What's Crazy About Mammogram and Colonoscopy Rules

By Michael Fine

Okay. We think women need mammograms if we are going to reduce the number of women dying from breast cancer. (Men also get breast cancer. It's less common. But it happens. There is no mammography recommendation for men, however.) We think everyone of a certain age needs screening for colon cancer, which is or sometimes leads to colonoscopy, if we are going to reduce the number of people dying from colon cancer.

But there is some real craziness that happens to women with at mammography time. And to many people, at colonoscopy time.

Here's the craziness: If you have dense breasts, but sometimes other times, the usual process for getting a mammogram (which is a kind of Xray) may not work as well at detecting cancers. Or the nice radiologists *may* think they see something and want to do more studies to make sure what they see isn't a problem. So the radiologists who run this whole process tell you that you need an ultrasound, a breast MRI or a 3D mammogram to make sure you don't have cancer -- all tests which cost more, and sometimes lots more money-- than a "regular" mammogram. But get this: insurance companies have to pay for screening mammograms without a copay, according to the law. But when radiologists think *maybe* they see something, those insurance companies often call the fancier, more expensive testing *diagnostic tests,* not screening tests, which means the person who gets them has to pay a copay. And the copays are often pretty big, sometimes $200 or more. Which lots of poor and working women can't afford.

Similar story with colonoscopy. Screening colonoscopy and other colon cancer screening is supposed to be covered under the Affordable Care Act, and state law. But sometimes the gastroenterologists who do the test see a polyp and remove it. Then they often recommend you have another colonoscopy in three or five years, and guess what, the nice insurance company calls that follow-up screening colonoscopy *diagnostic,* and you get to pay a co-pay of two, three or even six hundred dollars, even though you have insurance and the law requires that insurance to pay for screening colonoscopy.

Say what? We have a rule that says insurance companies have to pay for screening mammograms and colonoscopies, but some insurance companies say some of the imaging we use isn't really screening? And the radiologists and gastroenterologists who do this get to charge a bunch more money when they decide someone needs those fancy tests? And the radiologists and gastroenterologists get to keep the extra money? And all that means some poor and working women and men either can't afford screening, or get pushed to the brink financially because of the cost? What's going on here?

(I'm going to skip arguments about the value of mammography and colonoscopy itself. There is some disagreement among public health experts about the value of both, but I'm going not to review those disagreements here. I think the evidence supports screening, most of the time.)

What's going on here is that people with power and money are trying to game a attempt to make a tiny mini-system that screens for everyone, out of a market that exists for wealth extraction. Earth to insurance companies: *screening* is what you do when someone doesn't have a symptom, when you look for early manifestations of a disease to prevent that disease from causing disability and early death. (Screening works when there is a good test that identifies asymptomatic disease, when there is a good way to get the at-risk population screened, a good treatment to stop the progression of the uncovered disease, and a good way to get the people with the hidden disease treated.) *Diagnostic tests* are what you do when someone has a symptom, and you are trying to find out what is causing the problem. Having dense breasts, or polyps in your colon, is like being tall, or short, or Black, or white, and isn't a symptom. Calling those other tests or recommend repeat colonoscopy "diagnostic" is like putting a new name or new packaging on an old, inexpensive, but effective generic drug, and charging ten or a hundred times as much, which, unfortunately, happens all the time. Both are bald-faced attempts to game the system, such as it is, in the service of profit itself.

It makes me incredibly sad that the doctors and nurses who work for insurance companies, who have sworn oaths to put patient care first, and who staff the utilization review process -- which is supposed to protect the public from this kind of manipulation of the law and our medical processes -- haven't stopped this craziness. But here we are.

Why hasn't the Department of Health or the Attorney General or even the Health Insurance Commissioner stepped in to take the bad guys to court and end this abusive practice? I don't know. I'm incredibly disappointed in all of them as well. But it may be that the law as written allows the insurance companies just enough wriggle room to get away with this nonsense.

Why haven't the women and men who help run insurance companies and regulatory agencies stepped up to stop this nonsense? I don't know that either.

The good news is that some decent and courageous legislators -- Senators Zurier, Sosnowski, Miller, Gallo, and Lauria --introduced a bill -- S 2070 --last session to end this ridiculous and manipulative process. The bad news is that S2070 didn't pass. Yet.

We'd be crazy if everyone in Rhode Island didn't call their legislators today and urge them to pass 2070 in the next session. Enough!

(Many thanks to Maureen Natale MSN RN and Linda Eibel NP for bringing this particular craziness to my attention.)