

# Cost Sharing May Lower Mammography Rates

BY TIMOTHY F. KIRN  
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Greater use of copayment and deductibles may be reducing the number of women seeking mammography, a new study of women enrolled in Medicare managed-care plans shows.

The investigators reviewed data from 174 plans and found that, on average, 77% of women in plans with full coverage had received their biennial screening, compared with 69% of women in plans with cost sharing for their health care visits.

In addition, the study reviewed seven plans that instituted a copayment or a deductible in 2003 and compared them with 14 plans that did not. The mammography rates in those plans that adopted cost sharing declined by 5%. In contrast, mammography rates increased 3% in 14 plans that did not institute cost sharing, reported Dr. Amal N. Trivedi of the department of community health at Brown University, Providence, R.I., and colleagues (*N. Engl. J. Med.* 2008;358:375-83).

The study used data from the Medicare Health Plan Employer Data and Information Set from 2001 to 2004, for 174 Medicare health plans and 366,475 women aged 65-69.

Three of the plans had cost sharing in 2001, 9 in 2002, 10 in 2003, and 21 in 2004. The three plans with cost sharing in 2001 covered less than 1% of the women in the plans at that time. The 21 plans in 2004 covered 11%.

Copayments in the plans ranged from \$12.50 to \$35.

The study also found that black women and women with less education and lower incomes were more likely to be in cost-sharing plans. But the effect of cost sharing at reducing the rate of mammography was greater among whites than among blacks. Among white patients, cost-sharing plans had an 8% lower mammography rate than did plans with no cost sharing. Among black patients,

cost-sharing plans had a 4% lower mammography rate.

The adoption of cost sharing is increasing among health plans generally. Mammography rates appear to have declined since 2000, after increasing greatly throughout the 1990s, Dr. Trivedi wrote in the study, which was supported by a grant from the Agency for Healthcare Research and Quality.

One study that looked at mammography rates, conducted by researchers at the National Cancer Institute using a large, national database, reported that 70% of women had received a mammography within the past 2 years in 2000 (*Cancer* 2007;109:2405-9). By 2005, that figure had dropped to 66%.

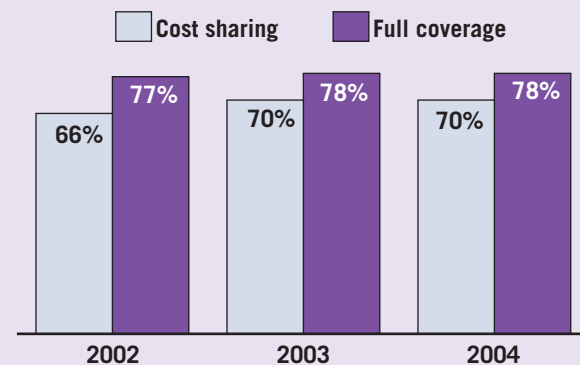
In an accompanying editorial, Dr. Peter B. Bach said the study by Dr. Trivedi and colleagues showed a "large" impact relative to the "modest" copayments and deductibles imposed on the patients.

"Their findings are robust, with similar findings in unadjusted analyses and in multivariable analyses adjusted for potential demographic and regional confounders," wrote Dr. Bach of the department of epidemiology and biostatistics, and the Health Outcomes Research Group, at Memorial Sloan-Kettering Cancer Center, New York (*N. Engl. J. Med.* 2008;358:411-3).

Noting that Dr. Trivedi and colleagues concluded that cost-sharing strategies apparently do more harm than good in mammography and should probably be waived for this important screening procedure, Dr. Bach said the study suggests a dilemma for insurers.

Deductibles and copayments are adopted by insurers to dissuade patients from using health care services extravagantly. But in some cases, the strategy may backfire, resulting in higher costs and poorer health.

## Biennial Rates of Screening Mammography Higher for Enrollees With Full Coverage



Note: Based on rounded data for 366,475 women aged 65-69 years in 174 Medicare managed-care plans.  
Source: *New England Journal of Medicine*

If, however, insurers choose to exempt some services from copayments or deductibles, they face the prospect of reconsidering all kinds of services and trusting that they can determine which ones are truly beneficial, he wrote.

It would be a very daunting task, he added.

The case of mammography is a particularly striking example, because mammography is a service that women tend to know is highly beneficial. Yet, the cost sharing kept 8% of consumers from seeking it out, Dr. Bach noted.

"This finding bodes poorly for the high-deductible movement, since one would expect that patients would make suboptimal decisions even more often in cases in which the health care service is more expensive, has received less publicity, has less rigorous quality control, or is more unpleasant or risky," Dr. Bach wrote. ■

# Patient Portals: Not the Open Floodgates Physicians Fear

BY MICHELE G. SULLIVAN  
Mid-Atlantic Bureau

NEW ORLEANS — Rather than unlocking a Pandora's box of nattering e-mails, an electronic patient portal that allows messaging and even access to test results can improve patient satisfaction and decrease patient visits.

"Many physicians think that this type of access is frightening," Dr. Gretchen P. Purcell said at the annual clinical congress of the American College of Surgeons. "They think they'll be barraged with messages, that patients will misinterpret their test results, and that physicians could even be held legally liable if they don't respond in time to an urgent message."

But health care providers, who are about 10 years behind the curve in the digital world, need to face up to the facts of the 21st century, said Dr. Purcell of the surgery department at the Children's Hospital at Vanderbilt in Nashville, Tenn. "Patients are demanding the same kind of online access to their medical information as they have for all other aspects of their lives. Those health care institutions that do not have a patient portal now probably will within the next 5 years."

Patient portals can be designed to suit the needs of different practices and to fulfill various functions. At a minimum, they allow patients to pay bills, schedule or change appointments, and request pre-

scription refills. Other portals are more robust and give patients the ability to review medical records, view test results, and send messages to their health care provider, said Dr. Purcell, who is also with the biomedical informatics department at Vanderbilt Medical Center.

Among the most controversial topics are messaging and the ability to access test results, she said.

"Messaging is probably the function physicians fear the most. Many think it's the equivalent of getting and sending personal e-mail, and this brings up all kinds of worries about security and privacy."

E-mail and messaging, however, are not the same things. Messages don't go to a personal e-mail account; instead, they go to a dedicated in-box. "This message box is routinely checked by an administrative assistant or nurse—someone who can often answer many of the questions, and who would involve the physician only when necessary—similar to phone call triage."

There also are concerns that these electronic exchanges aren't part of a patient's documented record. "Some portals can make messaging part of the medical record, and some physicians have found ways to charge for this 'online consultation,'" Dr. Purcell said.

It's important to set clear expectations about response time and emergency issues. Most messaging systems tell patients

that they may have to wait 2-3 business days for a personal reply and advise them to call 911 for a medical emergency.

It's not unreasonable to assume that electronic communication could allow patients to bombard offices with questions and requests. Although data are still limited, the studies that are out there suggest just the opposite, Dr. Purcell said.

Two studies published in 2005 indicate that messaging increases patient satisfaction without any corresponding increase in workload. The first study randomized 200 patients to secure messaging or usual care. Only 46% of the patients who were given access sent any messages at all; the average was just 1.5 messages per patient per year. And although messaging didn't reduce the number of telephone calls the office received, the number of office visits in the intervention group did go down (*Int. J. Med. Inform.* 2005;74:705-10).

The second study randomized 606 patients to a patient communication portal or to a Web site with general health information. Only 31% of the patients given access used the portal. The message box received only one message per day per 250 patients. Again, there was no difference in the number of office telephone calls between the groups, but the patients in the portal group reported better satisfaction with communication and overall care, even if they never used the portal (*J. Med. Internet Res.* 2005;7:e48).

The same study indicated that secure messaging probably would not overwhelm anyone during working hours, Dr. Purcell said. "Patients tended to use the portal during nonclinic hours—the most convenient time for them—with about 73% of messaging occurring from 5 p.m. until midnight."

Patients may even be willing to pay for the added convenience of messaging, the authors concluded. Of 341 patients surveyed, 162 (48%) were willing to pay for online correspondence with their physician, with \$2 cited as the median payment they thought fair.

Patient access to test results is another area of clinician concern, she said. "Obtaining test results is probably the most commonly desired and most commonly used function of a patient portal, and one that makes physicians very nervous," Dr. Purcell said.

The MyHealthAtVanderbilt system ([www.myhealthatvanderbilt.com](http://www.myhealthatvanderbilt.com)) has three tiers of test results—two can be available to patients online. "Some low-risk, high-value test results, such as cholesterol levels, are available immediately, and some results are available with a delay, such as tests that require interpretation in a specific clinical context," Dr. Purcell said. "But some results, such as cancer pathology and HIV tests, and others that require intensive patient counseling, are never available through the portal." ■