Cost Sharing Lowers Medicare Mammogram Rates

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TORONTO — Copayments exceeding $10 or coinsurance of more than 10% is 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).

'Relatively small copayments for mammography are associated with significantly lower biennial mammography rates' in women who should be screened.

"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 mammography 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 varied 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."

In his discussion of the study's limitations, Dr. Trivedi noted that the investigators were unable to analyze differential impacts of specific copayment amounts. They also used zip-code proxies, a fairly blunt instrument to measure socioeconomic status and education. ■