Colorectal Cancer Health Disparities and the Role of US Law and Health Policy

Health disparities are ubiquitous, but could be eliminated for preventable conditions by ensuring equitable access to and use of disease prevention, detection, and treatment services. Screening is an established tool for preventing premature death for many health conditions, including colorectal cancer (CRC).[1–3] The Affordable Care Act (ACA), in part, aimed to increase access to CRC screening by mandating coverage without cost sharing (effective September 23, 2010). However, ACA the did not address provisions in section 1834(d)(3)(D) of the Balanced Budget Act (BBA) of 1997, which disallows Medicare from waiving the beneficiary's share of coverage for the cost of screening (usually 20%) when a diagnostic procedure such as biopsy or polypectomy is performed during the course of a screening endoscopy. This provision also applies if endoscopy is performed because of a positive result on another screening test.

These legal restrictions hinder the goal of eliminating (and may exacerbate) longstanding disparities in mortality from CRC for Medicare beneficiaries. For low-income individuals without supplemental coverage for the coinsurance, cost-sharing may be an insurmountable barrier.[4] A disproportionately high percentage of Medicare beneficiaries from low-income background lack Medigap or supplemental insurance, even among retirees.[5–7]

Public Health Benefits of Screening for CRC

CRC is the second leading cause of cancer death in the United States. An estimated 49,190 people will die of CRC in the United States in 2016, and people in low socioeconomic status bear a disproportionate share of this burden.[8] The burden of CRC is greatest in the Medicare population. About 70% of CRC deaths occur in Medicare age-eligible people and the average age of people dying of CRC is 73 years.[9]

Screening is estimated to have prevented more than one-half million new cases of CRC between 1987 and 2010.[10] Importantly, about 63% of the deaths from CRC in 2010 were owing to not having been screened. A study estimated that increasing screening uptake from 58% in 2013 to 80% by 2018 in the United States could further reduce disease incidence by 17% and mortality rates by 19%.[11] Among Medicare beneficiaries, those from low-income backgrounds have half the rate of screening of high-income groups (Figure 1).[12] Thus, increasing screening uptake in low-income populations is critical to public health goals to decrease persistent disparities in CRC.

Definition of Screening and the CRC Screening Episode

The goal of screening is to prevent CRC or enable more effective

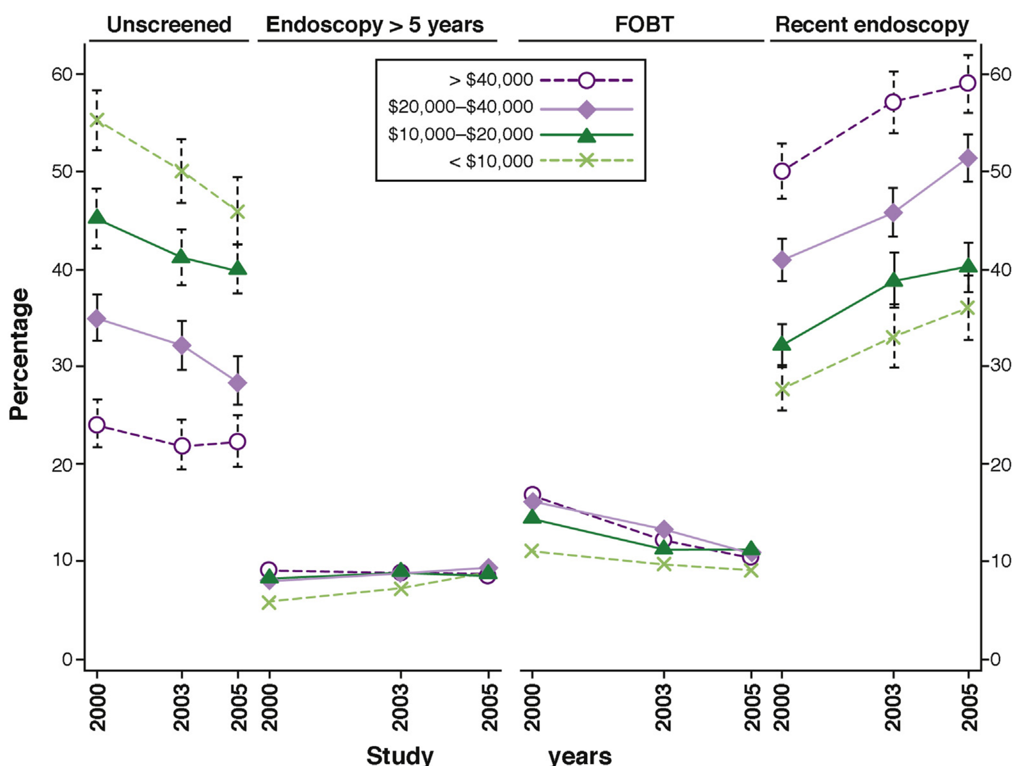

Figure 1. Patterns of colorectal cancer screening by income among Medicare enrollees ages 65 to 80 years, 2000–2005. Revised with permission from Doubeni et al.[12]

management through early detection, before symptoms that portend advanced, less curable, disease develop. Until recently, screening was thought of as a one-time clinical activity and many health policy groups recommended individual tests in their executive summaries and not the interrelated activities involved in the screening process. In practice, screening is a series of clinical activities involved in identifying and testing asymptomatic screen-eligible people, and performing diagnostic confirmation when necessary (Figure 2). Screening involves many tests and multiple steps.[3] Timely diagnostic workup of abnormal results is a central tenet of safe patient care,[13] and is essential for effective CRC screening. Colonoscopy allows for diagnostic procedures such as removal of precancerous lesions or biopsy to confirm cancer diagnosis to be performed at the time of screening or during workup for a positive result on another screening test. However, out-of-pocket costs may make diagnostic evaluation unaffordable for low-income patients.[4]

Medicare's Authority to Cover CRC Screening

Authority for Medicare's coverage for CRC screening under Part B is provided in Section 4104 of BBA. Medicare currently reimburses for the fecal occult blood test (FOBT), multitarget stool DNA test, sigmoidoscopy, barium enema, and colonoscopy. Medicare first implemented screening in January 1998 with coverage for FOBT, sigmoidoscopy, and barium enema for routine screening, and colonoscopy for high-risk populations. Amendments in the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Benefits Improvement and Protection Act of 2000 that authorize coverage for screening colonoscopy in average-risk persons became effective July 1, 2001. Coverage for immunoassay FOBT and stool DNA testing became effective November 4, 2003, and October 9, 2014, respectively.

Confusion about the Patchwork of Laws and Policies

The patchwork of CRC screening coverage laws and policies has resulted in considerable confusion for the public and providers. For Medicare beneficiaries, out-of-pocket costs depend on the type of facility in which the procedure is performed, supplemental insurance coverage status, and the provider accepting Medicare assignment.

Recommendations

Because the ACA did not address BBA provisions, the Centers for Medicare and Medicaid Services currently lacks the authority to waive the 20% or 25% coinsurance for diagnostic or therapeutic procedures done in the context of a screening episode, which was about \$163 or \$203 on average in 2014. This puts Medicare coverage at odds with the practice of many private insurers, who comply with ACA

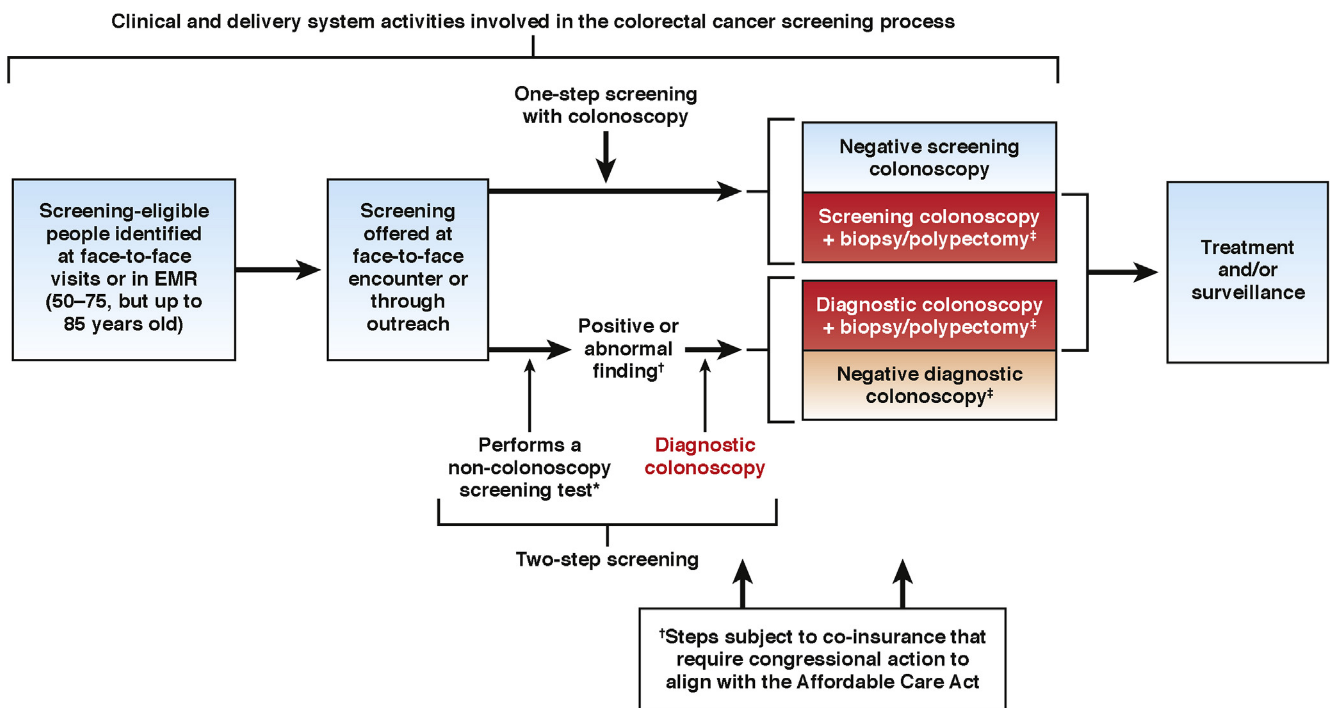

Figure 2. The colorectal cancer screening process and steps affected by coinsurance requirement.

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