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Eliminating Cost-Sharing Requirements for Colon Cancer Screening in Medicare

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Abstract

Medicare beneficiaries do not have to pay for screening colonoscopies but must pay coinsurance if a polyp is removed via polypectomy. Likewise, beneficiaries do not have to pay for fecal occult blood tests but are liable for cost-sharing for diagnostic colonoscopies after a positive test. Legislative and regulatory requirements related to colorectal cancer screening are described, and on the basis of Medicare claims, it is estimated that Medicare spending would increase by \$48 million annually if Medicare were to waive cost-sharing requirements for these services. The economic impact on Medicare if beneficiaries were not responsible for any cost-sharing requirements related to colorectal cancer screening services is described.

Keywords

cancer screening; colorectal cancer; health insurance; health reform; Medicare

INTRODUCTION

Colorectal cancer (CRC) screening identifies premalignant polyps that can be removed and early-stage tumors that can be treated effectively. Early detection is cost-effective or even cost-saving in comparison with no screening.¹ Despite screening recommendations and clear evidence for the benefits of CRC screening, many adults are not up to date with screening.² The US Preventive Services Task Force (USPSTF) strongly recommends screening for CRC beginning at the age of 50 years and continuing until the age of 75 years.³ Because of the important role of screening in reducing the incidence of CRC and mortality, increasing the

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CONFLICT OF INTEREST DISCLOSURES

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proportion of US adults aged 50 to 75 years who are screened for CRC in accordance with USPSTF recommendations is a leading national health indicator in Healthy People 2020.

When Medicare covers a preventive service rated as A or B by the USPSTF, the Affordable Care Act requires coverage without cost-sharing. Nongrandfathered private health plans must cover all USPSTF-recommended A and B services without cost-sharing. Consistent with the Affordable Care Act, Medicare beneficiaries do not have to pay the part B deductible or coinsurance when they have a screening colonoscopy or fecal occult blood test (FOBT). However, they may face unexpected out-of-pocket liabilities when a polyp is detected and removed during a screening colonoscopy. In that case, the service is considered to be a diagnostic procedure (colonoscopy with polypectomy) rather than a screening colonoscopy, and patients are billed a copay. Beneficiaries also are responsible for the part B deductible and coinsurance when a colonoscopy is performed as part of a 2-step screening process after a positive FOBT. Waiving the Medicare cost-sharing requirements under these 2 clinical scenarios could increase the use of CRC screening but could also increase costs to the Medicare program.

Colonoscopies performed with polypectomies can fall into a clinical gray zone in terms of whether they are categorized as preventive or therapeutic services. The USPSTF CRC screening recommendation states that “screening for colorectal cancer reduces mortality through detection and treatment of early-stage cancer and detection and removal of adenomatous polyps,” and it notes that polyp removal is a key component of CRC screening that makes it an effective clinical preventive service. In February 2013, the federal government issued frequently asked questions about the Affordable Care Act, which state that nongrandfathered group health plans are required to cover polypectomy without cost-sharing because “polyp removal is an integral part of a colonoscopy.”⁴ However, Medicare regulations currently require Medicare beneficiaries to pay coinsurance, but not a deductible, for colonoscopies performed with polypectomies. In 2013, representatives introduced legislation that would eliminate the coinsurance for polypectomies under Medicare.⁵

Efforts to reduce cost-sharing for CRC screening and detection have focused almost exclusively on patients initially screened with colonoscopy. None of the aforementioned policy changes affect cost-sharing for patients initially screened via FOBT. Physicians may be reluctant to recommend FOBT to their patients if payers eliminate cost-sharing for patients screened via colonoscopy but continue to require cost-sharing for colonoscopies performed after a positive FOBT.⁶

COST TO MEDICARE OF ELIMINATING THE COST-SHARING REQUIREMENTS

It is important to examine how waiving cost-sharing for colonoscopies performed with a polypectomy and colonoscopies after a positive FOBT would affect Medicare spending. Using data from the 2006-2010 Medicare Current Beneficiary Survey and linked claims, we estimated the number of colonoscopies currently subject to patient cost-sharing in Medicare among patients aged 65 to 75 years. The Medicare Current Beneficiary Survey is a random survey of Medicare beneficiaries and includes Medicare claims for respondents enrolled in

fee-for-service Medicare. We used linked claims from the beneficiaries' data to identify tests and procedures, Medicare reimbursements, and beneficiaries' out-of-pocket payments. The latter include payments by supplemental payers. Because our goal was to estimate total costs to the Medicare program, we did not limit the sample to beneficiaries with full-year part B enrollment. Likewise, we included colonoscopies regardless of whether they (or the FOBT that preceded them) occurred on or off the USPSTF-recommended time schedule, and we did not determine the appropriateness of a colonoscopy (or FOBT) on the basis of the time since a patient's previous screen.

Because claims data do not directly identify colonoscopies performed for purposes of screening versus diagnostic follow-up of symptoms, we restricted our attention to colonoscopies performed in beneficiaries without gastrointestinal symptoms or other conditions for which a diagnostic colonoscopy would be appropriate⁷ (see the online supporting information for a list of relevant procedure codes and other methodological details). We stratified colonoscopies by whether they were preceded by an FOBT in the previous 90 days. Colonoscopies performed within 90 days of an FOBT were considered FOBT follow-up colonoscopies, whereas all others were considered initial colonoscopies.

We projected costs to 2014 on the basis of projected growth in the population aged 65 to 75 years and the historical rate of growth in the Medicare Economic Index.⁸ We further inflated costs to account for Medicare reimbursements for anesthesiologist involvement in screening colonoscopies, which is increasing.⁹

We estimate that in 2014, Medicare will pay for 575,000 initial screening colonoscopies, of which 209,000 will be performed with a polypectomy (Table 1). Under current payment policies, Medicare will pay \$166 million for initial colonoscopies performed with a polypectomy, and the total coinsurance will be \$42 million (20% of total payments).

We estimate that Medicare will pay for 33,000 colonoscopies (with and without polypectomies) after an FOBT in 2014. Medicare will spend \$24 million for these procedures, whereas the total coinsurance for these procedures will be \$6 million. In total, we estimate that Medicare spending would increase by \$48 million (\$42 million plus \$6 million) annually if Medicare eliminated cost-sharing for initial screening colonoscopies performed with a polypectomy and colonoscopies performed after a positive FOBT. Medicare spending on colonoscopies would increase by approximately 10%. These figures may overestimate costs to Medicare because we did not distinguish between polypectomies performed during a screening colonoscopy and polypectomies performed during a diagnostic colonoscopy, which, unless it occurred after a positive FOBT, would not be exempt from cost-sharing.

POTENTIAL BENEFIT OF ELIMINATING COST-SHARING REQUIREMENTS

One potential barrier to CRC screening is cost. Out-of-pocket costs may discourage the use of preventive care, including CRC screening. Research examining the impact of eliminating coinsurance for CRC screening found that waiving coinsurance for colonoscopy screening resulted in an 18% increase in colonoscopy screening.¹⁰ We do not know to what extent Medicare beneficiaries are aware of their potential out-of-pocket liabilities when they

consent to a colonoscopy. If many are unaware, then the impact of eliminating cost-sharing for polyp removal could be smaller.

However, it is clear that eliminating cost-sharing requirements could increase the number of initial screening colonoscopies and follow-up colonoscopies after a positive FOBT. Thus, policies to reduce cost-sharing have the potential to increase the number of individuals receiving CRC screening as recommended. Increasing screening is a desirable approach not only to reduce the incidence of CRC and mortality but also to control the costs of CRC treatment.¹¹

DISCUSSION

CRC screening highlights the sometimes arbitrary distinctions between preventive, diagnostic, and even therapeutic services. Offering screening services without cost-sharing counteracts cognitive biases and promotes individuals' initial contact with the health care system. Such an incentive is needed to help improve the uptake of CRC screening. If, because of these same cognitive biases, patients are reluctant to follow up on a positive screen, payers could consider reducing cost-sharing requirements for diagnostic tests or reclassify them as screening tests.

An important component of colonoscopies is to find and remove adenomatous polyps. Colonoscopies and subsequent polypectomies, the mechanism through which the mortality benefit from screening is derived, could be considered part of the screening process. Similarly, FOBT follow-up colonoscopies could also be considered a part of the screening process because they are required to achieve the mortality benefit. Because the mortality benefit for CRC can be achieved only if the entire process is completed, all of these steps could be considered a part of the screening process. Efforts addressing barriers to CRC screening such as cost-sharing requirements may be effective in increasing screening rates and reducing the health and economic burden of CRC.

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TABLE 1

Projected 2014 Volume and Spending on Colorectal Cancer Screening–Related Procedures in the Medicare Fee-for-Service Population (Aged 65-75 Years)

	Total Procedures per Year (1000s) ^a	Spending (Millions of 2014 US Dollars) ^a	
		Medicare Reimbursements	Coinsurance
Initial colonoscopies			
Colonoscopy without polypectomy	366 (321-411)	287 (247-328)	0 (0-0)
Colonoscopy with polypectomy	209 (177-241)	166 (128-204)	42 (0-51)
Total	575 (513-637)	453 (394-512)	42 (0-50)
FOBT follow-up colonoscopies			
Colonoscopy without polypectomy	20 (0-40)	15 (1-28)	4 (0-10)
Colonoscopy with polypectomy	13 (9-18)	10 (8-12)	2 (0-3)
Total	33 (14-52)	24 (11-37)	6 (0-10)

Colonoscopies performed within 90 days of undergoing an FOBT were considered follow-up colonoscopies, whereas all others were considered initial colonoscopies.

^aNinety-five percent confidence interval are presented in parentheses.