The Importance of Waiving Cost-sharing for Follow-up Colonoscopies

Action Steps for Health Plans

Summary:

The Affordable Care Act (ACA) eliminates cost-sharing for routine screening tests that receive an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) for individuals who are privately insured.[i] The USPSTF has given an "A" rating to colorectal cancer screening tests, including fecal occult blood testing and colonoscopy, for adults between ages 50 and 75; thus, these services should be provided to health plan members without cost-sharing. Some health plans, however, apply cost-sharing to colonoscopies that follow a positive stool test. This creates a financial incentive for patients to select the more costly and invasive colonoscopy as their initial test. Additionally, this cost-sharing creates a financial disincentive that may lead patients to forego the follow-up test that they need.

Screening for colorectal cancer by high sensitivity stool test is inexpensive and effective, but it must be treated as a two-step screening process if the stool test is positive. The USPSTF clearly states in its colorectal cancer screening guidelines that "Follow-up of positive screening test results requires colonoscopy regardless of the screening test used."[1] Screening is not complete until patients with positive results receive follow-up by colonoscopy to rule out the presence of cancer or precancerous polyps (abnormal growths in the lining of the colon). Recall rates for positive stool test results commonly range from 4-8% depending on positivity thresholds.[2,3] To eliminate a financial disincentive for patients to choose stool testing as first-line screening, health plans should waive cost-sharing for colonoscopies following positive stool tests, as they are required to do for initial screening colonoscopies. Health plans should already be following the federal guidelines that state there must be no cost-sharing for screening colonoscopies, even if lesions or polyps are found and removed during the procedure.[4] Recent rulings also require plans to cover procedure-related costs of pre-exam consultation,[5] bowel prep,[6] anesthesia[7] and pathology[5] in initial screening colonoscopies, however, patients may be liable for ancillary costs such as facility fees.

REQUEST:

We are asking health plans to waive cost-sharing requirements for members when colonoscopy is ordered as follow-up to a positive stool test or other colorectal cancer screening test, just as cost-sharing is waived for colonoscopy when it is selected as the first-line screening exam. Many health plans have already adopted this policy.[8] In other instances, states such as Kentucky[9] and Oregon[10] are beginning to enact laws that waive cost-sharing across the screening continuum. Waiving cost-sharing for follow-up colonoscopy will reduce barriers to colorectal cancer screening and potentially save

[i] The ACA preventive services requirements do not apply to "grandfathered" health plans that were in existence prior to March 23, 2010, as long as such plans continue to meet certain standards for grandfathered plans.

health plans downstream costs, as described below.

Value for Health Plans:

Individuals are less likely to seek health services when they have to pay out-of-pocket costs.[11,12,13] Waiving cost-sharing across the two-step screening process can increase colorectal cancer screening and follow-up rates, resulting in:

- Elimination of financial incentives that could drive members to choose colonoscopy for initial screening even though they might prefer less expensive, less invasive stool testing.
- Elimination of financial barriers that may cause members to forego completing the screening process because of the cost of follow up colonoscopy.
- A decline in certain future health plan expenses, such as colorectal cancer treatment costs and inpatient hospital care, thanks to the prevention of colorectal cancer, or detection of the disease in earlier stages when treatment is more effective and less expensive.
- Improved performance on the Healthcare Effectiveness Data and Information Set (HEDIS®) screening measure and other quality measures.
- Potential to avoid member dissatisfaction when unexpected costs are imposed on preventive health services.
- Closed gaps in health disparities among price-sensitive members and the medically underserved.
- Recognition for the health plan as a leader in quality preventive care service delivery.

Background:

Colorectal cancer is the second most common cause of death from cancer in men and women in the United States. It is estimated that over 132,700 people will be diagnosed with colorectal cancer and almost 49,700 will die from this disease in 2015.[14] Treatment costs can be very high, especially for advanced forms of colorectal cancer. Estimates suggest that about $14.14 billion is spent on treatment for colorectal cancer each year in the United States[15] and annual treatment costs for an advanced case can exceed $300,000 for a year.[16]

Costs associated with advanced treatment and premature deaths due to colorectal cancer are largely avoidable. Regular screening can identify colorectal cancer at early stages when it is easiest and least expensive to treat. In addition, regular screening can actually prevent colorectal cancer by detecting and removing precancerous polyps, greatly reducing the possibility that they may progress to cancer. The American Cancer Society, the USPSTF and other expert medical and scientific panels have issued evidence-based recommendations for colorectal cancer screening.[17] Yet, many Americans do not receive colorectal screenings as recommended, and one in three adults between the ages of 50 and 75 are not up-to-date with screening.[18] Not receiving a recommendation from the doctor, not being provided with screening test options, and concerns about affordability are the leading reasons cited by unscreened individuals for not getting screened for colorectal cancer.[19,20,21,22,23]

- **Not all patients are willing or able to get a colonoscopy for initial screening.** Each test has pros and cons, and evidence shows that adults' values and preferences influence their choice of screening tests. While colonoscopy has the advantage of being able to biopsy and remove polyps, its drawbacks include high cost (as compared to other tests), the invasiveness of the procedure, aversion to the preparation and the test by some patients, inconvenience, and risk

(albeit small) of complications. In some communities, there also are significant capacity issues that make it difficult to access colonoscopy.

- **High sensitivity stool testing has the benefit of being non-invasive, safe and significantly less costly.**[24] When patients adhere to annual testing, high sensitivity stool testing can detect colorectal cancer and save lives at rates that are similar to colonoscopy. Only about 4% to 8% of high sensitivity stool tests are positive and require follow up with a colonoscopy, but the screening process is not complete until the follow-up exam has occurred.[1,2,3] It is noteworthy that a negative colonoscopy after a positive stool test means that the patient will not need to be screened again for 10 years.
- **Patients often prefer stool testing when given the choice.** Presenting options for colorectal cancer screening to all adults, but particularly for those with low income, has been shown to increase screening adherence. A recent study found more patients complete screening when offered a choice to screen by colonoscopy or stool test (69%) as compared to patients that are offered colonoscopy only (38%).[23] Recent consumer research conducted by the American Cancer Society found that unscreened consumers are very responsive to messages indicating that there are affordable take home options available.[22]
- **Financial issues are critical barriers to getting screened.** Individuals—including the insured—are less likely to seek health services when they have to pay out-of-pocket costs.[11,12,13]
- **Applying cost-sharing to follow-up colonoscopy has the potential to drive cost-sensitive members to choose the more expensive colonoscopy as a first-line screening exam** (currently reimbursed as high as $790 under Medicare), rather than a $22 fecal immunochemical test. It also makes it hard for clinicians to discuss screening alternatives to colonoscopy, in particular to cost-sensitive members, knowing that cost may prohibit the member from getting the needed follow-up exam if the stool test is positive.
- **Eliminating cost-sharing can help address health disparities.** Low-income individuals are more price sensitive compared to others.[25] Higher cost-sharing tends to make it harder for low-income patients to access prevention services. Thus, policies that apply cost-sharing to follow-up colonoscopy can prevent the most medically vulnerable populations from getting access to proven and effective prevention services. Reductions in preventive care can, in turn, have adverse consequences, including poorer health and greater subsequent use of high-cost services such as in emergency departments. Further, driving patients to select colonoscopy as a first-line screening exam can further aggravate colonoscopy shortages in some rural communities and increase costs to health plans.

This problem is atypical among USPSTF-recommended cancer screening tests. USPSTF states in their recommendations that "[c]olonoscopy is a necessary step in any screening program that reduces mortality from colorectal cancer."[1] Follow-up colonoscopy after a positive stool test is fundamentally different from other screening procedures, as colonoscopy is available to the beneficiary without cost-sharing, if the beneficiary chooses colonoscopy as a "first line" preventive screening exam. In other words, when a positive stool test triggers a follow-up colonoscopy and cost-sharing, that colonoscopy would have been available to the member free of procedure-related cost-sharing if the member selected colonoscopy rather than a stool test as the first-line screening exam. In contrast, when a screening mammogram or low-dose CT scan for lung cancer comes back positive, the recommended follow up includes procedures that are not available as a first line screening option.

Proposed Next Steps:

To successfully cover the colorectal cancer screening continuum, plans should:

- Waive health plan-imposed copayments and deductibles for colonoscopy that follows a positive stool test to align with cost-sharing benefits for initial screening colonoscopies, including costs related to pre-exam consultation, bowel prep, anesthesia, pathology and polyp removal;
- Make necessary adjustments with the plan sponsor during contract updates to ensure that the copayment is waived;
- Consider also waiving patient cost-sharing for costs related to the colonoscopy exam, including "Outpatient Hospitalization" fees; and
- Develop and communicate policies to your network to insure that copayments are waived throughout the process, including the gastroenterology consult.

Systematically implementing cost-sharing can pose challenges if changes need to be made to the way screening tests are coded and entered into the electronic health record. The National Colorectal Cancer Roundtable and the American Cancer Society Health Systems staff are here to support you as you work through this process.

By making the decision to waive cost-sharing across the colorectal cancer screening continuum, health plans have the potential to remove financial incentives that could drive members to choose colonoscopy for initial screening when they prefer less expensive stool testing, ensure that members with positive stool test findings don't face barriers getting needed follow up colonoscopies, and improve the health and quality of life of their members.

---

[1] Screening for colorectal cancer: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med 2008;149:627-37.

[2] Grazzini G, Visioli CB, Zorzi M, Ciatto S, Banovich F, Bonanomi AG, et al. Immunochemical faecal occult blood test: number of samples and positivity cutoff. What is the best strategy for colorectal cancer screening? Br J Cancer. 2009;100(2):259-265.

[3] Lee JK, Liles EG, Bent S, Levin TR, Corley DA. Accuracy of fecal immunochemical tests for colorectal cancer: systematic review and meta-analysis. Ann Intern Med. 2014;160(3):171.

[4] Centers for Medicare & Medicaid Services. Affordable Care Act Implementation FAQs - Set 12. 2015. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html (accessed November 9, 2015)

[5] Centers for Medicare & Medicaid Services. FAQS about Affordable Care Act Implementation Part 29, Mental Health Parity Implementation. October 23, 2015. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXIX.pdf (accessed April 2, 2018)

[6] Centers for Medicare & Medicaid Services. FAQs about Affordable Care Act Implementation Part 31, Mental Health Parity Implementation, and Women's Health and Cancer Rights Act Implementation. April 20, 2016. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31_Final-4-20-16.pdf (accessed April 21, 2016)

[7] Centers for Medicare & Medicaid Services. FAQs About Affordable Care Act Implementation (Part XXVI). May 11, 2015. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf (accessed November 9, 2015)

[8] The Kaiser Family Foundation, the American Cancer Society, and the National Colorectal Cancer Roundtable. Coverage of Colonoscopies Under the Affordable Care Act's Prevention Benefit. 2012. http://nccrt.org/wp-content/uploads/NCCRT.pdf (accessed November 9, 2015)

[9] Legislative News Releases. Kentucky Legislature. March 4, 2015. http://www.lrc.ky.gov/pubinfo/release.htm#colo (accessed November 9, 2015)
[10] 2015 Oregon State Legislative Accomplishments. ACS CAN. http://www.acscan.org/ovc_images/file/action/states/or/2015_ACS_CAN_Oregon_Legislative_Accomplishments_APPROVED.pdf (accessed November 9, 2015)
[11] Trivedi AN, Rakowski W, Ayanian JZ. Effect of cost sharing on screening mammography in Medicare health plans. N Engl J Med 2008;358:375-83.Manning, Willard et al. (1988).
[12] Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. Med Care 2011;49:865-71.
[13] Solanki G, Schauffler HH, Miller LS. The direct and indirect effects of cost-sharing on the use of preventive services. Health Services Research 2000;34:1331-50.
[14] Siegel RL, Miller KD, Jemal A. Cancer statistics, 2015. CA Cancer J Clin. 2015;65: 5-29.
[15] Mariotto AB, Yabroff KR, Shao Y, Feuer EJ, Brown ML. Projections of the Cost of Cancer Care in the United States: 2010–2020. J Natl Cancer Inst. 2011;103(2):117–128.
[16] Schrag D. The price tag on progress--chemotherapy for colorectal cancer. N Engl J Med 2004;351(4):317-9.
[17] Screening for colorectal cancer: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med 2008;149:627-37.
[18] CDC. Prevalence of colorectal cancer screening among adults—Behavioral Risk Factor Surveillance System, United States, 2012. MMWR 2013; Vol. 62.
[19] Kelly KM, Dickinson SL, Degraffinreid CR, Tatum CM, Paskett ED. Colorectal cancer screening in 3 racial groups. Am J Health Behav. 2007;31(5):502-513.
[20] Levy BT, Dawson J, Hartz AJ, James PA. Colorectal cancer testing among patients cared for by Iowa family physicians. Am J Prev Med. 2006;31(3):193-201.
[21] Guessous I, Dash C, Lapin P, Doroshenk M, Smith RA, Klabunde CN, et al. Colorectal cancer screening barriers and facilitators in older persons. Prev Med. 2010;50(1-2):3-10.
[22] National Colorectal Cancer Roundtable. 80% by 2018 Communications Guidebook: Effective messaging to reach the unscreened. 2015. http://nccrt.org/tools/80-percent-by-2018/80-by-2018-communications-guidebook/ (accessed November 9, 2015)
[23] Inadomi JM, Vijan S, Janz NK, et al. Adherence to colorectal cancer screening: a randomized clinical trial of competing strategies. Arch Intern Med 2012;172:575-82.
[24] Lee JK, et al. Accuracy of Fecal Immunochemical tests for Colorectal Cancer: A Systematic Review and Meta-analysis. Ann Intern Med. 2014;160:171-181.
[25] Chan D, Gruber J. "How Sensitive Are Low Income Families to Health Plan Prices?" American Economic Review: Papers & Proceedings 100 (May 2010):292-296.