

The Role of Potential Overutilization on Healthcare Spending: A Case Study Regarding Colonoscopies

The ever-growing issue of rising healthcare costs and budget deficits has become a routine point of discussion and debate for providers; insurers; consumers; and, policymakers over the past several years. In a recent analysis, the Congressional Budget Office (CBO) predicted that the rate of federal healthcare spending will continue to rise in future years relative to increases in the Gross Domestic Product (GDP).¹ Additionally, even projections that accounted for the CBO estimated that national healthcare spending—comprised of federal, private, self-pay, and other public healthcare plans—would still rise significantly (from 16.8% of GDP in 2010 to approximately 25% of GDP in 2037) even after accounting for the implementation of cost savings measures proposed by the Affordable Care Act (ACA) specifically.²

A recent study by The Commonwealth Fund found that in 2009, U.S. total healthcare expenditures exceeded that of 13 other comparable industrialized countries (all members of the *Organisation for Economic Cooperation and Development* (OECD)), and was generally associated with higher prices; more accessible technology; and, higher obesity rates. It was not, however, associated with higher income; population age; quality of care; outcomes; or, higher healthcare utilization rates, as might have been reasonably expected.³ The average rate of hospital cost spent per discharge in the U.S. (\$18,142) exceeded that of the next closest country (Canada) by almost \$5,000; was almost triple the cost of OECD median spending; and, per capita spending was \$2,608 higher than any other country.⁴ In another analysis by the International Federation of Health Plans, U.S. spending far exceeded that of comparable industrial countries for selected imaging procedures; cost per hospital day (\$4,287 compared to \$1,472 in Australia as the closest competitor); hospital and physician cost for selected invasive/surgical procedures; and, physician fees for various services.⁵

Several healthcare policy associations and industry experts have used the growth in utilization and the cost of colonoscopies as a case study to elicit a compelling view of how overpriced procedures can significantly drive up the annual cost by more than \$10 billion⁶. Colorectal cancer, although rates have decline over the past two decades, is still the third most common cancer

in the U.S.⁷ The U.S. Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer between ages 50-75 years (an “A” rated recommendation) via fecal occult blood testing; sigmoidoscopy; *or*, colonoscopy. It does not, however, recommend routine testing after age 76.⁸ Of these tests, one is not recommended over another for the purposes of screening, but the colonoscopy (one of the most expensive) has become the test of choice in the U.S. over the past decade. Some attribute this increase in utilization to “*The Katie Couric Effect*,” namely the increase in colonoscopies attributed to NBC’s anchor-person Katie Couric undergoing a live, on-air colonoscopy in March 2000 to raise awareness about colon cancer screening after losing her husband to colorectal cancer 2 years prior. One study found that the number of colonoscopies per physician per month significantly increased from 14.6 to 18.1 after the procedure was aired on national television, while rates of mammography and prostate cancer screening remained unchanged.⁹ Although colorectal cancer screening rates in 2010 remained significantly below target levels set by *Healthy People 2020* (58.6% versus 70.5%), rates increased by almost 20% from 2000 to 2010.¹⁰ While increased screening rates for colorectal cancer will inherently reduce the number of cancer cases, thereby reducing healthcare expenditures associated with treatment of the disease, the pricing and potential overutilization of the colonoscopy may be unnecessarily driving up healthcare spending.

Under the Affordable Care Act (ACA), any “*evidence-based items or services that have...a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force...*” must be covered by insurance.¹¹ However, there are scenarios in which the patient may experience cost sharing associated with colonoscopies, despite ACA regulations, principally if: (1) polyp removal is required; (2) the colonoscopy is performed as a follow-up screening test after a positive fecal occult blood test; (3) a higher-risk individual receives a colonoscopy more frequently than the average at-risk adult; or, (4) an individual is covered by a health plan that was grandfathered in under the ACA, and thereby is not subject to its stipulations.¹² These loopholes are further complicated by inconsistencies caused by non-standardization of billing, coding and payment practices across providers and health plans.¹³

The procedure price, and the likelihood of consumer cost-sharing, is also increased if an anesthesiologist or nurse anesthetist administers the intravenous sedation needed during the procedure. Of note is that for the typical “low-risk” patient undergoing a screening colonoscopy, sedation can be administered by the endoscopy team without the aid of an anesthesia provider.¹⁴ Yet, national spending for anesthesia providers during gastrointestinal procedures between 2003 and 2009 more than tripled, and of the \$1.3 billion paid to anesthesia providers for this service in 2009, only \$0.2 billion of that amount was attributable for procedures conducted on high risk patients.¹⁵

Not dissimilar to healthcare costs on a national level, drivers of increasing costs for colonoscopies are multi-factorial, including but not limited to the potential over-utilization; lack of price control and restraints; and, ambiguity in billing guidelines that allow extraneous costs to be charged. These same cost implications can be observed throughout the healthcare market and are a concern to economists and policymakers alike, e.g. a recent article in *The New York Times*, announced that several forthcoming articles would investigate “...*how the economic incentives underlying the fragmented healthcare market in the United States have driven up costs...*”¹⁶ Until a reliable and sustainable method to control healthcare spending can be implemented, public attention devoted to this particular topic is likely to remain in the forefront of healthcare policy debates for the foreseeable future.

¹ “The 2012 Long-Term Budget Outlook”, by the Congressional Budget Office, June 2012, p. 46

² *Ibid*, Congressional Budget Office, June 2012, p. 59-60.

³ “Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality”, by David A. Squires, The Commonwealth Fund, May 2012, p. 2-3

⁴ *Ibid*, David A. Squires, May 2012, p. 3, 6

⁵ “2012 Comparative Price Report: Variation in Medical and Hospital Prices by Country”, by the International Federation of Health Plans, p. 4-23

⁶ “The \$2.7 Trillion Medical Bill”, by Elisabeth Rosenthal, *The New York Times*, June 1, 2013, <http://www.nytimes.com/2013/06/02/health/colonoscopies-explain-why-us-leads-the-world-in-health-expenditures.html> (Accessed 6/12/13)

⁷ “A Snapshot of Colorectal Cancer”, by the National Cancer Institute, October 2012, p. 1

⁸ “Screening for Colorectal Cancer: Recommendation Statement”, by U.S. Preventive Services Task Force”, October 2008, www.uspreventiveservicestaskforce.org/uspstf08/colocancer/colors.htm#contents (Accessed 6/12/13)

⁹ “The Impact of a Celebrity Promotional Campaign on the Use of Colon Cancer Screening: The Katie Couric Effect”, by Cram et al., *Archives of Internal Medicine*, 2003, Vol. 163, p. 1602

¹⁰ “Cancer Screening—United States, 2010”, by Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, January 27, 2012, Vol. 61, No. 3, p. 42-43

¹¹ Section 2713 of the Patient Protection and Affordable Care Act, Public Law 111-148 (March 23, 2010), STAT 131

¹² “Coverage of Colonoscopies Under the Affordable Care Act’s Prevention Benefit”, by the Kaiser Family Foundation, American Cancer Society, and the National Colorectal Cancer Roundtable, September 2012, p. 1

¹³ *Ibid*, Kaiser Family Foundation, American Cancer Society, and the National Colorectal Cancer Roundtable, September 2012, p. 4-5

¹⁴ “Eliminating Discretionary Use of Anesthesia Providers During Gastroenterology Procedures Could Generate \$1.1 Billion in Savings per Year”, by Rand Health, 2012, p. 1

¹⁵ *Ibid*, Rand Health, 2012, p. 2-3

¹⁶ “The \$2.7 Trillion Medical Bill”, by Elisabeth Rosenthal, *The New York Times*, June 1, 2013, <http://www.nytimes.com/2013/06/02/health/colonoscopies-explain-why-us-leads-the-world-in-health-expenditures.html> (Accessed 6/12/13)



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