The Effect of Medicare Health Care Delivery Systems on Survival for Patients with Breast and Colorectal Cancer

Robert S. Kirsner,1,2,3,4 Fangchao Ma,1,4 Lora Fleming,2 Daniel G. Federman,5 Edward Trapido,2 Robert Duncan,2 and James D. Wilkinson2

Departments of 1Dermatology and Cutaneous Surgery, 2Epidemiology and Public Health, 3Sylvester Comprehensive Cancer Center, University of Miami School of Medicine; 4Department of Dermatology, Veterans Administration Medical Center, Miami, Florida; and 5Division of General Medicine, Veterans Administration Medical Center, Department of Internal Medicine, Yale University School of Medicine, West Haven, Connecticut

Abstract

Background: Two of the most common types of health care delivery systems in the U.S. are fee-for-service (FFS) and managed care systems such as health maintenance organizations (HMO). Differences may exist in patient outcomes depending on the health care delivery system in which they are enrolled. We evaluated differences in the survival of patients with breast and colorectal cancer at diagnosis between the two Medicare health care delivery systems (FFS and HMO).

Methods: We used a linkage of two national databases, the Medicare database from the Centers for Medicare and Medicaid Services, and the National Cancer Institute’s Surveillance, Epidemiology, and End Results program database, to evaluate differences in demographic data, stage at diagnosis, and survival between breast and colorectal cancer over the period 1985 to 2001.

Results: Medicare patients enrolled in HMOs were diagnosed at an earlier stage of diagnosis than FFS patients. HMO patients diagnosed with breast and colorectal cancer had improved survival, and these differences remained even after controlling for potential confounders (such as stage at diagnosis, age, race, socioeconomic status, and marital status). Specifically, patients enrolled in HMOs had 9% greater survival in hazards ratio if they had breast cancer, and 6% if they had colorectal cancer.

Conclusions: Differences exist in survival among patients in HMOs compared with FFS. This is likely due to a combination of factors, including but not limited to, earlier stage at the time of diagnoses. (Cancer Epidemiol Biomarkers Prev 2006;15(4):769–73)

Introduction

Two of the most common types of health care delivery systems in the U.S. are fee-for-service (FFS) and managed care systems (which include the health maintenance organizations, HMO). Medicare’s HMO program has grown rapidly in recent years; as of 1999, >6.5 million persons were enrolled, which accounted for 17% of the beneficiary population (1, 2). An important issue is whether, and how, the health care delivery system in which patients participate may affect patient outcomes. Managed care systems have been developed to contain health care costs, but their effect on quality of care has not been clearly established (3, 4). It has been reported that some differences in patient outcomes are associated with the type of health care delivery system in which they are enrolled (5-9).

Breast and colorectal cancer represent two of the most common cancer sites and screening tests exist. Breast cancer is the most common non–skin cancer among women in the U.S., and is second only to lung cancer as a cause of cancer-related death. In 2004, an estimated 216,000 new cases of breast cancer were diagnosed in American women, and >40,000 women died of the disease (10). Forty-one of every 1,000 women die of breast cancer (11). Colorectal cancer is the second leading cause of cancer-related deaths in the U.S. for men and women combined; examined by gender, it is the third leading cause of cancer-related mortality for both women (after lung and breast cancers), and for men (after lung and prostate cancers; refs. 10, 12). An individual’s lifetime risk of dying of colorectal cancer in the U.S. has been estimated to be 2.6%.

Materials and Methods

This study represents an analysis of the linkage of two national databases: the Medicare database from the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration), and the National Cancer Institute’s Surveillance, Epidemiology, and End Results (SEER) program database (2). The linked database combining the SEER and Medicare data represents a large population-based source of information for cancer-related epidemiologic and health services research.

SEER Data. The SEER program is an epidemiologic surveillance system sponsored by the National Cancer Institute consisting of population-based tumor registries that routinely collect information on all newly diagnosed cancer (incident) cases that occur in persons residing in SEER areas (22). The information collected about each incident cancer diagnosis includes the patient’s demographic characteristics, date of
diagnosis, tumor data (e.g., histology, stage, and grade), type of treatment recommended or provided within 4 months of diagnosis, follow-up of vital status, and cause of death, if applicable.

Although SEER data do not constitute a national probability sample, they are the primary source of national information on cancer incidence and survival (2, 22). SEER areas were initially concentrated in western states, encompassing a lower proportion of blacks and a higher proportion of “other” races than the average U.S. population. Reported information include month and year of diagnosis, stage at diagnosis, date of death, and county and census tract of residence.

**Medicare Data.** Medicare enrollment files contain entitlement dates to part A and part B, zip code of residence, health care delivery type, and months in which the beneficiary was enrolled in a Medicare HMO. Medicare is the primary health insurer for 97% of the U.S. population 65 years and older (2). All Medicare beneficiaries receive part A benefits, which cover inpatient care in short- and long-stay hospitals, skilled nursing facilities, home health, and hospice care. Ninety-five percent of beneficiaries also subscribe to part B of Medicare to obtain benefits that cover physician services, outpatient care, durable medical equipment, and home health in some cases. Medicare, in a master enrollment file known as the “Enrollment Database,” maintains information about each beneficiary’s enrollment and entitlement, demographics, and HMO membership.

**Data Linkage.** The linkage of the SEER and Medicare data is the result of the collaborative effort of the National Cancer Institute, the SEER registries, and the Centers for Medicare and Medicaid Services (2). It reflects the linkage of two large population-based sources of data that provide detailed information about Medicare-aged persons with cancer. The linkage of these two data sources results in a unique population-based source of information that can be used for an array of epidemiologic and health services research. For example, this combined data set may have use for studying patterns of care for persons with cancer before a cancer diagnosis, over the period of initial diagnosis and treatment, and during long-term follow-up. Additional examination of cancer tests and procedures and the costs of cancer treatment is possible.

For each linked data set, among persons in the SEER data who were 65 years or older, 94% were matched to the Medicare enrollment database (2). We choose to use this link data set as it provides information on Medicare-managed care patients as opposed to the SEER-Medicare database, which does not. Use of this linked data, however, lacks access to claims data, limiting the further assessment of comorbidities.

**Patient Selection.** We first selected all SEER incident cases of either breast or colorectal cancers in women ages 65 years or older for breast cancer, and for all patients with colorectal cancer diagnosed between 1985 and 2001 that were entitled to Medicare part A and part B (Medicare HMO) at the time of diagnosis, and who were matched to the Medicare enrollment files. Demographic (age, race, and marital status) and cancer diagnostic information was obtained through SEER and information on Medicare entitlement and utilization through Medicare enrollment records. Because of the lack of information on individual income and educational level, 1990 U.S. census data were used as proxy measures.

The HMO indicators determined HMO status at the time of diagnosis. If a patient was indicated as not being a member of HMO and the claim was processed by the Centers for Medicare and Medicaid Services, then he/she was classified as Medicare FFS.

**Cancer Staging and Survival.** For the staging of the breast and colorectal cancer cases, the SEER summary staging system was used, which is based on the extent of disease at diagnosis as reported by the individual SEER registries (22). These registries abstract information from a variety of sources, including inpatient hospital records, outpatient records, and pathology reports. The histologic staging system consists of five tumor stages: in situ, local, regional, distant, and unknown stage. Cancer cases with an unknown stage were excluded from the present analysis. Of note, there was a greater percentage of unstaged cancers for HMO patients for both breast cancer [2,337 (11.0%) HMO patients compared with 11,149 (10.2%) FFS patients (P < 0.01)], as well as for colon

---

**Table 1. Study population characteristics for patients with primary breast and colorectal cancer**

<table>
<thead>
<tr>
<th>Age (mean ± SD)</th>
<th>HMO (n = 21,336)</th>
<th>FFS (n = 109,000)</th>
<th>P</th>
<th>HMO (n = 16,343)</th>
<th>FFS (n = 89,047)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>74.5 ± 6.5</td>
<td>74.9 ± 7.3</td>
<td>&lt;0.01</td>
<td>76.4 ± 7.0</td>
<td>76.9 ± 7.6</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Female</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
<td>7,790 (47.7)</td>
<td>40,253 (45.2)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Race (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>17,718 (83.4)</td>
<td>95,762 (88.5)</td>
<td>&lt;0.01</td>
<td>12,786 (78.8)</td>
<td>75,468 (85.7)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Black</td>
<td>1,423 (6.7)</td>
<td>6,881 (6.4)</td>
<td></td>
<td>1,355 (8.4)</td>
<td>6,924 (7.9)</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>450 (2.1)</td>
<td>1,127 (1.0)</td>
<td>&lt;0.01</td>
<td>324 (2.0)</td>
<td>750 (0.9)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Other</td>
<td>1,633 (7.8)</td>
<td>4,428 (4.1)</td>
<td></td>
<td>1,760 (10.8)</td>
<td>4,890 (5.5)</td>
<td></td>
</tr>
<tr>
<td>Census  tract median income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$20,000</td>
<td>1,062 (5.1)</td>
<td>8,996 (8.7)</td>
<td>&lt;0.01</td>
<td>988 (6.2)</td>
<td>8,678 (10.4)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>≥$20,000</td>
<td>19,887 (94.9)</td>
<td>94,462 (91.3)</td>
<td></td>
<td>14,986 (93.8)</td>
<td>75,175 (89.6)</td>
<td></td>
</tr>
<tr>
<td>Census tract % of some college</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;30</td>
<td>14,112 (67.4)</td>
<td>72,520 (70.2)</td>
<td>&lt;0.01</td>
<td>11,134 (69.8)</td>
<td>61,975 (74.0)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>≥30</td>
<td>6,222 (32.6)</td>
<td>30,829 (29.8)</td>
<td>&lt;0.01</td>
<td>4,829 (30.2)</td>
<td>21,776 (26.0)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>9,651 (46.6)</td>
<td>44,781 (42.4)</td>
<td>&lt;0.01</td>
<td>7,054 (44.7)</td>
<td>42,554 (49.3)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Other</td>
<td>11,053 (53.4)</td>
<td>60,786 (57.6)</td>
<td></td>
<td>8,734 (55.3)</td>
<td>43,812 (50.7)</td>
<td></td>
</tr>
<tr>
<td>Stage at diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In situ</td>
<td>2,489 (13.1)</td>
<td>10,515 (10.8)</td>
<td>&lt;0.01</td>
<td>770 (5.6)</td>
<td>4,254 (5.5)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Local</td>
<td>11,958 (62.9)</td>
<td>58,176 (59.5)</td>
<td></td>
<td>5,252 (38.0)</td>
<td>26,549 (36.7)</td>
<td></td>
</tr>
<tr>
<td>Regional</td>
<td>3,765 (19.8)</td>
<td>23,460 (24.0)</td>
<td>&lt;0.01</td>
<td>5,312 (38.4)</td>
<td>29,712 (38.2)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Distant</td>
<td>787 (4.2)</td>
<td>5,670 (5.7)</td>
<td></td>
<td>2,503 (18.0)</td>
<td>15,201 (19.6)</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Column totals may not add up due to missing data.
cancer [2,505 (15.3%) unstaged cancers for HMO patients compared with 11,331 (12.7%) for FFS patients (P < 0.01)].

Data Analysis. Student’s t tests for continuous variables and χ² test for discrete variables were used to compare the demographic data, as well as the stage at the diagnosis for breast or colorectal cancer by HMO status. Kaplan-Meier survival analysis was done to evaluate the overall survival, as well as stage-specific survival, between HMO and FFS patients with breast or colorectal cancer. We then did multivariate analysis using Cox proportional hazards models to assess whether the HMO patients had better survival than the FFS patients. In the multivariate models, we adjusted for the stage at diagnosis, as well as a range of potential confounding factors including age, race, marital status, census tract median income and educational level (proxy measures for socioeconomic status), and gender (for colorectal cancer only).

Results

As shown in Table 1, both FFS breast and colorectal cancer patients were slightly older than HMO patients [breast (mean ± SD), 74.9 ± 7.3 versus 74.5 ± 6.5 (P < 0.01); colorectal, 76.9 ± 7.6 versus 76.4 ± 7.0 (P < 0.01)]. There were slightly different distributions of gender in HMO compared with FFS (P < 0.01); in both groups, female patients represented a majority of patients with colorectal cancer (FFS, 54.8% and HMO, 52.3%). The majority of patients with breast and colorectal cancer were non–Hispanic Whites. White patients represented a larger percentage of patients in FFS with either breast or colorectal cancer than in HMO [breast, 88.5% versus 83.4%; colorectal, 85.7% versus 78.8% (P < 0.01 for both cancers)].

Compared with the HMO patients, FFS patients had a greater proportion from census tracts with a median income less than $20,000 [breast, 8.7% versus 5.1%; colorectal, 10.4% versus 6.2% (P < 0.01 for both cancers)], and from census tracts with <30% of residents with a college education [breast, 70.2% versus 67.4%; colorectal, 74.0% versus 69.8% (P < 0.01 for both cancers)]. These cut points were used as proxy measures of lower socioeconomic areas and patients who lived in these census tracts. Patients with breast cancer enrolled in a HMO had a significantly higher proportion of being married at the time of diagnosis (46.6%) than the FFS patients (P < 0.01), but the opposite was observed for colorectal cancer [HMO, 44.7% versus 49.3% (P < 0.01)].

A greater proportion of HMO patients with either breast or colorectal cancer were diagnosed at an early stage. For example, the proportion of those diagnosed at an in situ stage was 13.1% in HMO patients versus 10.8% in FFS for breast cancer; and 5.6% of HMO patients versus 5.5% for FFS patients for colorectal cancer (P < 0.01 for both cancers). The proportion diagnosed at a local stage was 62.9% of HMO patients versus 59.5% of FFS patients for breast cancer and 38.0% of HMO patients versus 36.7% of FFS patients for colorectal cancer (P < 0.01 for both cancers).

The results of the Kaplan-Meier survival analyses were presented in Figs. 1-4. Patients with breast cancer enrolled in HMOs had significantly better overall survival than FFS patients (Fig. 1, P < 0.01); the same was true for HMO patients with colorectal cancers (Fig. 2, P < 0.01) where the overall survival was better for patients enrolled in a HMO. The comparisons of survival by stage at diagnosis for breast cancer revealed that HMO patients diagnosed at a local stage
ThemainstudyfindingwasthatMedicarepatientsenrolledin
diagnosed at the colorectal cancer where patients enrolled in an HMO had
had significantly improved survival than their FFS counter-
among HMO patients were still significant for both breast
marital status, census track income and education, and gender (colorectal cancer only), these improvements in survival
among HMO patients were still significant for both breast
cancer (0.91; 0.88-0.93) and colorectal cancer (0.94; 0.92-0.97).

Multivariate analyses using Cox proportional hazards model
were done to evaluate the survival between HMO and FFS
patients (Table 2). After initial adjustment for stage at diagnosis, patients with breast cancer enrolled in a HMO had a 14% signifi-
cantly better survival than FFS patients (hazard ratio, 0.86; 95%
confidence interval, 0.83-0.88), and patients with colorectal cancer enrolled in a HMO a 9% significantly better survival than
FFS patients (hazard ratio, 0.91; 0.89-0.93). After further adjustment for potential confounding factors [i.e., age, race, marital status, census track income and education, and gender (colorectal cancer only)], these improvements in survival
among HMO patients were still significant for both breast cancer (0.91; 0.88-0.93) and colorectal cancer (0.94; 0.92-0.97).

Discussion

The main study finding was that Medicare patients enrolled in
HMO health care delivery systems had greater survival when
diagnosed with either breast and colorectal cancer compared
with patients enrolled in FFS systems. These differences remain even after attempting to control for potential confounders (such as stage at diagnosis, age, race, socioeco-
nomic status, and marital status). Patients enrolled in FFS compared with those enrolled in HMOs had a 9% better survival for female breast cancer, and 6% better survival for colorectal cancer. The existence of a health care delivery system effect is strengthened by the consistency of our findings for two cancer sites that are epidemiologically and clinically quite distinct.

In our study, both breast cancer and colorectal cancer were
diagnosed at earlier stages for patients enrolled in HMO as
compared with FFS. For breast cancer, for example, 13.1% of
HMO patients were diagnosed at an in situ stage compared with 10.8% of FFS patients. The differences were much less
dramatic for colorectal cancer, with 5.6% of HMO patients
diagnosed at an in situ stage compared with 5.5% for FFS
patients, and 38.0% of HMO patients diagnosed at a local stage
compared with 36.7% of FFS patients.

One explanation for these findings could be the phenom-
enon termed the “HMO effect.” This term has been used to
describe the greater likelihood of HMO patients, compared
with FFS patients, to use preventive services including
disease screening (6). This effect could be related to either
plan differences in promotion and access to preventive services, or to qualitative differences among HMO patients in terms of
education, income, or health consciousness (23-24). We have
found data for differences in either promotion or access to preventive services (25). Although we attempted to adjust for
differences in socioeconomic data, limitations of using
information related to which census tract a person resided may
either not completely correlate with individual level
data (26).

Differences in preventive health services have been found
between different health care delivery systems, and between
uninsured compared with insured populations as well as
within racial and ethnic minorities (27, 28). For example, patients in HMOs were more likely to report receiving preventive services (4). In a survey of >7,500 patients, greater frequency of both clinical breast
examination and Pap smear use were reported among HMO
patients (5). Others have found similar results of differences in
the use of screening tests among patients enrolled in different
health care delivery systems. In one such study, the use of six
different cancer screening tests (i.e., mammography, clinical
breast exam, Pap smear, fecal occult blood test, and digital
rectal exam) varied according to type of health care coverage.
HMO enrollees at all ages were ~10% more likely to be
screened than persons enrolled in private FFS plans (8).

However, in addition to earlier detection, other survival
advantages seem to be associated with HMO enrollment. For
stage-specific diagnoses using the Kaplan Meier statistic, as
well as after controlling for stage at diagnosis, patients
enrolled in HMOs showed significantly greater survival. In
addition to screening utilization, differences in treatment
patterns have been noted between health care delivery systems
as well. For earlier stage breast cancer cases requiring surgery,
HMO enrollees were significantly more likely to receive
radiation therapy (9). Age may also affect treatment choices
because a higher percentage of breast-conserving surgery and
radiation therapy has been found among elderly women with
early stage breast cancer (29). Both cancer stage at diagnosis
and treatment patterns may result in differences in mortality,
therefore, possible differences in cancer survival among health
care delivery systems should be evaluated as well. Systems
within HMOs (such as the use of case managers), devised to
improve patient compliance with care and follow-up, could be
at play in the improved survival noted. It may also be possible
that, in general, healthier patients are enrolled in HMO plans,
however, comorbid conditions were not evaluated in this
study (30). Although we did not study regional variation,
others have found that differences in the managed care market
share had a limited effect on care for cancer patients (31).

The current study has several additional limitations. By
definition, the study population was 65 years of age or older,
and it is not clear that the results are generalizable to a younger
patient population. Furthermore, the SEER data do not
constitute a probability sample of the nation, despite being
the primary source of national information on cancer incidence
and survival (2, 22); SEER areas are mostly urban and
concentrated in western U.S. states, with an undersampling
of African-Americans. Health plans and patients from these
SEER areas may not be representative of the nation as a whole.
Additionally, performance among individual or types of
HMOs may vary (9). However, we did not study whether
differences exist for specific type of managed care plans.
Furthermore, despite controlling for potential confounders,
differences in overall health of patients enrolled in the
different health care systems might exist, which we did not
assess. Finally, we also were not able to measure smoking or
dietary factors that may affect patient outcomes.

Nevertheless, the principal finding of significantly im-
proved survival after diagnosis with breast cancer or colorectal
cancer, especially after controlling for potential confounding

--

Table 2. Cox proportional hazard ratios of mortality from primary breast and colorectal cancer for HMO versus FFS patients

<table>
<thead>
<tr>
<th></th>
<th>Breast cancer</th>
<th>Colorectal cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hazard ratio (95% confidence interval)</td>
<td>Hazard ratio (95% confidence interval)</td>
</tr>
<tr>
<td>Crude</td>
<td>0.80 (0.78-0.83)</td>
<td>0.89 (0.87-0.91)</td>
</tr>
<tr>
<td>Adjusted for stage at diagnosis</td>
<td>0.86 (0.83-0.88)</td>
<td>0.91 (0.89-0.93)</td>
</tr>
<tr>
<td>Further adjusted for other covariables*</td>
<td>0.91 (0.88-0.93)</td>
<td>0.94 (0.92-0.97)</td>
</tr>
</tbody>
</table>

*Includes age, race, marital status, census track income and education, and gender (the latter, for colorectal cancer only).
factors, in patients enrolled in HMOs compared with FFS warrants further evaluation. Eventually, modeling “best practices” which result in improved outcomes should become the standard of care.

References

The Effect of Medicare Health Care Delivery Systems on Survival for Patients with Breast and Colorectal Cancer

Robert S. Kirsner, Fangchao Ma, Lora Fleming, et al.


Updated version
Access the most recent version of this article at:
http://cebp.aacrjournals.org/content/15/4/769

Cited articles
This article cites 29 articles, 6 of which you can access for free at:
http://cebp.aacrjournals.org/content/15/4/769.full.html#ref-list-1

Citing articles
This article has been cited by 3 HighWire-hosted articles. Access the articles at:
/content/15/4/769.full.html#related-urls

E-mail alerts
Sign up to receive free email-alerts related to this article or journal.

Reprints and Subscriptions
To order reprints of this article or to subscribe to the journal, contact the AACR Publications Department at pubs@aacr.org.

Permissions
To request permission to re-use all or part of this article, contact the AACR Publications Department at permissions@aacr.org.