

October 17, 2025

Prostate Cancer Study Committee (PCSC)

Dear Chair Young and Members of the Prostate Cancer Study Committee,

I'm writing today to provide additional information requested at the latest committee meeting regarding the cost of screening, treatment, and prostate cancer disparities.

Fluctuating PSA screening recommendations from the USPSTF in 2012 and 2018 have worsened screening rates, racial disparities, and late-stage prostate cancer.^{1,2} Patients of all races experienced an increase in late stage prostate cancer cases from 2014-2016, but the percentage of patients diagnosed at late stage increased disproportionately for Black men, Hispanic men, and men with incomes under \$30,000.³ Younger men also experienced an increase in prostate cancer mortality.⁴ Screening further declined 73% during the pandemic, despite the existing state mandate for screening coverage.⁵

Coverage with no cost-sharing equalizes screening access, which is an effective method of improving screening utilization and mitigating racial disparities in prostate cancer. Equal access systems like Tricare's no-cost PSA screening system have demonstrated that Black patients achieve similar or better outcomes than White patients when provided equitable access to screening and care.⁶ Years of research indicate that, "persistent racial disparities observed in the non-Medicaid private insurance group could be a result of differences in patient willingness to pay out-of-pocket costs for health care services such as cancer screening."⁷ **Subsequent studies have confirmed this finding that "access to early prostate cancer screening is arguably one of the most significant causes for this disparity."**^{1,2,8}

The health plans suggested that the \$10-20 out-of-pocket cost they charge for the PSA test is not an issue, but research suggests otherwise. Men are nearly half as likely to get screened if they have out-of-pocket costs over \$10.⁹ Many high-risk men can't afford the highest average out-of-pocket cost to be screened (\$620).¹⁰ Half U.S. adults can't afford an unexpected \$500 out-of-pocket cost, including 75% of Black patients, who are at-risk for prostate cancer, and 66% of Hispanic patients, who've experienced increases in late-stage prostate cancer in the last decade.¹¹

Cost-sharing has a significant impact on prostate cancer screening utilization, because men, especially high-risk men, respond more to financial incentives than women. Research shows men facing no cost-sharing or low cost-sharing are most likely to be screened (87%-93%), while men facing high copayments (\$11+) and high deductibles (\$250+) were least likely (49%-67%) to receive screening.⁹ Men with worse health and financial statuses are less likely to pay out-of-pocket for prostate cancer screening.¹² Among men unwilling to pay for screening who were surveyed, 43% believed the cost should be covered and 35% cited cost barriers to screening.¹²

Researchers are worried that rising out-of-pocket costs are deterring screening and delaying diagnoses, which drives up costs for late-stage treatment.^{10,13,14} The out-of-pocket costs insurers are charging patients for follow up testing, and the number of patients charged by insurance, are skyrocketing. The out-of-pocket cost for an MRI quadrupled from 2010 to 2020, from \$81.79 to \$490.91.¹⁰ The number of patients that paid out-of-pocket for an MRI and biopsy grew by 50% in the last decade, from 50.8% of patients in 2010 to 79.6% of patients in 2020.¹⁰ **Treatment for late-stage cancer is, on average, \$309,000 more expensive to treat compared to early-stage disease,¹⁵ and each prevented prostate cancer death would save \$125,200.**¹⁶ Among men aged 55-69, research shows that screening 1000 men should detect 3 late-stage cases early,¹⁷ and screening 385 men should save one life.¹⁸ There is less data on

screening under 55, but we know that men under age of 55 represent 10% of new cases diagnosed in the US,¹⁹ and are twice as likely to be diagnosed with aggressive disease.²⁰ By not screening this population, Medicaid is likely missing those cases, and the associated cost savings from early detection. Cost savings from early detection aren't immediately realized by insurers due to high employee turnover which disincentivizes private insurers from covering guideline-recommended prostate cancer screening.²¹

Srivastava et. al.¹⁰ wrote that their 2024 study provides a rationale for removing the cost barrier to prostate cancer screening:

“We find that the OOPCs (out-of-pocket costs) associated with diagnostic testing are not only substantial, but also increased considerably between 2010 and 2020. For some patients, these costs may be significant and stand to deter necessary care following prostate cancer screening. Consequently, we recommend that policymakers and payers consider prostate cancer screening a multistep process and eliminate cost sharing for indicated diagnostic testing.”

In analyzing similar legislation that cuts screening out-of-pocket costs for high-risk men, Kentucky,²² Maryland,²³ Tennessee,²⁴ Texas,²⁵ and Virginia²⁶ found no significant impact on premiums or state budgets, with Kentucky anticipating long-term savings via improved screening access. Virginia's mandate review program determined that a similar bill does not create a new benefit mandate or require deferral, and creates only a 4 cent per member per month impact. For these reasons, 9 states have removed the cost barrier to screening,²⁷ and Alabama, Maine, New Jersey, Ohio, and Pennsylvania are considering similar legislation this year. The Virginia bill was passed this year with the support of the Virginia Association of Health Plans. We hope that this committee's leadership will help build consensus in support of risk-based cost free prostate cancer screening for high-risk men in South Carolina.

We thank this committee for the discussion, and ask that you send any questions or requests for additional information to Georgia@zerocancer.org

Respectfully,



Georgia Bates

State Government Relations & Advocacy Manager, ZERO Prostate Cancer

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