether the plan charges any cost-sharing for preventive services.

■ **Why is this new benefit important?**

No one wants to get sick. Vaccinations and preventive screenings can help beneficiaries stay healthy. Despite this, 17 percent of women over age 65 have not received a mammogram in the past two years, even though studies show that this screening reduces breast cancer deaths. In addition, even though people over age 65 represent the majority of new cases of colorectal cancer, more than one-third have not received a colorectal cancer screening.¹ For some people, the out-of-pocket expense that came with getting a mammogram or colonoscopy was too much, and they never received these screenings. The Affordable Care Act removes this barrier by making these services available at no cost. This allows beneficiaries to work with their health care providers to determine what screenings are needed and when, without worrying about whether they can afford them.

The new preventive services benefit in Medicare is just one of the many ways that the Affordable Care Act will help beneficiaries improve their health and take more control over their health care through improved communication and coordination with their health care providers. A new helpful tool for Medicare beneficiaries is the *Preventive Services Checklist*, which is available online at www.medicare.gov. Beneficiaries can print out this checklist and consult with their health care provider to determine which screenings they have already had, which ones they need, and when they will need them. They can complete this form at any time, but a good time to do so would be during their Welcome to Medicare exam or during their annual wellness visit.

■ **What preventive services are free?**

Medicare will cover the preventive services that the U.S. Preventive Services Task Force recommends with a grade of “A” or “B.” The task force uses scientific research to determine which preventive services are safe and effective and who should receive them. The preventive services that Medicare covers, and any associated cost-sharing, are explained on the preventive services page at www.medicare.gov and in the *Medicare and You* handbook. However, our review of these resources has found that some of the information in those sources is not accurate. To ensure that you understand which services are covered for which beneficiaries, and at what cost-sharing, it is best to review the regulation and the table on page 3. A more detailed table that may also be helpful is available online at <http://www.ama-assn.org/ama1/pub/upload/mm/380/cms-prevention-coverage-cptcode.pdf>.

The services shown in the table below will be covered by Medicare at no cost for beneficiaries who meet the coverage criteria.

Preventive Services that Medicare Covers at No Cost to Beneficiaries

| Preventive Services | What's Covered | Who's Covered |
|---|---|---|
| Cardiovascular Screenings | Tests for cholesterol, lipid, and triglyceride levels | All people with Medicare |
| Breast Cancer Screenings | Breast exams, mammograms, and digital technology | Women with Medicare aged 40 and older |
| Cervical and Vaginal Cancer Screenings | Pap tests and pelvic exams | All women with Medicare |
| Colorectal Cancer Screenings | Fecal occult blood test, flexible sigmoidoscopy, screening colonoscopy | All people with Medicare aged 50 and older |
| Prostate Cancer Screenings | Prostate specific antigen (PSA) test | All men with Medicare aged 50 and older |
| Vaccinations | Flu shot, pneumococcal (pneumonia) shot, Hepatitis B shot | Flu and pneumonia shots: all people with Medicare; Hepatitis B shot: people with Medicare who are at medium or high risk |
| Osteoporosis Screening | Bone density measurement | People with Medicare who are at risk for osteoporosis and who have estrogen deficiency, vertebral abnormalities, or hyperparathyroidism; or who are receiving steroid treatments or taking an osteoporosis drug |
| Diabetes Screening | Fasting blood glucose test | People with Medicare who are at risk for diabetes |
| Medical Nutrition Therapy | 3 hours of one-on-one counseling services for the 1 st year and 2 hours each year after that | People with Medicare who have diabetes or renal disease, or who have had a kidney transplant within the last 3 years |
| Tobacco Use Cessation Counseling | Up to 8 face-to-face visits during a 1-year period | People with Medicare who use tobacco but have not been diagnosed with an illness caused by tobacco use |
| HIV Screening | HIV test | Pregnant women with Medicare and beneficiaries who are at increased risk |
| Abdominal Aortic Aneurysm Screening | Ultrasound | People with Medicare who have received a referral from their provider during their Welcome to Medicare exam and who are at risk |

- **Which preventive services are not free?**

It is important to explain to beneficiaries that not every preventive service is available to them at no cost. For example, Medicare currently covers glaucoma screenings, diabetes self-management training, prostate cancer screening by digital rectal examination, and colorectal screening by barium enema. However, the Preventive Services Task Force has not yet rated these screenings. As a result, Medicare cannot eliminate cost-sharing for these services. Beneficiaries may have to meet a deductible and/or pay co-insurance, depending on whether they have some form of supplemental coverage or whether their Medicare Advantage plan provides different coverage.

As the task force issues more recommendations, Medicare will determine whether to add the service to the list of \$0 cost-sharing preventive services. This means that, in time, more preventive services could be covered by Medicare at no cost to beneficiaries.

- **What are the other reasons a beneficiary may have to pay out of pocket?**

There are other instances in which a beneficiary may have to pay some out-of-pocket expenses. For example, a colon cancer screening can become a diagnostic test in which the doctor, having detected an abnormality, must take samples. The beneficiary will not owe a deductible for the test, but he or she may owe a co-insurance payment, depending on what type of supplemental coverage the beneficiary has. Beneficiaries may also have to meet a deductible or pay co-insurance for the office visit at which they receive the preventive service. And if the beneficiary receives other services during the same visit, he or she may have to pay for those services.

If a beneficiary needs to have screenings more often than is recommended, he or she may have to pay for the more frequent screenings.

Finally, a beneficiary may have to pay for preventive services if he or she receives them in an ambulatory surgical center or in a hospital's outpatient department rather than in a doctor's office.

What to Do if a Beneficiary Is Charged for a Preventive Service

If beneficiaries contact you for assistance because they believe they have been inappropriately charged for preventive services, you should first contact their health care providers. The preventive services benefit is new to providers, and they might have made a simple mistake due to their lack of knowledge about the new benefit. Also, at the beginning of 2011, some Medicare administrative contractors had incorrect information in their systems that resulted in improper denials of payment for preventive services. This problem should have been resolved by now, but you may need to check with 1-800-Medicare to determine if the contractor improperly denied coverage.

If the problem can't be resolved this way, determine the following:

1. Does the health care provider accept Medicare assignment?
2. Is the preventive service covered by Medicare?
3. Is the preventive service available at \$0 cost-sharing?
4. Does the beneficiary meet Medicare's coverage criteria for the service? (For example, is the woman who got a mammogram aged 40 or older?)

If the answer to all of these questions is "yes," it is likely that the beneficiary won't have to pay any cost-sharing, but you should check questions 5-8 to be sure.

5. Was the cost-sharing for the office visit or for another service that was provided during the visit rather than for the preventive service itself? The health care provider will be able to tell you whether this is the case, or you can check the beneficiary's Medicare Summary Notice (MSN) or Explanation of Benefits (EOB).
6. Did the beneficiary receive the service in an ambulatory surgical center or hospital outpatient setting rather than a doctor's office? If so, he or she may well have to pay some amount of cost-sharing.
7. Did a colorectal cancer screening become a diagnostic test? If so, the beneficiary will likely have to pay some cost-sharing.
8. Does the beneficiary have a Medicare Advantage plan that does not provide \$0 cost-sharing for preventive services? Ideally, beneficiaries who are in Medicare Advantage plans should contact their plans *before* obtaining preventive services to find out if they will have cost-sharing.

If you determine that the beneficiary was inappropriately charged cost-sharing for the preventive service, file an appeal with Medicare.

Helpful Resources

Medicare has a number of publications that discuss preventive benefits that may be helpful to advocates or beneficiaries. They are available online at www.medicare.gov. Key publications include the following:

- *Your Guide to Medicare's Preventive Services*, available online at <http://www.medicare.gov/publications/pubs/pdf/10110.pdf>.
- Medicare's *Preventive Services*, available online at <http://www.medicare.gov/navigation/manage-your-health/preventive-services/preventive-service-overview.aspx?AspxAutoDetectCookieSupport=1>.
- Medicare's *Preventive Services Checklist*, available online at [http://www.medicare.gov/\(X\(1\)S\(bu2w1nbudg4t3s55hlcg155\)\)/navigation/manage-your-health/preventive-services/preventive-service-checklist.aspx?AspxAutoDetectCookieSupport=1](http://www.medicare.gov/(X(1)S(bu2w1nbudg4t3s55hlcg155))/navigation/manage-your-health/preventive-services/preventive-service-checklist.aspx?AspxAutoDetectCookieSupport=1).
- The *Medicare and You* handbook, available online at <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>.

In addition, for more information on the Preventive Services Task Force and the services it recommends, go to their website at www.uspreventiveservicestaskforce.org.

¹ Department of Health and Human Services, *Enhancing Use of Clinical Preventive Services among Older Adults: Closing the Gap* (Washington: Department of Health and Human Services, 2011), available online at www.cdc.gov/aging.

This fact sheet was made possible by a grant from the Retirement Research Foundation (RRF) to identify and address the systemic issues that affect Medicare beneficiaries at the local and national levels.

