Urological Survey

Socioeconomic Factors, Urological Epidemiology and Practice Patterns

Re: Kentucky's Medicaid Expansion Showing Early Promise on Coverage and Access to Care

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Editorial Comment: State Medicaid expansion is a key component for increasing access to care in the Affordable Care Act (Obamacare). To date, 30 states have expanded their Medicaid coverage as part of the Affordable Care Act and have received federal matching funds to cover increased expenses. The majority of the 20 states that elected not to expand Medicaid are located in the Southeastern United States and have Republican governors and/or state legislatures, most of which are vehemently opposed to anything having to do with Obamacare. This study explores the impact of Medicaid expansion in Kentucky (which elected to expand its program in January 2014 by considering access to care and whether a patient had a regular source of care in comparison to the states of Virginia, Missouri and Tennessee, none of which expanded Medicaid). The authors found that households in Kentucky with less than $25,000 yearly income were significantly less likely to report being uninsured and were significantly more likely to report having a regular source of health care after state Medicaid expansion compared to the surrounding states that did not expand Medicaid. It is noteworthy that these differences were not small.

Are these results particularly surprising? No. If you offer people health insurance (even suboptimal health insurance, which many people believe Medicaid is), they will sign up for coverage. The question is, who pays for this coverage? The federal government is committed to footing at least part of the bill through 2020 but what happens after that? This situation has a direct impact on us not only as citizens, but also as urologists. Increased health insurance coverage results in more patients seeking urological care. While this may seem like a good thing at first glance, we have to be able to meet demand. Whether we can do this is not entirely clear. Obamacare has clearly succeeded in achieving 1 of its 3 key goals—increasing access to health care for Americans. Now we have to address the unintended consequences of this action.

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Re: Economic Analysis of Prostate-Specific Antigen Screening and Selective Treatment Strategies

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Editorial Comment: To date, the debate around prostate cancer screening has focused primarily on the effectiveness of testing and has not really considered the issue of cost. In an era of constrained health care resources even if all parties agree that screening is an effective intervention, we would still have to ask whether there is "value" in prostate specific antigen (PSA) testing. The best way to address this issue is with rigorous cost-effectiveness analysis, which the authors have done. They explored 18 different prostate cancer screening and treatment strategies by varying the age at which PSA screening was started, the threshold at which prostate biopsy was performed, the frequency of repeat testing and the use of active surveillance for men diagnosed with low grade disease. The study clearly shows that population wide yearly screening using a PSA threshold of 4.0 ng/ml is not the most cost-effective approach. Furthermore, increased use of active surveillance in low risk patients makes PSA testing considerably more cost effective.

As urologists, we have to accept that it is time to reexamine the way we screen and treat men with prostate cancer. We cannot continue to support population wide yearly testing in all men older than 50 years just because it is the way we have always done it. This study clearly demonstrates that we have to be more selective with our screening strategies and consider different ways to minimize the harms and maximize the benefits of screening. If we do not take the lead in identifying better screening strategies, the "prostate cancer nihilists" on the U.S. Preventive Services Task Force will maintain their grade D recommendation, and ultimately there will be no screening for this common malignancy.

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