

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3 - A-02
(June 2002)

Subject: Coverage for Periodic Preventive Medical Evaluations
and Services
(Resolution 236, A-01)

Presented by: F. Maxton "Mac" Mauney, MD, Chair

Referred to: Reference Committee A
(Dorothy M. Kahkonen, MD, Chair)

1 At the 2001 Annual Meeting, the House of Delegates referred Resolution 236, introduced by the
2 New York Delegation, which calls for the AMA to “seek regulatory change and/or legislation that
3 screening for hypertension, vision and hearing, as well as counseling for tobacco cessation,
4 physical activity and nutrition be included as covered services under Medicare and that additional
5 federal appropriations be made for these services.” In addition, the House adopted Resolution 133
6 (A-01) as amended, which calls for the AMA to study the impact of insurance coverage for
7 evidence-based preventive services and prospective medical evaluations on the health of patients,
8 and the financial impact on the health care system, including options for payment. The Board of
9 Trustees referred both resolutions to the Council for a report back to the House at the 2002 Annual
10 Meeting.

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12 In this report, the Council on Medical Service suggests a need to focus on financial constraints that
13 would mitigate against expanding coverage to a selection of preventive services. The Council
14 discusses the financial solvency of the Medicare program and the financial outlook for health care
15 generally; describes AMA support of pluralism and its importance to the strategic success of the
16 AMA proposal for health system reform; summarizes recent preventive service benefit additions to
17 Medicare coverage and their associated costs; and highlights relevant AMA policy and reports.

18 19 BACKGROUND

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21 The sponsor of Resolution 133 (A-01), the Organized Medical Staff Section (OMSS), responded to
22 an invitation from the Council on Medical Service to provide additional comment. The OMSS
23 response indicated that its Assembly, which considered a resolution that sought to require Medicare
24 and other health insurance companies to pay for at least one annual physical examination per
25 enrollee, expressed concern about the cost and impact on a budget neutral payment system if
26 Medicare was required to pay for annual physical exams. Accordingly, the Section sponsored
27 Resolution 133 (A-01), which called for a study.

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29 The Council also was contacted by the College of American Pathologists (CAP) regarding
30 Resolutions 133 (A-01) and 236 (A-01). CAP provided information concerning its advocacy of
31 recent changes in Medicare coverage and payment for screening clinical laboratory tests, including
32 expanded coverage of screening pap tests and pelvic examinations, and increased payment for pap
33 tests. CAP also discussed the potential consideration by the Centers for Medicare and Medicaid
34 Services (CMS) of its request for a national coverage decision on the role of family history as a

1 medical justification for clinical diagnostic laboratory testing. The information provided by CAP
2 demonstrates efficient advocacy on behalf of the College's members.

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4 MEDICARE SOLVENCY

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6 The sluggish economy will likely result in fewer tax revenues for 2001 and 2002, and possibly
7 longer. Previous predictions of a bountiful federal budget surplus have dissolved. Referred
8 Resolution 236 (A-01) seeks "additional federal appropriations" for the coverage of various
9 preventive services under Medicare, which is financed with beneficiary premiums and federal
10 general revenues. Because it is an entitlement, increased Medicare expenditures are not subject to
11 the authorization and appropriations process that so-called "discretionary spending" is. However,
12 Medicare costs are noted so that when benefit expansions are approved, Congress is apprised of the
13 financial impact and seeks to balance increased expenses with cuts elsewhere.

14
15 Medicare is experiencing mounting financial pressure as the Medicare population grows larger and
16 older, and the population of working taxpayers increases much more slowly. The General
17 Accounting Office (GAO) estimates that, if left unchanged, the current tax-based "pay-as-you-go"
18 entitlements of Medicare, Social Security, and Medicaid will consume more than 75% of the
19 federal budget by 2030. As Medicare legislation moves through Congress, the AMA will seek a
20 long-term solution to the problems with the Sustainable Growth Rate formula, hospitals and health
21 plans will seek more favorable payment rates, Medicare beneficiary groups will seek a
22 pharmaceutical benefit, and others will seek to secure their particular portion of the finite
23 resources.

24
25 Congressional awareness of Medicare's financial peril is precisely the reason for the difficulty in
26 reaching an agreement on the addition of a pharmaceutical benefit. In two separate reports in 2001,
27 the GAO provided spending estimates for adding a new Medicare pharmaceutical benefit, and
28 concluded that the new benefit would be detrimental to the overall sustainability of the Medicare
29 program. Nevertheless, a Medicare pharmaceutical benefit has become a high priority for the
30 public and highlights the need to restructure Medicare. Meanwhile, coverage of screening for
31 hypertension, vision and hearing, and counseling for tobacco cessation, physical activity, and
32 nutrition, while beneficial to patients, have not been as widely portrayed as necessary as are
33 pharmaceutical benefits, perhaps because many patients did not have coverage for such services
34 prior to their coverage under Medicare, or perhaps because many beneficiaries feel they are already
35 getting that care.

36
37 COST INCREASES IN PRIVATE INSURANCE

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39 Resolution 133 (A-01) speaks to adding coverage of preventive services under health insurance
40 generally, although its whereas clauses indicate a concern with Medicare. Regarding private
41 insurance, with the economic slowdown, it is increasingly apparent that the number of the
42 uninsured for 2001 will increase from 2000. In fact, some policy analysts predict that the increase
43 may be the largest in a decade. Meanwhile, health insurance premiums skyrocketed last year, with
44 many employers facing double-digit increases. Given these indications of a health care financing
45 system under stress, advocating for the addition of coverage for general health physical
46 examinations may be considered imprudent because such examinations would primarily benefit
47 asymptomatic patients. Patients with symptoms would generally have their diagnosis and
48 treatment covered. Council on Medical Service Report 13 (A-02), which is also before the House

1 at this meeting, provides an in-depth analysis of growth in health care costs and health insurance
2 premiums.

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4 PREVENTIVE SERVICES UNDER MEDICARE

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6 Medicare currently provides coverage for a number of preventive services. Most recently, the
7 Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), added
8 coverage for the following:

- 9
10 • Screening pap smears and pelvic exams as frequently as every two years, instead of every three
11 years for women not at high risk for uterine or vaginal cancers. These services are covered
12 annually for women who meet Medicare's definition of high risk.
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14 • Glaucoma screening exams annually for individuals who meet Medicare's definition of high
15 risk for glaucoma, have a family history of the disease, or have diabetes.
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17 • Screening colonoscopy every 10 years for people not at high risk for colorectal cancer; this
18 previously had been covered only for individuals with high risk of colon cancer.
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20 • Medical nutritional therapy and counseling services for individuals with diabetes or chronic
21 renal disease, or who are post-transplant patients.
22

23 Medicare also covers the following preventive services:

- 24
25 • Four tests for colorectal cancer screening, including a yearly home fecal-occult blood test,
26 flexible sigmoidoscopy every four years, colonoscopy every two years for individuals who
27 meet Medicare's definition of high risk, and barium enema as an alternative to the colonoscopy
28 or sigmoidoscopy.
29
30 • Baseline mammograms for women aged 35 to 39, and annual mammograms for those aged 40
31 and older.
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33 • Bone mass measurements for individuals considered by Medicare to be at risk for osteoporosis.
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35 • Prostrate cancer screening exams for men aged 50 and older, including a digital rectal exam
36 and a Prostate Specific Antigen (PSA) test annually.
37
38 • Flu vaccine each season.
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40 • Pneumonia vaccine if needed.
41
42 • Hepatitis B vaccine for individuals who meet Medicare's definition of medium to high risk for
43 hepatitis.
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45 Regarding the financial and health impact of insurance coverage for preventive services and
46 prospective medical evaluations, the Congressional Budget Office (CBO) estimated that BIPA's
47 new preventive provisions would increase Medicare spending in the fee-for-service sector by

1 \$4.1 billion through 2010. It would be extremely difficult to estimate the health impact of
2 insurance coverage for a general set of “evidence-based preventive services and prospective
3 medical evaluations” as called for in Resolution 133 (A-01). Accordingly, in its BIPA cost
4 estimates, CBO did not include estimates of the amount of savings offset due to the potential
5 prevention of disease and illness. Though presumably positive, it is too early to know the
6 magnitude of BIPA’s health impact on beneficiaries.

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8 Despite Medicare’s noncoverage of routine screening, there is credible evidence that Medicare
9 beneficiaries perceive routine services as covered benefits. At its January 2002 meeting, MedPAC,
10 the independent advisory body to Congress on issues related to Medicare, considered the adequacy
11 of the Medicare benefits package. As a point of discussion, MedPAC reviewed a summary of a
12 study by Gail Janes, et al., published in the Centers for Disease Control and Prevention *MMWR*
13 *Surveillance Summaries*, December 1999. The study summarized national, regional, and state-
14 specific patterns of access to and use of preventive services among people aged 55 and older, and
15 indicated that Medicare beneficiaries obtain some preventive services despite formal coverage
16 limitations. For example, although periodic physical and gynecological exams are not covered,
17 85% of beneficiaries ages 65 through 74, and 88% of those aged 75 and over, reported having had
18 a routine checkup in the preceding 2 years.

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20 It is possible that some of the study’s patient respondents perceived having received a routine
21 checkup, when the physician visit actually was more focused on diagnosing a complaint or
22 symptom. Nevertheless, there appears to be a high level of agreement among beneficiaries that
23 routine screenings are provided for under Medicare.

24 AMA POLICY AND REPORTS

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27 Council on Medical Service Report 7 (A-00) responded to three resolutions that sought to expand
28 coverage of preventive services. The report summarized recent preventive benefit additions to
29 Medicare, expressed concern with mandated benefits, and discussed the importance of cost-
30 effectiveness analysis of preventive services. In adopting the recommendations contained in
31 Council Report 7 (A-00), the House established Policy H-425.997[3] (AMA Policy Database),
32 which states that any preventive service that is being considered for inclusion in public or private
33 sector insurance products have evidence-based data to demonstrate improved outcome or quality of
34 life and cost effectiveness of the service.

35
36 Longstanding AMA policy favors pluralism of health care delivery systems and financing
37 mechanisms (Policy 165.920[1]). More specific policy advocates that all insurers make available
38 for purchase a wide variety of group and individual health insurance policies that provide for a
39 range of clinical preventive services (Policy H-165.880[3]). Regarding the potential addition of a
40 Medicare pharmaceutical benefit, AMA Policy H-165.872 advocates that Medicare coverage of
41 pharmaceuticals be addressed in the broader context of transforming Medicare into a fiscally
42 solvent program.

43 IMPORTANCE OF PLURALISM TO AMA STRATEGIC GOALS

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45
46 The AMA proposal for health system reform was designed as a means to ensure patient choice. It
47 advocates the use of refundable tax credits for the purchase of individually owned health insurance.
48 It also encourages employers to provide employees with a defined contribution for use toward the

1 employee's choice of health coverage, rather than the current employment-sponsored insurance
2 practice of offering employees a defined benefit, which amounts to a predetermined, one-size-fits-
3 all assumption of employee preference. By emphasizing choice, the AMA proposal anticipates and
4 encourages a wide range of choice, from comprehensive high-cost and low-deductible options, to
5 "bare-bones" high-deductible catastrophic options. Therefore, the Council believes that proposals
6 to mandate coverage of specific services run the risk of conflicting with the AMA policy goals of
7 expanding patient choice and coverage for the uninsured.
8

9 DISCUSSION

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11 Given that the number of uninsured Americans will likely grow this year beyond the current 38.7
12 million, the Council believes it would be inappropriate at this time to advocate for the coverage of
13 additional benefits under the Medicare program and in the private sector. Rising health insurance
14 premiums, rising numbers of the uninsured, and financial pressures on Medicare all indicate a need
15 to prioritize health care decisions. In addition, long-standing AMA advocacy on pluralism would
16 seem to caution against advocating the coverage of new benefits by all payers, because doing so
17 would diminish insurance product options from which patients should have the right to choose.
18

19 RECOMMENDATIONS

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21 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
22 236 (A-01), and that the remainder of the report be filed:
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- 24 1. That the AMA reaffirm Policy H-165.920[1], which states that our AMA affirms its
25 support for pluralism of health care delivery systems and financing mechanisms in
26 obtaining universal coverage and access to health care services. (Reaffirm HOD Policy)
27
- 28 2. That the AMA reaffirm Policy H-165.880[3], which urges all health insurers to make
29 available for purchase a wide variety of group and individual health insurance policies that
30 provide coverage for a range of clinical preventive services. (Reaffirm HOD Policy)