



Colorectal Cancer Screening

Issue Brief ♦ Health Care Survey of DoD Beneficiaries (HCSDB) ♦ January 2009

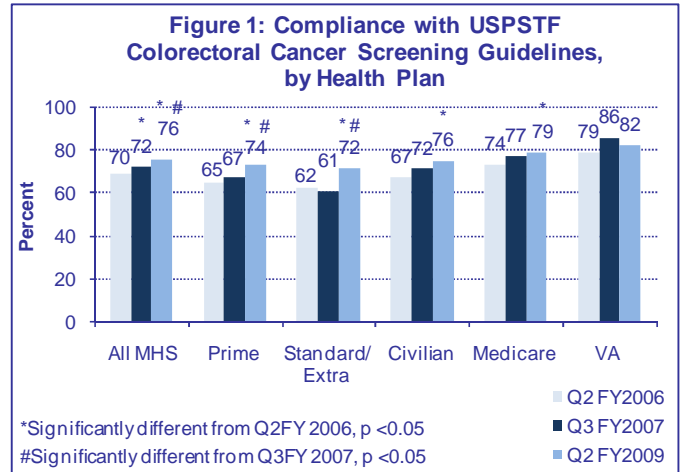
HEALTH PROGRAM ANALYSIS & EVALUATION DIRECTORATE

Colorectal cancer is currently the third leading cancer-related cause of death in the United States. In 2008, an estimated 50,000 Americans died from the disease.¹ Colon and rectal cancer deaths can be prevented through screening at recommended intervals. Screening helps catch the disease in an earlier and more treatable stage, and has been shown to save lives.² In 2002, The United States Preventive Service Task Force (USPSTF) issued guidelines for colorectal cancer screening. The guidelines recommended screening for all adults age 50 and over via (1) colonoscopy every 10 years, or (2) sigmoidoscopy every 5 years, or (3) a fecal occult blood stool test (FOBT) every 12 months. In October 2008, USPSTF modified the guidelines. The revised guidelines recommend screening only for adults age 50 to 75, via (1) colonoscopy every 10 years, or (2) a high sensitivity FOBT every 12 months, or (3) flexible sigmoidoscopy every 5 years with a high-sensitivity FOBT every 3 years. American Cancer Society recommendations are similar, but include some alternative methods, and do not exclude beneficiaries over 75.

Colonoscopy is considered the “gold standard” screening method because it is the only method that detects precancerous polyps, and therefore prevent cancer.^{3,4} As of March 15th, 2006, TRICARE expanded its benefits to include colonoscopy every 10 years for all adults age 50 and over, a benefit similar to that of Medicare and many other civilian health plans. Researchers hypothesize that expanded coverage for colonoscopy caused the decline in colorectal cancer mortality rate seen over the last 10 years.

Colorectal cancer screening rates, prevalence, and mortality rates differ by race and ethnicity. African Americans, Hispanics, and Asian Americans are significantly less likely to undergo any type of colorectal cancer screening compared with non-hispanic whites.⁵ Prevalence of colorectal cancer is significantly greater among African Americans than whites.⁶ Similarly, African Americans’ CRC mortality rates are almost 50 percent higher than whites’.⁷

This issue brief will review changes in compliance with the 2002 guidelines among TRICARE beneficiaries age 75 or under, since the 2006 expansion of colonoscopy coverage, using HCSDB results from January 2006, April 2007, and January 2009. It will also compare variations by race and ethnicity in screening rates among TRICARE beneficiaries to those in the general American population.



Screening Rates among TRICARE Beneficiaries Have Increased Since 2007

Overall, compliance with the USPSTF screening guidelines among all TRICARE beneficiaries aged 50 to 75 has increased significantly since 2006, rising from 70 percent to 76 percent (Figure 1). Rates increased for Prime and Standard/Extra health plan users and for users of other civilian health insurance and Medicare.

Despite the increase in screening rates among Prime and Standard/Extra users, in 2009, screening rates of TRICARE plans still lagged behind those of other health plan users. VA users had the highest compliance rates (83 percent) followed by Medicare (79 percent) and other civilian plans (76 percent). Standard/Extra users (72 percent) and Prime (74 percent) rates were significantly below those of Medicare users, but not significantly different from those of other plans (p <0.05).

The increased screening rates are attributable to an increase in colonoscopy screening. The proportion of all MHS beneficiaries with colonoscopy screening in the last 10 years increased from 58 percent to 70 percent. Colonoscopy screening increased among Prime and Standard/Extra health plan users, as well as users of Medicare and other civilian insurance (Table 1). Sigmoidoscopy screening and FOBT did not change substantially. The increase in the colonoscopy screening rate for VA users from 2006 to 2009 was not significant and was accompanied by nonsignificant drops in sigmoidoscopy and FOBT.

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Table 1: Colorectal Cancer Screening, by Health Plan
Percent of beneficiaries age 50-75 screened with:

	Colonoscopy within the last 10 years			Sigmoidoscopy within the last 5 years			FOBT within the last 12 Months		
	2006	2007	2009	2006	2007	2009	2006	2007	2009
All MHS	58	65*	70*#	28	25*	25	20	16*	17*
Prime	55	61*	69*#	27	21*	24	15	15	14
Standard/Extra	53	55	65*#	21	17	19	13	12	17
Civilian	55	64*	68*	25	25	26	20	15*	15*
Medicare	65	72*	75*	29	28	28	18	17	17
VA	56	68*	62	40	36	30	51	40	42

*Significantly different from 2006, p <0.05

#Significantly different from 2007, p <0.05

No Significant Disparities between Racial/ Ethnic Groups

Despite the disparities that exist in the civilian population in screening and mortality rates, screening rates do not differ substantially between white TRICARE beneficiaries and TRICARE beneficiaries of other ethnic groups. Figure 2 indicates that no ethnic groups have been excluded from the increase, including both TRICARE and non-TRICARE users. The results suggest that screening increased least

for Hispanic TRICARE users, whose TRICARE screening rate in 2009 is significantly less than the non-TRICARE screening rate.

Conclusion

Due in large part to the increase in colonoscopy screening rates, the percentage of MHS beneficiaries in compliance with the 2002 USPSTF colorectal cancer screening guidelines increased significantly between 2006 and 2007, and also between 2007 and 2009. TRICARE's expanded coverage of colonoscopy beginning in 2006 appeared to play a large role in this increase. Screening rates have increased for all ethnic groups, and disparities that are evident in the civilian population do not appear among MHS beneficiaries.

In previous years, VA compliance has been significantly above rates for other health plans, but not in 2009. While FOBT screening rates for VA beneficiaries continue to exceed rates for other plans, colonoscopy rates are not correspondingly high. VA users are more likely than users of other health plans to be compliant only through FOBT. The results suggest a difference in screening methods that should be monitored for impact on patient outcomes.

Sources

¹ American Cancer Society, Cancer Facts & Figures 2008, available at: <http://www.cancer.org/downloads/STT/2008CAFFfinalsecured.pdf>

² Screening for Colorectal Cancer, Recommendation Statement. US Preventative Service Task Force, October 2008. Available at: <http://www.ahrq.gov/clinic/uspstf08/colocancer/colors.htm>.

³ Ransohoff DF and Sandler RS. Clinical Practice: Screening for Colorectal Cancer. NEJM 2002; 346:40-44.

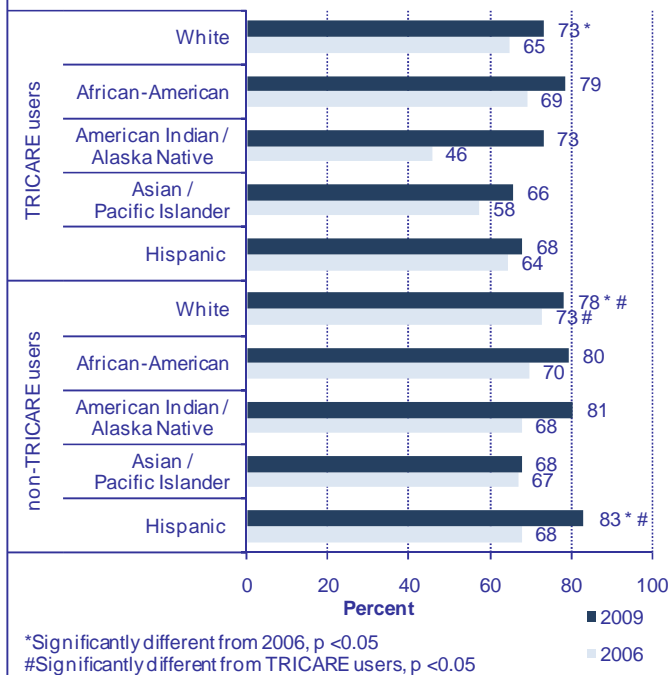
⁴ American Society for Gastrointestinal Endoscopy. "Colorectal Cancer Rate Declines in US" Available at: <http://www.healthnewstrack.com/health-news-830.html>

⁵ Jerant, Anthony F., Joshua J. Fenton, Peter Franks. Determinants of Racial/Ethnic Colorectal Cancer Screening Disparities. Archives of Internal Medicine 2008 vol. 168 issue 12; p. 1317-1324.

⁶ Lieberman, David A. et al. Prevalence of Colon Polyps Detected by Colonoscopy Screening in Asymptomatic Black and White Patients. Journal of the American Medical Association 2008 vol. 300 issue 12. P. 1417-1422.

⁷ Racial gap in colon cancer deaths grows: Colon, Rectal Cancer Death Rates Nearly Twice As High For African Americans. CBS News Interactive Healthwatch, December 15, 2008. Available at: <http://cbs5.com/health/colon.cancer.racial.2.887583.html>

Figure 2: Compliance with USPSTF Colorectal Cancer Screening Guidelines, by TRICARE Use and Race



*Significantly different from 2006, p <0.05

#Significantly different from TRICARE users, p <0.05