

Cost Sharing Reduces Mammography Compliance

ARTICLES BY DEBRA L. BECK
Contributing Writer

TORONTO — Copayments exceeding \$10 or coinsurance of more than 10% are associated with lower rates of breast cancer screening, Dr. Amal Trivedi said at the annual meeting of the Society of General Internal Medicine.

Across all study years, rates of breast cancer screening were 77.5% in plans with full coverage, compared with 69.2% in plans with cost sharing.

Differences in screening rates between full coverage and cost-sharing plans ranged from 8% to 11% during each year.

The negative effect of cost sharing on mammography rates was significantly greater for enrollees residing in less-affluent and less-educated areas and for enrollees with Medicaid eligibility (*P* less than .001).

“Cost sharing disproportionately affects vulnerable populations, and its prevalence is dramatically increasing in Medicare managed care,” said Dr. Trivedi, of Brown

University, Providence, R.I. “Cost sharing should be tailored to the underlying value of the health service,” he said. “Eliminating copayments may increase adherence to appropriate preventive care.”

Asked somewhat facetiously whether he thought perhaps patients should be paid to get regular mammograms, Dr. Trivedi conceded that was unlikely to happen. “But we do need to remove barriers to regular screening,”

he said. “Copayments reduce [the] moral hazard to ‘overconsume’ health care with full insurance, but they may also reduce use of appropriate preventive care.”

Dr. Trivedi’s abstract was a Hamolsky Junior Faculty Research Award finalist, a designation given to the top-rated abstracts submitted for presentation at the meeting.

The investigators reviewed mammog-

raphy coverage for 366,475 women aged 65-69 years enrolled in 174 health plans in 2001-2004. They examined rates of biennial breast cancer screening in plans requiring a copayment of more than \$10 or

more than 10% coinsurance for mammography, and compared them with screening rates in plans with full coverage for this service.

They also looked at whether the impact of copayments or coinsurance var-

ied by income, education, Medicaid eligibility, or race. Finally, they looked at the change in mammography rates of seven health plans that instituted cost sharing in 2003, compared with a control group of plans with continuous participation in Medicare from 2002 through 2004 that did not institute cost sharing.

The number of Medicare plans with cost sharing for mammography increased

from 3 in 2001 (representing 0.5% of women in the study) to 21 in 2004 (11.4% of women). The median copayment was \$20 (range \$13-\$35). Five plans charged 20% coinsurance.

In multivariate analyses, the presence of cost sharing was associated with a 7.2% lower adjusted rate of screening (*P* less than .001), an effect that was greater in magnitude than any other plan-level covariate in the model.

When they looked only at the seven plans that instituted cost sharing in 2003, adjusted rates dropped 5.5% in 2004 from 2002 levels, compared with a 3.4% increase in utilization in 14 control plans that retained full coverage.

“Relatively small copayments for mammography are associated with significantly lower biennial mammography rates among women who should receive breast cancer screening according to accepted clinical guidelines,” Dr. Trivedi concluded. “For important preventive services such as mammography, exempting the elderly from cost sharing may be warranted.” ■

Differences in screening rates between full coverage and cost-sharing plans ranged from 8% to 11% during each year, a top-rated study found.

Shorter Resident Hours May Cut Hospital Deaths

TORONTO — In the second year after the new Accreditation Council for Graduate Medical Education duty-hours rules became effective, mortality in patients hospitalized for four common medical conditions—acute myocardial infarction, heart failure, gastrointestinal bleeding, and stroke—were significantly reduced at more-teaching-intensive hospitals, compared with less-teaching-intensive hospitals.

This apparent survival benefit was not seen for surgical patients. No changes in mortality were seen in surgical patients during either the first or second year post reform, Dr. Kevin Volpp and his colleagues at the Philadelphia VA Medical Center and the University of Pennsylvania, Philadelphia, reported at the annual meeting of the Society of General Internal Medicine.

The Accreditation Council for Graduate Medical Education (ACGME) duty-hour reform policy went into effect in July 2003. Designed to improve patient safety, the rules limit the number of hours residents can work to 80 per week, with a minimum 10 hours of time off between shifts.

The study cohort included 320,685 unique patients admitted to acute-care VA hospitals between July 2000 and June 2005 with principal diagnoses of acute myocardial infarction (AMI), heart failure, gastrointestinal bleeding, stroke, or Diagnosis-Related Group classification of general, orthopedic, or vascular surgery.

Logistic regression analysis was used to examine the change in mortality for patients in more- versus less-teaching-intensive hospitals before and after

duty-hour reform. The primary study outcome was all-cause mortality within 30 days of hospital admission.

In the first year after duty-hour reform, no significant relative changes in death rates were reported for either the medical or surgical patients.

In the second year after reform, a significant 26% reduction in mortality risk was seen at the more-teaching-intensive hospitals for patients with any of the four medical conditions. That change was primarily driven by a highly significant 52% relative reduction in mortality risk in AMI patients.

For patients in hospitals in the 75th percentile of teaching intensity, mortality improved from prereform year 1 to postreform year 2 by 0.70 percentage points—or a relative improvement of 11.1% for medical patients—compared with patients in hospitals in the 25th percentile of teaching intensity, Dr. Volpp said.

At hospitals in the 90th percentile of teaching intensity, the improvement in mortality was even greater: about 0.88 percentage points, or a relative improvement of about 14%, compared with hospitals in the 10th percentile of teaching intensity.

Dr. Volpp noted during his presentation that the study was limited because “we don’t have any information on compliance with the ACGME rules or actual number of hours worked.”

VA hospitals are the largest single site for residency training in the United States, Dr. Volpp noted. Ongoing studies are assessing mortality and other outcomes in non-VA settings, he added. The study was funded by a unit of the VA Health Services. ■

Medical Leaders May Quite Often Double as Corporate Directors

TORONTO — If accepting free pens or lunches from industry represents a potential conflict of interest for physicians, what do you call it when a medical school dean is also the corporate director of a large, for-profit health care company?

“An academic medical leader serving on the board of directors of a health care corporation could entail huge conflicts of interest,” Dr. Roy M. Poses said at the annual meeting of the Society of General Internal Medicine.

“Directors of a for-profit corporation have legally enforceable fiduciary responsibilities to its stockholders for the corporation’s direction and financial viability, including its profitability,” said Dr. Poses, president of the Foundation for Integrity and Responsibility in Medicine, a not-for-profit educational group.

In a cross-sectional study, Dr. Poses and his colleagues scrutinized the biographies of all board members of “pure” health care companies among the Standard & Poor’s (S&P) 1500. Their data came from publicly available company proxy statements, annual reports, and Web sites.

In 2005, there were 164 U.S. health care companies in the S&P 1500, and 125 U.S. medical schools. The investigators identified 198 people who served on the companies’ boards of directors and had faculty or leadership positions at a medical school. Of the 125 medical schools, 65 (52%) had at least one faculty member and/or academic leader who also served on a health care corporation’s board of directors. Four schools had 10 or more such individuals, and 15 schools had 5 or more.

Of the 125 medical schools, 7 reported to university presidents who also were directors of health care corporations, 11 reported to vice presidents for health affairs who were corporate directors, and 5 were lead by deans who also were health care corporate direc-

tors. Also, 11 schools had academic medical center CEOs who were corporate directors, and 22 schools had at least one top leader who also was a director of a health care corporation.

“There are a lot of factors at play, including how aware you are of the potential conflict and how much transparency protects you from acting in a conflicted way if you are conflicted,” said Dr. Nicole Lurie, codirector for public health at the Center for Domestic and International Health Security, in an interview.

“Many physicians in practice don’t perceive a conflict at all. The first thing is to open yourself up, look at yourself, and examine the issue. Then you have to think, if these relationships exist, are there things you can do to make them work, because I don’t think as a matter of public policy that we’re going to succeed in obliterating all these relationships,” Dr. Lurie said.

Amid efforts to prevent physicians from accepting small gifts, meals, and travel reimbursement from company sales representatives, the new study highlights a potentially much bigger problem.

“The bottom line is that a substantial portion of medical schools are led or influenced by people who are also obligated to have ‘unyielding loyalty’ to stockholders of for-profit health care corporations,” Dr. Poses said.

The study used readily accessible public data only and did not collect data on board members of smaller U.S. health care corporations, other U.S. corporations with major health care activities, corporations outside the United States, or privately held corporations. “So, our data really only give lower-bound estimates of the number of medical schools influenced or led by people who also have fiduciary duties to health care corporations that may conflict with their academic leadership obligations,” Dr. Poses said. ■