

## Colonoscopy Screening after the Affordable Care Act: Cost Barriers Persist for Medicare Beneficiaries

*Lynda Flowers*  
*Claire Noel-Miller*  
AARP Public Policy Institute

*Deanna Okrent*  
Alliance for Health Reform<sup>1</sup>

**The Affordable Care Act (ACA) sought to address low rates in the use of recommended preventive services—including colonoscopy—by partially eliminating Medicare beneficiary cost sharing. Beneficiaries continue to be exposed to costs if polyps are found and removed, if tissue is biopsied during the procedure, or if the colonoscopy is administered following a stool blood test indicating that cancerous cells *might* be present in the colon. These remaining costs could be a barrier to the use of this lifesaving test. This report discusses these barriers and presents policy options that may help overcome them.**

### Introduction

Colorectal cancer—cancer of the large intestine or rectum—is the second leading cause of cancer deaths in the United States and the third most common cancer in men and women.<sup>2</sup> It is almost entirely preventable by taking advantage of recommended screening tests, including colonoscopy, which is considered the gold standard for early detection and prevention of cancers of the colon and rectum.<sup>3</sup>

It is estimated that between \$12 and \$14 billion are spent every year on colorectal cancer treatment in the United States, with Medicare bearing more than one-half of these costs.<sup>4</sup>

Despite Medicare's coverage of colorectal cancer screening tests, fewer than two-thirds of adults aged 65 and over (58.1%) were screened in 2008.<sup>5</sup> This falls short of the Healthy People 2020 goal of a 70 percent screening rate.<sup>6</sup>

The ACA<sup>7</sup> sought to address low rates in the use of recommended preventive services—including colorectal cancer

screening—by partially eliminating Medicare beneficiary cost-sharing obligations associated with highly recommended preventive services.<sup>8</sup> In spite of this important change in policy, cost barriers to colonoscopy in Medicare persist. This paper discusses these barriers and presents policy options that may help overcome them.

### Impact of the ACA on Medicare Cost Sharing for Screening Colonoscopy

Medicare beneficiaries typically have cost-sharing obligations for certain health care services they receive. In addition to monthly Part B premiums (\$104.90 for the standard premium in 2013 and 2014),<sup>9</sup> beneficiaries are also responsible for an annual Part B deductible (\$147.00 in 2013 and 2014), and coinsurance (typically 20 percent of the Medicare allowable charge for a service).<sup>10</sup>

Cost-sharing obligations create a barrier to receipt of important preventive services and screenings.<sup>11</sup> The ACA

eliminates the Medicare Part B deductible and coinsurance requirements for routine *screening* tests that receive an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF)—an independent panel of private sector experts in prevention and primary care (see appendix A for a complete description of Medicare covered colon cancer screening tests and their USPSTF ratings).<sup>12</sup> For individuals between ages 50 and 75, colonoscopy has an A-rating from the USPSTF, which means that the panel believes that the test provides a substantial benefit to people in this age range.<sup>13</sup>

In spite of changes made by the ACA, Medicare continues to require beneficiaries to bear a portion of the cost when their screening colonoscopies are deemed *diagnostic* in nature. A colonoscopy is considered diagnostic, rather than screening, when a polyp or abnormal growth is removed during the procedure, or when suspicious-looking tissue is removed for laboratory analysis—called a biopsy. Beneficiary cost sharing also applies when a colonoscopy is received following a positive result on an alternative colorectal cancer screening test, called fecal occult blood test (FOBT).<sup>14</sup>

## Waiving Beneficiary Cost Sharing

### Polyp Removal and Tissue Biopsy

Before the ACA was enacted, when a polyp was identified and removed during a screening colonoscopy, or when suspicious-looking tissue was removed for biopsy, Medicare considered the test to be diagnostic—as opposed to a routine *screening*. In these cases Medicare beneficiaries were responsible for both the Medicare Part B deductible and coinsurance.

The ACA partly addressed the issue by expressly waiving the Medicare Part B

deductible, regardless of whether a polyp is removed or a biopsy is taken during the procedure. However, the ACA *did not* eliminate the 20 percent coinsurance requirement associated with polyp removal or tissue biopsy during colonoscopy.

In contrast to Medicare, federal agency interpretation of ACA provisions related to private sector coverage clarified that polyp removal and tissue biopsy are an “integral part of a colonoscopy” and therefore not subject to cost sharing in the *private insurance market*.<sup>15</sup> This administrative ruling created a lack of parity in colonoscopy cost-sharing policy between Medicare and private sector coverage.

Some advocates believe that the Administration has similar authority to waive cost sharing associated with polyp removal and tissue biopsy in the Medicare program.<sup>16</sup> Alternatively, Congress could act to bring about such parity. Recently, federal legislation was introduced to “waive coinsurance under Medicare for colorectal cancer screening tests, regardless of whether therapeutic intervention is required during the screening.”<sup>17</sup> Although not likely to pass this year, the bill sets a precedent for future congressional action on the issue.

### Colonoscopy Following a Positive FOBT Screening Test

A positive FOBT indicates that cancerous cells *might* be present in the colon. Therefore, colonoscopy is recommended as a follow-up to definitively determine whether there are polyps or suspicious-looking tissue in the colon or rectum.

Under current Medicare rules, a colonoscopy performed subsequent to a positive FOBT is considered a separate diagnostic procedure rather than an integral and necessary part of a comprehensive colorectal cancer

screening process. Because they are considered to be benefiting from a *diagnostic* procedure rather than a *screening* procedure, Medicare beneficiaries who receive a colonoscopy following a positive FOBT are responsible for both the Medicare Part B deductible and the 20 percent coinsurance associated with the colonoscopy. This rule applies regardless of the results of the follow-up colonoscopy.

According to the USPSTF, “follow-up of positive screening test results requires colonoscopy regardless of the screening test used.”<sup>18</sup> This suggests that the USPSTF views colorectal cancer screening as a continuum of tests, that together lead physicians to conclusively establish the presence or absence of cancerous cells.

## Policy Considerations

The current distinction between screening and diagnostic colonoscopy in Medicare exposes beneficiaries to unexpected cost sharing, creates cost barriers to the receipt of this lifesaving test, and perpetuates an arbitrary distinction in payment policy between private sector and Medicare coverage. The federal government could—through either law or regulatory interpretation—eliminate cost sharing associated with colonoscopy regardless of polyp removal or biopsy. It could also consider a policy that encourages Medicare beneficiaries to access colonoscopy following a positive FOBT, by eliminating cost barriers.

Low rates of colorectal cancer screening among Medicare beneficiaries coupled with extensive research demonstrating the efficacy of these screenings underscores the importance of removing cost barriers.

Appendix A. Medicare Coverage of Colorectal Cancer Screening Tests

**Figure 1**  
**Medicare Coverage of Colorectal Cancer Screening Tests<sup>19</sup>**

	Description of Test	Medicare-Covered Periodicity Schedule	Medicare Deductible Applies?	Medicare 20% Coinsurance Applies?	20% Office Visit Coinsurance Applies?	USPSTF Rating
<b>Fecal Occult Blood Test (FOBT)</b>	Uses chemically treated paper card to test for human blood in the stool in 2–3 consecutive stool samples	1 test per year for beneficiaries aged 50 and older	No	No	Yes	A
<b>Fecal Immunochemical Test (FIT)</b>	Uses paper card treated with antibodies to test for human blood in the stool in 3 consecutive stool samples	1 test per year for beneficiaries age 50 and older	No	No	Yes	A
<b>Flexible Sigmoidoscopy</b>	Flexible lighted tube inserted into the rectum to visually check for polyps or cancerous lesions in the rectum and <i>lower third of the colon</i>	1 test every 4 years for beneficiaries aged 50 and older or once every 10 years for those who have had a previous screening colonoscopy	No	Yes; increased to 25% for those tested at outpatient hospitals or ambulatory surgical centers	No; if provider accepts assignment**	A
<b>Screening Colonoscopy</b>	Flexible lighted tube inserted into rectum to visually check for polyps or cancerous lesions in the rectum and <i>entire colon</i> Considered the “gold standard” test for colorectal cancer screening	1 test every 10 years for beneficiaries who are not at high risk (regardless of age) but not within 4 years of a screening sigmoidoscopy 1 test every 2 years for high-risk beneficiaries regardless of age*	No; even if results in a biopsy or removal of a growth	No; unless results in a biopsy or removal of a growth	No; if provider accepts assignment**	A
<b>Barium Enema</b>	X-rays are taken of the large intestine after the colon is filled with contrast after the administration of an enema containing barium (a chemical element that makes the colon more visible)	1 test every 4 years for beneficiaries aged 50 and older who are not at high risk, in lieu of sigmoidoscopy or colonoscopy 1 test every 2 years for those at high risk regardless of age	No; even if results in a biopsy or removal of a growth	Yes; 20% for the physician’s services. There is also a copayment for receiving the service in a hospital outpatient setting	No	I

\*Medicare defines high risk of developing colorectal cancer as having one or more of the following risk factors: a close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp (a polyp that consists of benign tissue that resembles cancerous tissue); a family history of familial adenomatous polyposis (an inherited condition in which numerous polyps form in the large intestine); a family history of hereditary nonpolyposis colorectal cancer (a genetic condition associated with high risk for developing colon cancer); a personal history of adenomatous polyps; a personal history of colorectal cancer; or a personal history of inflammatory bowel disease, including Crohn’s disease and ulcerative colitis.

\*\*Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services.

## Endnotes

<sup>1</sup> The views expressed in this paper are solely those of the author and do not reflect those of the Alliance for Health Reform.

<sup>2</sup> U.S. Cancer Statistics Working Group, *United States Cancer Statistics: 1999–2009 Incidence and Mortality Web-based Report* (Atlanta, GA: Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; 2013). Available at <http://www.cdc.gov/uscs>.

<sup>3</sup> During a colonoscopy, a flexible lighted tube is inserted into the rectum to visually check for polyps or cancerous lesions in the rectum and *entire* length of the colon. Polyps and samples of suspicious-looking tissue can be removed during this procedure. Several national organizations have endorsed colonoscopy as the preferred colorectal cancer screening method because, unlike the other screening tests, colonoscopy has the ability to both detect *and* prevent colon cancer throughout the *entire* colon. Cancers are detected because the entire colon can be visualized; they are prevented by allowing the practitioner to remove polyps (noncancerous or cancerous) and suspicious tissue throughout the colon. D. L. Rex, “Clinical Guideline: Colorectal Cancer Screening,” *American Journal of Gastroenterology* 104 (2009), pp. 739–750. Accessed at <http://gi.org/guideline/colorectal-cancer-screening/>.

<sup>4</sup> Fight Colorectal Cancer, *Screening Saves Lives and Money* (March 2012). Accessed at <http://fightcolorectalcancer.org/>.

<sup>5</sup> Refers to the proportion of individuals aged 65 and over who received either a fecal occult blood test (FOBT) within the past year, sigmoidoscopy within the past 5 years, or a colonoscopy within the past 10 years. American Cancer Society, *Colorectal Cancer Facts & Figures 2011–2013* (Atlanta, GA, 2011). Accessed at <http://www.cancer.org/acs/groups/content/@epidemiologysurveillance/documents/document/acspc-028323.pdf>.

<sup>6</sup> U.S. Department of Health and Human Services, *Healthy People 2020 Objectives*, Objective C-16. Accessed at <http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=5>.

<sup>7</sup> *The Patient Protection and Affordable Care Act*, Pub. Law 111–148, March 23, 2010.

<sup>8</sup> There are other potential barriers to colorectal cancer screening. Examples include cost sharing associated with certain types of anesthesia, low public awareness of the importance of screening, beneficiary reluctance to be screened, and availability of providers to perform colorectal cancer screening.

<sup>9</sup> Since 2007, single Medicare Part B beneficiaries with a yearly income above \$85,000 and couples with a yearly income above \$170,000 have been required to pay a monthly Part B premium that is higher than the standard premium.

<sup>10</sup> The Centers for Medicare & Medicaid Services, *Medicare 2013 and 2014 Costs at a Glance*. Accessed at <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html>.

<sup>11</sup> H. K. Koh and K. G. Sebelius, “Perspectives: Promoting Prevention through the Affordable Care Act,” *New England Journal of Medicine* 363 (September 30) (2010), pp. 1296–1299.

<sup>12</sup> The USPSTF gives one of five grades to preventive services: A = The USPSTF recommends the service. There is high certainty that the net benefit is substantial; B = The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial; C = The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small; D = The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits; and I = The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

<sup>13</sup> According to USPSTF guidelines, screening for people between ages 75 and 85 is recommended only under certain circumstances and given a “C” recommendation. Screening is discouraged for those ages 85 and older and given a “D” recommendation.

<sup>14</sup> The fecal occult blood test—also known as FOBT—is a lab test used to check stool samples for hidden (occult) blood. The FOBT test involves smearing feces onto absorbent paper that has been treated with a chemical. Occult blood in the stool may indicate colon cancer or polyps in the colon or rectum—though not all cancers or polyps bleed. Typically, occult blood is passed in such small amounts that it can be detected only through the chemicals used in a fecal occult blood test. In addition to being sensitive to human blood, the FOBT is also sensitive to nonhuman sources of blood (e.g., blood in undigested red meat). The FOBT is often prescribed before a colonoscopy because it is less invasive, has lower risks of complications, and is less costly than colonoscopy. R. Labianca and B. Merelli, “Screening and Diagnosis for Colorectal Cancer: Present and Future,” *Tumori* 96(6) (2010), pp. 889–901. Accessed at [http://www.tumonline.it/r.php?v=548&a=6506&l=9031&f=allegati/00548\\_2010\\_06/fulltext/02-Labianca%28889-901%29.pdf](http://www.tumonline.it/r.php?v=548&a=6506&l=9031&f=allegati/00548_2010_06/fulltext/02-Labianca%28889-901%29.pdf).

<sup>15</sup> U.S. Department of Labor, *FAQs about Affordable Care Act Implementation Part XII* (February 20, 2013). Accessed at <http://www.dol.gov/ebsa/faqs/faq-aca12.html>. These FAQs were prepared jointly by the Departments of Labor, Health and Human Services (HHS), and Treasury.

<sup>16</sup> American Cancer Society Cancer Action Network (ACSCAN) letter to the Secretary of the U.S. Department of HHS dated September, 4, 2013, Reference no. RIN 0938-AR56 / File Code CMS-1600-P.

<sup>17</sup> H.R. 1070, *Removing Barriers to Colorectal Cancer Screening Act of 2013*, introduced March 12, 2013, by Rep. Charles Dent. The bill was referred to Health Subcommittee.

<sup>18</sup> U.S. Preventive Services Task Force, “Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement,” *Annals of Internal Medicine* 149 (2008), pp. 627–637.

<sup>19</sup> U.S. Department of HHS, Centers for Medicare and Medicaid Services, *Medicare and You 2014*. Accessed at <http://www.medicare.gov/Pubs/pdf/10050.pdf>.

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AARP Public Policy Institute,  
601 E Street, NW, Washington, DC 20049  
[www.aarp.org/ppi](http://www.aarp.org/ppi)  
202-434-3890, [ppi@aarp.org](mailto:ppi@aarp.org)  
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