Cost Sharing Cuts Compliance on Mammograms

Mammography rates in plans that adopted cost sharing dropped 5% vs. a 3% rise in plans that did not.

BY TIMOTHY F. KIRN
Sacramento Bureau

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.

On average, 77% of women in plans with full coverage had received their biennial screening vs. 69% of women in plans with cost sharing.

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.

Among the 174 plans, only 3 had cost sharing in 2001; 9 had it 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 mammogram 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.

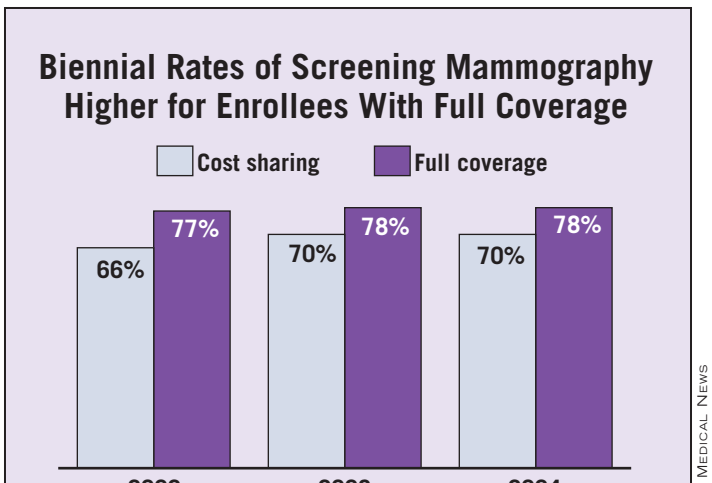
But in some cases, the strategy may backfire, resulting in higher costs and poorer health.

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 concluded. ■



Decline in Radiotherapy After BCS Seen as Recurrence Risk

BY BRUCE JANCIN
Denver Bureau

SAN ANTONIO — The use of radiotherapy following breast-conserving surgery for invasive cancer is declining in the United States—and that's a trend spelling trouble, Beth A. Virnig, Ph.D., asserted at the San Antonio Breast Cancer Symposium.

Breast-conserving surgery (BCS) without radiotherapy constitutes a failure to provide adequate local tumor control.

Some prominent epidemiologists predict this will lead to increased late mortality, although that prediction is controversial.

Regardless, compelling evidence indicates this failure results in increased risk of local recurrences requiring additional, more aggressive surgery—often mastectomy—along with systemic chemotherapy.

Thus, the declining rate of radiotherapy serves to undermine the whole point of breast-conserving therapy: to provide outcomes equivalent to mastectomy, but with better quality of life, explained Dr. Virnig, who is with the University of Minnesota School of Public Health, Minneapolis.

"On a population basis, this trend is going to cause some real problems," she added in an interview.

"It seems like in the end what we're doing is delaying treatment for these women until they'll end up needing more aggressive therapies that probably could have been avoided."

'We were particularly troubled that it was the younger women who had the steepest decline, and the ones with estrogen receptor–negative tumors.'

She analyzed treatment trends in more than 175,000 women in the National Cancer Institute Surveillance, Epidemiology, and End Results registry who underwent treatment for nonmetastatic breast cancer during 1992-2003.

In 1992, the year after an NCI consensus panel declared BCS plus irradiation to be the preferred strategy over mastectomy in women with early-stage cancer, 41% of patients received BCS. That rate climbed to 60% by 2003.

Meanwhile, the use of radiotherapy following BCS dropped from 79% to 71% during the same period.

Among patients under age 55 who received BCS, the rate of radiotherapy fell from 81% in 1992 to 67% in 2003.

Radiotherapy use was also less frequent in women with estrogen receptor–negative tumors.

"We were particularly troubled that it was the younger women who had the steepest decline, and the ones with estrogen receptor–negative tumors, because they have the highest risk of recurrence and they don't have tamoxifen or the aromatase inhibitors as a protective net. These are women for whom there really isn't a preventive treatment available right now other than chemotherapy or irradiation," Dr. Virnig observed.

The task now, she added, is to figure out why the decline in radiotherapy is occurring and how to address it.

It's unclear how much of the problem is caused by insurance issues, lack of convenient access, truly informed patient preference, or surgeon reluctance to refer to radiation oncologists.

Dr. Kenneth Smith, a Columbus, Ga., general surgeon, asserted that local recurrence rates are surely lower today with BCS alone with clear margins than in the 15- to 20-year-old studies on which the National Cancer Institute endorsement of BCS plus irradiation were based. He credited the decline to better imaging, improved pathology, and refinements in surgical technique.

Dr. Smith pointed out that a number of recent large single-center studies have reported no increase in local recurrences after BCS alone, at least in cases of ductal carcinoma in situ.

"The problem is that patients who go to those institutions—M.D. Anderson Cancer Center, University of Minnesota, Memorial Sloan-Kettering Cancer Center—those aren't your typical patients and they're not your typical doctors," Dr. Virnig replied.

Dr. Smith conceded that it's not reasonable to extrapolate from the data accrued by highly experienced specialists to "the guy who does maybe five or six lumpectomies per year." ■