Chapter 1
Executive Summary

Medicare is prohibited by law from offering benefits for preventive services except when they are specifically added to the scope of covered benefits through amendments to the Medicare act. So far, vaccines for pneumococcal pneumonia and Hepatitis B and screening Pap smears are the only preventive services covered by Medicare. The wisdom of this blanket exclusion with legislated exceptions has been questioned by many experts.

How should decisions be made about Medicare coverage of preventive services? This question has two components:

. What criteria should govern the decision-making process?
. Where should the responsibility for such decisions lie?

CRITERIA FOR INCLUDING PREVENTIVE SERVICES AS COVERED BENEFITS

Because they have traditionally been excluded from insurance benefit packages, preventive services have been held to a burden of proof of effectiveness or cost-effectiveness that exceeds that required for diagnostic and therapeutic procedures.

Third-party payers, including Medicare, generally accept diagnostic or therapeutic services as "reasonable and necessary' unless obvious abuse is encountered. In contrast, for preventive services to be included in a benefit package, evidence must exist that they are at least effective, and sometimes that their medical benefits are worth their costs. This standard may seem unduly harsh, and proponents of preventive services often argue that it is unfair to hold preventive services to a higher standard than that required for other medical services. Two powerful arguments favor a tough standard for preventive services, however. First, like all services, preventive services involve potential risks as well as potential benefit. However, unlike diagnostic and therapeutic services, which are rendered in response to patient complaints or symptoms, preventive services are offered to ostensibly healthy individuals and therefore involve an implied promise that they will improve the patient's health. Second, the more appropriate response to the double standard may be to raise the level of evidence required for diagnostic and therapeutic services, not to lower that for preventive services. That one genie is out of the bottle is no justification for letting others out, too.

Even accepting that the decision to include preventive services as an insured benefit requires explicit evidence, criteria must be selected to govern the coverage decision and the standards of validity required of the evidence that does exist. Possible criteria include:

- effectiveness of the intervention in prolonging life or improving its quality,
- cost-effectiveness of the intervention in achieving given levels of health effects at the lowest possible cost, and
- impact of the intervention on net Medicare outlays.

The notion that a preventive health service should be effective is widely accepted by health care providers and policymakers. There is less agreement about whether the cost of such services should be considered in either coverage or clinical decisions. The U.S. Preventive Services Task Force, convened in 1984 to develop guidelines for preventive services, adopted stringent standards of effectiveness but explicitly rejected cost-effectiveness as a criterion for their task in judging these services. In fact, no professional group in the United States making recommendations on preventive services for the elderly has explicitly accepted cost-effectiveness as a criterion for making such judgments.

Using the net impact on Medicare expenditures as the criterion for coverage is unduly stringent, because it assumes that if a preventive intervention costs Medicare money, it is not worth it, regardless of whatever health benefits it provides. A highly effective preventive service could also fail the test of being cost-saving to Medicare if by prolonging life it induces additional future Medicare expenditures for unrelated illnesses.

Even specifying a criterion for decisions leaves a great deal of potential for differing judgments. Evidence on the effectiveness of preventive services is often poor and conflicting. Little effectiveness research has been conducted in elderly populations, and the validity of applying findings generated from studies of other populations to the elderly population is questionable. The Medicare Preventive Services

Demonstration Projects currently underway will not add much to the information base on the effectiveness or cost-effectiveness of these services, although they will tell a great deal about how elderly people respond to financial incentives to use such services. To collect adequate data on effectiveness of preventive services in the elderly would take many years and many millions of dollars.

Those responsible for the decision of whether to make preventive services a Medicare benefit will be taking risks either way. On the one hand, including these benefits in the Medicare package could increase Medicare outlays without appreciably reducing older people's mortality, morbidity, or disability. On the other hand, if preventive services continue to be excluded from Medicare payment, real opportunities for better health or savings in health care costs could be lost for years to come.

LOCUS OF RESPONSIBILITY FOR COVERAGE DECISIONS

Responsibility for expanding Medicare to cover preventive services currently resides with Congress. To date, such expansions have been limited to specific procedures, but Congress could authorize the Health Care Financing Administration (HCFA) to offer an "appropriate" package of preventive services to elderly Medicare beneficiaries. Authorizing legislation could include criteria for assessing the "appropriateness" of such services. For example, Congress could direct HCFA to consider the cost-effectiveness of alternative packages in its implementation of regulations.

Vesting HCFA with the authority to decide about specific packages of services would probably increase the flexibility of the Medicare program to respond to new evidence on effectiveness or cost-effectiveness as it arises. By removing specific coverage decisions from the legislative process, preventive services would not have to compete for approval directly with other uses of the Federal health budget. However, if the authority for coverage decisions is vested in HCFA, the resulting package of services offered to the elderly would be unpredictable. As was noted just above, conclusions about the health and cost consequences of specific preventive services depend in poorly understood ways on the composition of the recommending groups and the criteria and standards used to judge the evidence. Even directing HCFA to use cost-effectiveness as a criterion for coverage decisions would leave a great deal of uncertainty about how the available evidence would be assessed. A process administered by HCFA, however, might be no more unpredictable than the current legislative process and would still be subject to oversight by Congress.

RESEARCH PRIORITIES

The Health Care Financing Administration is currently supporting six Medicare demonstration projects that offer preventive health services to Medicare beneficiaries. Although these projects are unlikely to provide much additional evidence on effectiveness, opportunities do exist for obtaining some effectiveness data at relatively low additional cost if extended follow-up studies are funded at selected demonstration sites where participation rates have been high. Since all but one of these demonstrations were congressionally mandated, extending their length might require an amendment to the legislation.

Because effectiveness research is costly, it should be targeted to services that offer the potential for large impacts on health status or health care costs of the elderly. Research to clarify the appropriate components of and target populations for comprehensive geriatric assessments has been recommended by a National Institute of Health consensus conference panel (65). Because the costs of institutional care for the disabled elderly are high, these tertiary preventive health services are a promising subject for effectiveness and cost-effectiveness research.