Approved: February 10, 2009
Date

MINUTES OF THE HOUSE INSURANCE COMMITTEE

The meeting was called to order by Vice Chairman Virgil Peck at 3:30 p.m. on February 5, 2009, in Room 784 of the Docking State Office Building.

All members were present.

Committee staff present:
Bruce Kinzie, Office of the Revisor of Statutes
Melissa Calderwood, Kansas Legislative Research Department
Cindy Lash, Kansas Legislative Research Department
Sue Fowler, Committee Assistant

Conferees appearing before the committee:
Natalie Haag, Security Benefit Life Insurance Company
Representative Kay Wolf, District 21
Representative Lisa Benlon, District 22
Dick Morrissey, Kansas Department of Health & Environment
Dr. James Hamilton, The American Cancer Society
Doug Farmer, Kansas Health Policy Authority
Representative Jo Ann Pottorff, District 83
Marlee Carpenter, Kansas Association of Health Plans
Rachelle Colombo, Kansas Chamber

Others attending:
See attached list.

Hearings on:

HB 2089 - Life insurance, valuation of policies, reserves.

Melissa Calderwood, Kansas Legislative Research Department, gave a brief overview for **HB 2089**.

Vice-Chairman, Representative Peck, opened the hearing on **HB 2089**.

Proponent:
Natalie Haag, Security Benefit Life Insurance Company, (Attachment 1), appeared before the committee in support of **HB 2089**.

Hearing closed on **HB 2089**.

HB 2075 - Providing insurance coverage for colorectal cancer screening.

Melissa Calderwood, Kansas Legislative Research Department, (Attachment 2), gave a brief report of the Special Committee on Insurance to the 2009 Kansas Legislature.

Vice-Chairman, Representative Peck, opened the hearing on **HB 2075**.

Proponents:
Representative Kay Wolf, District 21, (Attachment 3), appeared before the committee in support of **HB 2075**.
Representative Lisa Benlon, District 22, (Attachment 4), gave testimony before the committee in support of **HB 2075**.
Dick Morrissey, Kansas Department of Health & Environment, (Attachment 5), presented testimony before the committee in support of **HB 2075**.
Dr. James Hamilton, The American Cancer Society, (Attachment 6), appeared before the committee in support of **HB 2075**.

Minutes of the House Insurance Committee at 3:30 p.m. on February 5, 2009, in Room 784 of the Docking State Office Building.

Doug Farmer, Kansas Health Policy Authority, (Attachment 7), appeared before the committee in support of **HB 2075**.
Representative Jo Ann Pottorff, District 83, (Attachment 8), presented Written Testimony in support of **HB 2075**.

Opponents:
Marlee Carpenter, Kansas Association of Health Plans, (Attachment 9), gave testimony in opposition to **HB 2075**.
Rachelle Colombo, Kansas Chamber, (Attachment 10), presented Written Testimony in opposition to **HB 2075**.

Hearing was closed on **HB 2075**.

The next meeting is scheduled for February 10, 2009.

The meeting was adjourned at 5:00 p.m.

House Insurance Committee
Guest Sign In Sheet
Thursday, February 5, 2009

Name	Representing
Janet Neff	KDHE
Effie Swanson	KHPA
Leigh Keck	Main Law Firm
Natalie Haag	Security Benefit
Gail Bright	Office of the Kansas Securities Commissioner
Patrick Lithgow	KGC
Bill Sneed	AHIP
Mike Beezley	Foulston Siefkin
John Metz	KID
Kathleen Graham	KSNA
Barbara Robertson	KID
Linda Sheppard	KID
Rachelle Colombo	KS Chamber
Will Deer	Tiger Financial Management
Dan Murray	NFIB
KEN DANIEL	TIBA
Lori Church	KAPCIC
Mallee Carpenter	KAHP
John Peterson	Capitol Strategies
Anne Spiess	American Cancer Society
Diane Kern	

HOUSE INSURANCE COMMITTEE
Testimony on HB 2089
February 5, 2009
Presented by:

Natalie G. Haag
2nd Vice President
Dir. of Gov. Affairs, Asst. Gen. Counsel
Security Benefit Life Insurance Company
Topeka, Kansas

Mr. Chairman and members of the committee:

Thank you for the opportunity to testify on House Bill 2089, which amends KSA 40-409, to grant the Commissioner of Insurance authority to modify reserving requirements for life insurance companies as the Commissioner deems reasonable. As you may know, Security Benefit focuses in large part on annuities rather than life insurance; however, annuities provide many of the same protections and advantages as life insurance, such as a guaranteed death benefit.

In light of the enormous and historic economic challenges facing the life insurance industry, capital has become increasingly scarce and expensive. These challenges are compounded by the fact that in some instances, current reserving methods are simply too conservative, needlessly reducing stated capital positions. Although your initial reaction may be to assume that reserves can never be too high, the reality is that unnecessarily high reserves harm consumers. They increase the price and limit the availability of life insurance, variable and fixed annuities, and variable annuity riders that provide significant security and protection to policyholders, particularly in these turbulent markets at the very time when security and protection are needed the most by these policyholders.

In short, holding capital represents a cost to the policyholder. That cost is reflected in the mortality and expense charges he or she pays to the company. Consequently, regulators must balance the need for sufficient policyholder reserves and capital and surplus to assure the payment of claims under adverse economic circumstances, while recognizing that the establishment of excessive reserves and capital requirements is a cost that companies pass directly on to the policyholders.

Life insurance companies compete, not only with other life insurance companies, but with other firms, with minimal reserve requirements, offering similar products in the financial services industry. Requiring excessive reserves and capital and surplus seriously threatens the industry's ability to compete in the marketplace. Likewise, requiring excessive amounts to be held in reserve is a disservice to the policyholders and prospective policyholders of the industry. It causes greater fees to be charged, thereby making insurance products less appealing and marketable to the consumer. We have seen current examples of cases where the cost associated with financing excessive reserve and capital standards has caused some otherwise profitable

companies to withdraw products from the marketplace or increase the price at which they sell products to consumers.

Additionally, requiring excessive amounts to be held in reserve impairs the industry's ability to access its ultimate safety net, the capital markets. The requirement to hold excessive amounts of reserves and capital and surplus reduces the return on capital produced by the industry. This makes investment in the industry less appealing to investors.

An example of the inflexibility of the existing Kansas statute is the manner in which reserves are required to be set for death benefits under variable annuities (e.g., guaranteed minimum death benefits). Reserves are set assuming no lapses are experienced – when lapses are experience by Security Benefit and the industry as a whole. Thus, the statute requires setting reserves for death benefits much higher than our experience would indicate is necessary, as no death benefits would be paid on contracts which ultimately lapse before death. Again, because the statute does not allow the Commissioner to take into account an insurer's actual lapse experience, or anything else not specifically set forth in the statute, the Commissioner is not allowed to work with an insurer to set a reasonable reserve.

The language in House Bill 2089 is drafted in a manner that would allow the Commissioner discretion in setting a reasonable reserve similar to the authority the Commissioner currently has to make reasonable modifications to an insurance company's capital requirements. Additionally, several other states are attempting to address this reserve requirement issue for their domestic life insurance companies. Specifically, Iowa has issued a Bulletin notifying insurers domiciled in Iowa of changes made by the Commissioner to the Statement of Statutory Accounting Principles criteria for determining the admitted amount of deferred income taxes for reporting periods ending on or after December 31, 2008; Ohio adopted emergency rules regarding the calculation of policy reserve limits for life insurance products; and New York granted Met Life $1.8 billion in reserve relief.

Because the entire reserving law is set out in statute, the Kansas Commissioner doesn't have the same ability to adjust reserving requirements as some other commissioners. This bill would help equalize the playing field by granting the Commissioner the same flexibility that currently exists for capital requirements under Kansas law. See KSA 40-2c01 et. seq.

Security Benefit would appreciate your vote to pass favorably House Bill 2089.

DRAFT

SPECIAL COMMITTEE

Report of the Special Committee on Insurance to the 2009 Kansas Legislature

CHAIRPERSON: Representative Clark Shultz

VICE-CHAIRPERSON: Senator Ruth Teichman

RANKING MINORITY MEMBER: Representative Cindy Neighbor

OTHER MEMBERS: Senators David Haley and David Wysong; and Representatives Anthony Brown, Virgil Peck, Scott Schwab, and Vince Wetta

STUDY TOPICS

- **Small Employer Health Insurance.** Review health insurance legislation proposed during the 2008 Legislature, with particular attention to SB 540 and SB 564. SB 540 would create the Kansas Small Business Health Policy Committee, amend coverage requirement for dependent children and create a reinsurance pool for very small groups. SB 564 would create the Small Employer Health Care Act and would make amendments to specify coverage requirements in the Kansas Uninsurable Health Insurance Act and the State Employee Health Benefits Program. The bill also would establish a "qualified health insurance premium" as part of federal taxable income (subtraction modification).

- **Colon Cancer Screening.** Study requiring that colon cancer screening be included in health insurance policies. Review the benefits of colon cancer screening and the American Cancer Society's guidelines for such screening.

- **Medical Liability Reform Act.** Study 2008 HB 2782 which would have enacted the Kansas Medical Liability Reform Act. The proposed legislation would have required the collection of Kansas-specific information about medical malpractice litigation costs. Review the possibility if such additional reporting requirements were enacted how they could best be coordinated with other reporting requirements. Review and analyze relevant model acts of the National Association of Insurance Commissioners that might relate to HB 2782.

December 2008

DRAFT

Special Committee on Insurance

Review and Study of Colon Cancer Screening

Conclusions and Recommendations

The Special Committee on Insurance recommended that the House and Senate Insurance Committees hold a hearing regarding colon cancer screening mandates, including any proposed legislation, during the 2009 Session.

Proposed Legislation: None.

Background

The charge to the Special Committee on Insurance was to study and review significant issues associated with small employer health insurance, colon cancer screening, and the proposed Medical Liability Reform Act.

On the subject of colon cancer screening, the Committee was directed to:

- Study requiring that colon cancer screening be included in health insurance policies.
- Review the benefits of colon cancer screening and the American Cancer Society's guidelines for such screening.

The topic was requested by Representative Kay Wolf and was assigned by the Legislative Coordinating Council for study and review.

Committee Activities

In December, the Committee received an overview of the assigned topic including the current American Cancer Society (ACS) guidelines and laws in other states. The Committee also received testimony from the State Chairman for the Commission on Cancer and heard comments from a representative of the Kansas Health Policy Authority on colon cancer benefits in the State Employee Health Benefit Plan. Additionally, the Committee received written comment from representatives of the Kansas Department of Health and Environment and the Kansas Association of Health Plans.

Topic Overview. Legislative Research Department staff presented an overview on the assigned topic, noting the charge to the Committee included a review of the benefits associated with colon cancer screening and the ACS Guidelines. The intern analyst then reviewed the guidelines, indicating that individuals at average risk for developing colon cancer should begin to have screening tests at age 50. Individuals who are at an increased risk may need to begin tests at an earlier age or be screened more frequently (*e.g.* an individual as a personal history of colon cancer or adenomatous polyps). She noted the screening tests acknowledged by the ACS:

- Flexible sigmoidoscopy every five years; colonoscopy every ten years; double contrast barium enema every five years; or CT colonography (virtual colonoscopy) every five years. Additionally, she noted the screening tests which mainly find cancer include: fecal occult blood test (FOBT) every year; fecal immunochemical test (FIT) every year; or stool DNA (sDNA) interval

uncertain. After highlighting the incidences nationwide, she then noted that 27 states and the District of Columbia require coverage of colon cancer screening tests, with colon cancer screening coverage differing greatly from state to state. The analyst then noted the proposed legislation during the 2007-2008 biennium, including 2007 SB 218 which would have required individual and group health insurance policies to include coverage for colon cancer examination and laboratory tests specified by ACS Guidelines beginning January 1, 2008. She also noted a House Committee of the Whole amendment added colon cancer screening requirements (identical to those in SB 218) into Sub. for HB 2601. The analyst also noted the increased coverage for colon cancer screening in the State Employee Health Benefits Plan, with the coverage having been expanded in 2007 to now include a preventive care benefit for medically appropriate colonoscopy screening (removed the previous requirement of routine diagnosis and eliminated the limit of one colonoscopy per person per lifetime).

Colon Cancer Screening, Current ACS Recommendations. Representative Kay Wolf offered some introductory remarks about the topic and spoke about the issue of early detection and prevention and the impact on the cancer cure rate. The Deputy Director for the State Employee Health Benefits Plan (SEHBP), Kansas Health Policy Authority, addressed the 2007 changes in colon cancer screening made in the SEHBP. He noted that there has been an increase in those screenings with enrollees taking advantage of the benefit. A Committee member questioned if there had been any change in the premium rates based on the increased benefit. The conferee indicated there had been a rate increase for the plan year, but it was not clear if this increased utilization had been a factor. Representative Wolf reported that in 2008, there had been 5,756 colonoscopies among the enrollees, which is an increase from the previous year.

The Kansas State Chairman for the Commission on Cancer and the Volunteer Legislative Advisor, American Cancer Society, then made a presentation, "Screening for Colorectal Cancer: Rationale for Current ACS Recommendations." The medical doctor began his presentation by providing facts about colon and rectal cancers, noting that the lifetime risk is about one in nineteen and that colorectal cancer is the third leading cause of cancer-related deaths in the United States with an estimated 49,906 deaths predicted in 2008. The conferee noted this death rate is decreasing and that screening is part of the cure, as the removal of pre-cancerous polyps prevent cancer and early detection markedly improves chances of long-term survival. Screening rates, however, are low with less than half of Americans over age 50 reported having had a recent colorectal cancer screening test. He then reviewed the screening methods noting that both the FOBT and the colonscopy cost less than mammography. He contrasted the costs for these screening tests with the costs of prescription drug costs for the treatment of Stage III and Stage IV colon cancer. The conferee's testimony also noted the existing cancer benefits provided to insureds in Kansas: mammograms, prostate, and breast reconstruction after cancer surgery.

Committee Discussion. The Committee discussed the policy implications for adding a requirement for coverage given the benefits of prevention and whether most insurance companies were already providing this coverage. The conferee responded yes, when a medical condition is presented. The patient, he continued, may not go for the screening if there is concern that the insurance will not cover the test (cost). The Committee then discussed screening options and whether colonoscopy remained the gold standard. The conferee replied yes, noting, however, that virtual colonoscopy may replace this standard. The Committee members then discussed the costs of the testing and the preparation required to have a colonoscopy.

The Committee also discussed the bills before the Legislature; it was noted that the bills specify screening tests as allowed by the ACS guidelines and did not limit test type. Written testimony was received from Paula Clayton, Director of the Office of Health Promotion, Kansas Department of Health and Environment, on the importance of colon cancer screening and Marlee Carpenter, Kansas Association of Health Plans, which stated an opposition to additional health insurance mandates because of the increased cost imposed on health insurance plans. Ms. Carpenter's testimony noted that KAHP believes preventative care is necessary and all of the KAHP member plans pay for colon cancer screening procedures.

Conclusions and Recommendations

The Special Committee on Insurance recommended that the House and Senate Insurance Committees hold a hearing regarding colon cancer screening mandates, including any proposed legislation, during the 2009 Session.

KANSAS LEGISLATIVE RESEARCH DEPARTMENT

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December 8, 2008

To: Special Committee on Insurance

From: Kelly Navinsky-Wenzl, Legislative Intern

Re: LCC Assigned Topic 2, Colon Cancer Screening

Brief

The Legislative Coordinating Council assigned the topic of colon cancer screening to be included in health insurance policies to the 2008 Interim Special Committee on Insurance. The Committee is required to review the benefits associated with colon cancer screening and the Guidelines for screening as determined by the American Cancer Society. This memorandum outlines the current American Cancer Society Guidelines, colon cancer screening coverage requirements (mandated benefits) in other states, and the legislative review of and benefits offered to state employees in Kansas.

American Cancer Society Guidelines

The American Cancer Society has specific Guidelines recommended for persons at risk for colon cancer. According to the Guidelines, individuals at an average risk for developing colon cancer should begin to have colon cancer screening tests at age 50. Individuals who are at an increased risk for colon cancer may need to begin screening tests at an earlier age or be screened more often. The American Cancer Society has determined that an individual is at an increased risk for colon cancer if he or she exhibits one of the following: a personal history of colon cancer or adenomatous polyps; a personal history of chronic inflammatory bowel disease (Crohns disease or ulcerative colitis); a strong family history of colon cancer or polyps (cancer or polyps in a first-degree relative [parent, sibling, or child] younger than 60 or in two or more first-degree relatives of any age); or a known family history of hereditary colon cancer syndromes such as familial adenomatous polyposis (FAP) or hereditary non-polyposis colon cancer (HNPCC).

The American Cancer Society recognizes various screening tests, and recommends a person discuss his or her options with a physician. The American Cancer Society acknowledges the following screening tests:

- Tests which find polyps and cancer include:
  - Flexible sigmoidoscopy every five years;
  - Colonoscopy every ten years;
  - Double contrast barium enema every five years; or
  - CT colonography (virtual colonoscopy) every five years.

- Tests which mainly find cancer include:
    - Fecal occult blood test (FOBT) every year;
    - Fecal immunochemical test (FIT) every year; or
    - Stool DNA test (sDNA) interval uncertain.

The Guidelines can be located on the American Cancer Society website at: www.cancer.org.

Incidences Nationwide

The American Cancer Society has estimated that:

- Excluding skin cancers, colon cancer is the third most common cancer diagnosed in both men and women in the United States;
- About 108,070 new cases of colon cancer (53,760 in men and 54,310 in women) will be diagnosed in 2008; and
- Colon cancer is the third leading cause of cancer-related deaths in the United States when men and women are considered separately, and the second leading cause when both sexes are combined. It is expected to cause about 49,960 deaths (24,260 men and 25,700 women) during 2008.

Other States

In 2008, the Council for Affordable Health Insurance reported that 27 states and the District of Colombia had implemented insurance mandates that required the coverage of colon cancer screening tests. The states reported to have implemented mandates include: Alabama, Alaska, Arizona, Connecticut, Delaware, Georgia, Illinois, Indiana, Louisiana, Maryland, Minnesota, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Virginia, Washington, West Virginia, and Wyoming.

Conversely, the National Conference of State Legislatures reported in 2006 that 18 states have implemented insurance mandates that required the coverage of colon cancer screening tests. States that have implemented an insurance mandate include: Arkansas, Connecticut, Delaware, Georgia, Illinois, Indiana, Louisiana, Maryland, Missouri, Nevada, New Jersey, North Carolina, Oregon, Rhode Island, Texas, Virginia, West Virginia, and Wyoming. Additionally, Alabama, California, Oklahoma, and Tennessee require the coverage of the screening tests be offered or available through Medicare Supplemental policies.

According to the National Conference of State Legislatures, colon cancer screening coverage differs greatly from state to state. The main differences in coverage requirements include: which policies provide coverage, which consumers are covered, and which benefits and services are covered. Examples of the variations in insurance coverage follows.

Policies

In most states, all health insurance plans cover colon cancer screening. In Arkansas, the plans which cover colon cancer screening include: individual and group HMO's, Medicaid, State Employees' and Public School Teachers' Health Insurance Program. In Oregon, HMOs and all individual and group plans that cover medical, surgical and hospital costs, after January 1, 2006 are covered.

Consumers

In most states, coverage is provided for individuals defined as average or high risk for colon cancer by the American Cancer Society Guidelines. In Texas, coverage is provide for individuals age 50 or older. In West Virginia, coverage is provided for persons age 50 and over, symptomatic persons less than 50 years of age when reimbursement or indemnity for laboratory or X-ray services are covered under the policy.

Benefits and Services

In most states, benefits and services that are in accordance with the American Cancer Society Guidelines are covered. In California, benefits and services that are covered include: preventive medical care coverage of up to $120 per year for services not covered by Medicare, including fecal occult blood tests and tests may be done at a frequency considered medically appropriate.

Kansas

Proposed Legislation 2007-2008 Sessions

In 2007, one bill addressing colon cancer screening benefits was requested for introduction in the Senate Financial Institutions and Insurance Committee. Senate Bill 218 would have required individual and group health insurance policies to include coverage for colon cancer examination and laboratory tests specified by American Cancer Society Guidelines beginning January 1, 2008. Also, the American Cancer Society Guidelines would have determined the frequency of the administration of examinations and laboratory tests. The bill would have required benefits be provided to insured individuals who are either at least 50 years of age, or individuals less than 50 years of age who are considered to be at high risk for colon cancer. The bill would have required individual or group health insurance policies to provide coverage at the same annual deductibles, co-payments, or co-insurance limits as established for similar covered benefits. The coverage would not have applied to any specific policy or limited supplemental benefit policy.

According to the fiscal note prepared by the Division of the Budget, the Kansas Insurance Department would have been required to review and approve all new and previously approved accident and health policy forms that would be submitted by all insurers in this market. The Department indicated that the bill could have been implemented within its budget and staffing resources. Additionally, the fiscal note indicated that numerous insurance policies already provide coverage for screening tests; and the number of insurance policies that do not provide coverage is unknown. Therefore, an accurate fiscal impact on insurers and insurance consumers could not be estimated. The bill died at the end of the biennium in the Senate Financial Institutions and Insurance Committee. (The Senate Financial Institutions and Insurance Committee requested an interim review of all current and proposed health insurance mandates; this topic request was not approved by the LCC.)

2008 Sub. for House Bill 2601 (as amended by House Committee of the Whole) included the provisions from 2007 SB 218. The bill would have updated the requirement for individual and group health insurance policies to include coverage for examinations and laboratory tests beginning January 1, 2009. The bill died at the end of the biennium in the Senate Financial Institutions and Insurance Committee.

2008 State Employee Health Benefits Plan (SEHBP) Coverage

The State Employee Health Benefit Plan coverage for colon cancer screening was increased in 2007. Previously, the SEHBP required an individual to confirm he or she needed a colon cancer screening test, and coverage was only provided for a single test. After the increase in coverage, the SEHBP began to provide coverage for members to have a colon cancer exam and related laboratory testing pursuant to the American Cancer Society Guidelines. The SEHBP coverage has been expanded to include a preventative care benefit for medically appropriate colonoscopy screenings, remove the previous requirement of routine diagnosis, and eliminate the limit of one colonoscopy per person per lifetime.

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Testimony to House Insurance Committee

February 5, 2009

HB 2075—Providing Insurance Coverage for Colorectal Screenings

Thank you Mr. Chairman and Members of the Committee for the opportunity to appear before you today to testify in favor of HB2075. This bill assures Kansan's insurance coverage for colorectal screenings based on the American Cancer Society's guidelines.

Colon Cancer is the 3rd most common cancer in the United States with approximately 150,000 new cases yearly nationwide. It is the 2nd most deadly cancer. More than 1.2million Americans are living with colorectal cancer today. It is important to note that less than half of Americans over age 50 report having had a recent screening and just 39% of colorectal cancers are detected at the earliest stage. Most cancers start with a small polyp which can be seen, biopsied and removed during a colonoscopy. Other methods of screening such as a sigmoidscopy, or a fecal blood test are also utilized to detect colon cancer.

The American Cancer Society recommends the first screening is at the age of 50 if no family history of colon cancer exists. If no polyps are detected the next screening is recommended to be repeated in 10 years. The American Cancer Society commissioned an independent study by the Lewin Group, which is attached, to determine the cost of a colonoscopy at 10 years as compared to the cost of an annual mammogram.

Colonoscopy: Cost per member per year - $6.64 and per member per month $0.55 cents

Mammogram: Cost per member per year - $8.99 and per member per month 0.75 cents

This is compared with a wholesale drug cost for treatment in 1995 of $500 per patient (4.5 months) and $250,000 per patient (9 months). Screening presents the opportunity to reduce the high cost of treatment for advanced disease.

If colorectal cancer is caught in the early stages there is a 90% survival rate as compared with a 10% when detected in the advanced stages.

There are currently 24 states which assure coverage. In 2008 Kansas received an "F" on their legislative report card as compared with other states (see attachment).

Providing adequate health care for Kansans is and continues to be a priority for us as Legislators. Assuring colorectal screening coverage is a one more step in this on-going process.

Respectfully submitted,

Kay

Representative Kay Wolf, 21st District

House Insurance
Date: 2-05-09
Attachment # 3

The Kansas Legislature Has the Power to Eliminate Colon Cancer as a Major Killer

Colon Cancer Can Be Prevented...

Screening Legislation Will Save Lives.

Colon cancer is the third most common cancer in Kansas and causes 10% of all cancer deaths. Most of these deaths are preventable. Precancerous growths can be detected before they become cancer and removed without invasive surgery.

So, why do we expect more than 500 Kansans to die of colon cancer in 2008?

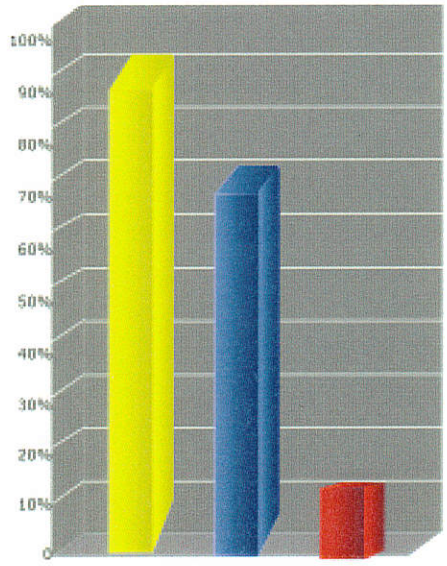
Currently, not all insurance companies are required to cover colon cancer screening tests in Kansas. Detected early through screening tests, colon cancer is more than 90% curable. Late detection, when the cancer has spread to other parts of the body, leaves little room for hope—and only a 10% chance of survival.

Colon cancer screening assurance legislation would require insurance companies to cover these lifesaving screening tests according to the American Cancer Society's guidelines.

Facts About Colon Cancer Screening Legislation

- ☑ Access to screening tests could reduce colon cancer deaths by 80%.
- ☑ Screening tests have not been a factor in rising health insurance premiums. In fact, early detection of precancerous colon polyps is significantly less expensive than the treatment for late detected cancer.
- ☑ 22 states provide colon cancer screening coverage.
- ☑ Studies have shown that doctors often do not refer their patients for tests if those tests are not covered by insurance. Insurance coverage is an imporant factor in screening rates.
- ☑ Screening rates are significantly higher in the states that have passed coverage laws. By 2004, screening rates in states that passed colon cancer coverage laws had risen 40% faster than other states.

Five-Year Relative Survival Rates for Colon Cancer by Stage at Diagnosis



Localized colon cancers, those that are detected before spread to other parts of the body, are 90% survivable. Regional colon cancers, those that have spread to nearby tissue, are 68% survivable. Only 10% survive colon cancers that have spread to distant organs.

For more information, contact:
Lisa Benlon, Government Relations Director, American Cancer Society
(913) 747-6019 or email Lisa.Benlon@cancer.org

Please Support Access to Colon Cancer Screening

The Lewin Group
3130 Fairview Park Drive
Suite 800
Falls Church, VA 22042

MEMORANDUM

June 14, 2002
Updated September 2004

To: American Cancer Society
National Government Relations Department

From: The Lewin Group

Subject: The Federal Employee Health Benefit Program Health Plan Analysis on Colorectal Cancer Screening: *Survey Results*

The following memorandum outlines the findings from the review of health plans offered through the Federal Employees Health Benefits Program (FEHBP) and discusses the implications on insurance coverage status of colorectal cancer screening.

BACKGROUND

Colorectal cancer is a disease that kills over 56,000 men and women in the US every year. Through screening, colorectal cancer can be detected early, and it also can be prevented through removal of potentially precancerous polyps.

Four colorectal cancer screening tests are currently recommended by the American Cancer Society and other leading health organizations: the Fecal Occult Blood Test (FOBT); flexible sigmoidoscopy; colonoscopy; and double contrast barium enema (DCBE). The effectiveness of these tests is not equivalent. FOBT, for example, is the least expensive test, but its effectiveness is lower than the other screening tests. Furthermore, successful screening with FOBT depends on regular annual screening with strict adherence to recommended testing procedures. One-time screening with FOBT detects fewer than half of colorectal cancers and offers little potential for prevention since smaller polyps generally do not bleed. While all the screening tests save lives, colonoscopy is the most complete and accurate. It is widely considered to be the gold standard for colorectal cancer screening tests, not only because it is highly effective and can view the entire colon, but also because pre-cancerous polyps can be removed during screening colonoscopy – potentially preventing cancer altogether. Additionally, due to it's high level of precision in detecting pre-cancerous polyps and cancer, all positive results from the other exams need to be followed by a colonoscopy.

Currently, despite strong evidence about the benefits of screening, colorectal cancer screening rates are discouragingly low. Increased access to colorectal cancer screening could decrease the number of deaths from colorectal cancer, but the extent to which colorectal cancer screening benefits are covered by insurers remains unclear. While it is difficult to obtain information about private health plan coverage, the 100 plus plans that participate in the Federal Employee Health Benefit Program (FEHBP) make their coverage information publicly available through the Office of Personnel Management (OPM) website.

The LEWIN GROUP

Approximately nine million individuals across the nation are covered through the FEHBP in plans of various sizes, demographics and types (Fee for Service, PPO, HMO, POS).[1] Because of its breadth and diversity and other similarities to commercial private insurance plans, an analysis of FEHBP coverage offers insight on what private insurance companies are covering with respect to colorectal cancer screening in the US. For these reasons, the Society commissioned The Lewin Group[2] to analyze the plans that participate in the FEHBP to determine the extent to which the different options for colorectal cancer screening are being covered.

METHODOLOGY

The Lewin Group conducted an analysis of both large and small health plans that participate in the FEHBP. Plans are required by OPM to cover colorectal cancer screening, but plans can decide which of the colorectal cancer screening tests to cover. The purpose of the review was to determine to what extent insurers were covering the following four colorectal cancer screening tests:

- FOBT
- Flexible Sigmoidoscopy
- Colonoscopy
- DCBE

Lewin reviewed 60 of the FEHBP plan brochures listed on the OPM website in order to acquire an appropriate baseline of plan coverage of colorectal cancer screening. To ensure a representative sample, The Lewin Group selected the top 40 plans covering the most lives and then selected another 20 small plans at random. Thus, the sample represents both large and small plans, nationwide, regional and state-based plans, plans of varying types (Fee for Service, HMO, POS, PPO) and plans offered government wide, as well as plans offered only to specific employee groups (Foreign Service, Secret Service, etc.).

When analyzing the plans, the following questions were asked:

1. Does the plan offer colorectal cancer screening coverage?
2. Does the plan cover FOBT? If yes, at what age and frequency?
3. Does the plan cover Flexible Sigmoidoscopy? If yes, at what age and frequency?
4. Does the plan cover Colonoscopy? If yes, at what age and frequency?
5. Does the plan cover Double Contrast Barium Enema? If yes, at what age and frequency?

The plans were also analyzed to identify any notable differences between plans that do not cover the full range of colorectal cancer and the plans that do – including reviewing plan characteristics and co-pay amounts

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[1] See appendix for definitions of FEHPB plan types.

[2] The Lewin Group is a premier national health consulting firm specializing in health economics with more than 30 years experience.

The LEWIN GROUP

RESULTS

- All plans analyzed cover FOBT and flexible sigmoidoscopy.
- Only three percent of the plans cover colonoscopy. Additionally, the same percentage of plans (3%) cover DCBE.
- There are no appreciable differences between the plans that offer the full range of colorectal cancer screening and those that do not in terms of number of enrollees, geographic location, coverage area, plan type, union status or coverage levels.
- The copay amounts do not differ between the plans that cover the full range of screening tests and plans that only cover FOBT and flexible sigmoidoscopy.
- *2004 Update:* Thanks in part to ACS intervention, 29% of FEHBP plans now cover the full range, including some of the largest plans, such as BCBS

CONCLUSIONS

As evidenced by those plans affiliated with the FEHBP it is reasonable to conclude that:

- Plans are covering FOBT and flexible sigmoidoscopy to a great extent.
- Most plans are not providing comprehensive coverage for colorectal cancer screening that includes colonoscopy.
- Without intervention most plans do not cover screening colonoscopy and thus, do not provide comprehensive coverage for colorectal cancer screening.
- More comprehensive benefits for colorectal cancer screening do not appear to have a significant impact on member out-of-pocket expenses.

DISCUSION

The data establish that plans are covering FOBT and flexible sigmoidoscopy, but are not covering colonoscopy. This is significant, because scientific evidence has shown that colonoscopy is highly effective and can prevent the greatest number of cancers and save the most lives. Furthermore, while colorectal cancer screening rates are low nationwide, it is important that the full range of screening tests are offered in order to address such issues as screening capacity, patient preference, risk of complications, patient health, effectiveness, and physician judgment. Offering the full range of screening tests to individuals makes sense to ensure the greatest number of patients obtain screening.

While the reasons insurers are not covering colonoscopy remain unclear, it has been assumed that colonoscopy is the most expensive of the colorectal cancer screening strategies. However, a recent American Cancer Society-commissioned analysis conducted by The Lewin Group studied the short term costs of colorectal cancer screening. The data suggest that colonoscopy is actually less costly than flexible sigmoidoscopy combined with FOBT in terms of Per Member Per Month (PMPM) costs. PMPM is a figure that demonstrates how much a benefit would cost individual plan members, thus determining the financial impact of screening. Essentially, it is the price tag of a new benefit for plan members. Over the short term, colonoscopy every 10 years is actually 11 cents less PMPM than annual FOBT combined with flexible sigmoidoscopy every five years. When the cost study is considered together with this FEHBP analysis, it becomes readily apparent that expanding coverage to

include colonoscopy can save lives at little or no additional cost to insurers. Given that insurers are already offering FOBT and flexible sigmoidoscopy, there is no compelling economic reason not to offer colonoscopy as well.

In fact, Congress enacted bi-partisan legislation in 2000 that updated the Medicare coverage policy to provide for the full range of colorectal cancer screening options. Expanding coverage for Federal employees and other members of the under-65 population is the next logical step. The analysis suggests that public policies assuring the inclusion of the full range of colorectal cancer screening tests are integral to ensuring that health plans include such benefits in their coverage policies, as plans largely do not cover the full range of colorectal cancer screening tests on their own accord.

In conclusion, saving lives by increasing colorectal cancer screening rates will require a concerted effort that includes education, promotion and access. National policies assuring comprehensive coverage for colorectal cancer can be a part of the effort to increase screening rates and -- given the current state of coverage -- can be implemented at minimal cost, if any.

SAVE LIVES.
MAKE COLORECTAL CANCER SCREENING A NATIONAL PRIORITY.

Colorectal cancer is the second leading cause of cancer deaths for men and women combined in the United States, but it doesn't have to be. With proper screening, colorectal cancer is often preventable and can be successfully treated more than 90% of the time when detected early. In February 2008, the American Cancer Society reported that the colorectal cancer death rate has continued to decline. Down approximately 3% from 2004 to 2005, colorectal cancer saw one of the largest declines in death rates of all leading cancers.

GET TESTED. BEAT THIS DISEASE.

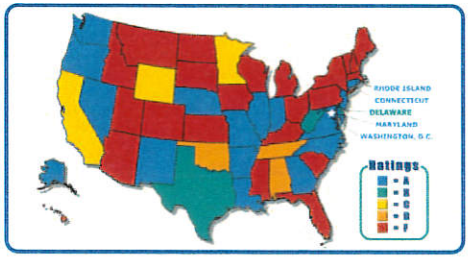
Unfortunately, there is no federal legislation requiring insurance providers to cover the cost of preventative screenings, leaving many people uncertain about whether their insurance covers these tests. In recent years, a number of states have adopted preventative screening legislation for colorectal cancer.

In this 2008 Report Card for Colorectal Cancer, find out if your state has passed preventative screening legislation, and what you can do if your state fails to make the grade.

Colorectal cancer is highly preventable, yet fewer states* have passed screening legislation when compared to breast cancer.

	NUMBER OF STATES MANDATING COVERAGE OF SCREENING			
TYPE OF CANCER	REQUIRE COVERAGE	INSUFFICIENT COVERAGE	NO COVERAGE	DEATHS PER YEAR
Colorectal	25	3	23	49,960
Breast	50	0	1	40,930

US figures estimated for 2008, American Cancer Society
* Including Washington D.C.



What You Can Do:

We all have the ability to prevent colon cancer from taking lives by simply getting involved and demanding action from our political, corporate, healthcare and insurance leaders:

- Reach out to legislator(s). Log on to **www.fightcolorectalcancer.org/reportcard** to find contact information for your local decision makers. Send an email or make a quick call if you don't like your state's grade.
- Talk to your employer. Ask if their health plan covers colorectal cancer screening, and if not, encourage them to consider it.
- Contact your insurance provider. Understand what screenings your policy covers and what it does not.
- Check in with your friends and family. Share this report (at **www.nccra.org**) with them and encourage them to talk to their doctor about getting screened.

Grading Criteria - States with above average grades (A-B) generally cover all policyholders age 50 and over, and those under 50 at high risk. Coverage includes:

- Colonoscopy screenings every 10 years
- Flexible sigmoidoscopy or double contrast barium enema screenings every 5 years
- Fecal occult blood tests (FOBT) or fecal immunochemical test (FIT) every year
- FOBT or FIT annually plus a flexible sigmoidoscopy every 5 years

A States receiving an A reference accepted screening guidelines*, allowing the legislation to include coverage of future advances in screening methods.

B States receiving a B meet current screening guidelines*, but no guidelines are specifically referenced. Therefore the legislation may potentially fall short of providing coverage for future advances in screening methods.

C States receiving a C have passed legislation that covers preventative cancer screenings, but the legislation is vague and does not specifically mention which types of colorectal cancer screenings are covered.

D States receiving a D have passed legislation that recommends insurance providers *offer* coverage, but does not *require* coverage.

F States receiving an F do not currently have any legislation that requires insurance providers to cover preventative colorectal cancer screenings.**

* Screening guidelines of the American Cancer Society, American Gastroenterological Association, American College of Gastroenterology and American Society for Gastrointestinal Endoscopy.
** This report card grades legislation only. Some states with F grades are working with insurance providers to implement voluntary programs that will ensure widespread coverage for colorectal cancer screening.

STATE GRADES

A
Alaska
Arkansas
Connecticut
Georgia
Illinois
Indiana
Louisiana
Maryland
Missouri
Nebraska
Nevada
New Jersey
New Mexico
North Carolina
Oregon
Rhode Island
Virginia
Washington
Washington D.C.

B
Delaware
Texas
West Virginia

C
California
Minnesota
Wyoming

D
Alabama
Oklahoma
Tennessee

F
Arizona
Colorado
Florida
Hawaii
Idaho
Iowa
Kansas
Kentucky
Maine
Massachusetts
Michigan
Mississippi
Montana
New Hampshire
New York
North Dakota
Ohio
Pennsylvania
South Carolina
South Dakota
Utah
Vermont
Wisconsin

The Lewin Group
3130 Fairview Park Drive
Suite 800
Falls Church, VA 22042

MEMORANDUM June 17, 2002

To: American Cancer Society
National Government Relations Department

From: The Lewin Group

Subject: Short Term Costs of Colorectal Cancer Screening Cost Model Results

Background:
Colorectal cancer is a disease that kills over 56,000 men and women in the US every year. Through screening, colorectal cancer can be detected early, and it also can be prevented through removal of potentially precancerous polyps. However, despite strong evidence about the benefits of screening, screening rates are discouragingly low. Increased access to colorectal cancer screening would decrease the number of deaths from this disease, but reservations about the cost of screening remain an issue. The American Cancer Society is sensitive to concerns about costs to insurers as well as the effect those costs have on consumers. For this reason, the Society commissioned The Lewin Group[1] to determine the costs of colorectal cancer screening on health plans and their members through cost modeling.

Methodology:
The Lewin Group developed a model to calculate the short-term costs for three colorectal cancer screening methods over a one year period:

- Annual Fecal Occult Blood Test (FOBT)
- Annual FOBT and Flexible Sigmoidoscopy every 5 years
- Colonoscopy every 10 years

The model provides a Per Member Per Month (PMPM) cost for plans to cover the full range of tests listed above, at the intervals described. PMPM cost represents how much a new benefit would cost individual plan members, thus determining the financial impact of screening. It is basically the "price tag" of a benefit.

The model simulated all immediate events following each colorectal cancer screening test and the associated costs for each event. For example, the model includes treatment costs for colorectal cancers detected through screening and also takes into account that a colonoscopy would be needed as a follow up to the other positive colorectal cancer screening tests. Annual and Per Member Per Month (PMPM) cost estimates were calculated by screening

[1] The Lewin Group is a premier national health consulting firm specializing in health economics with more than 30 years experience.

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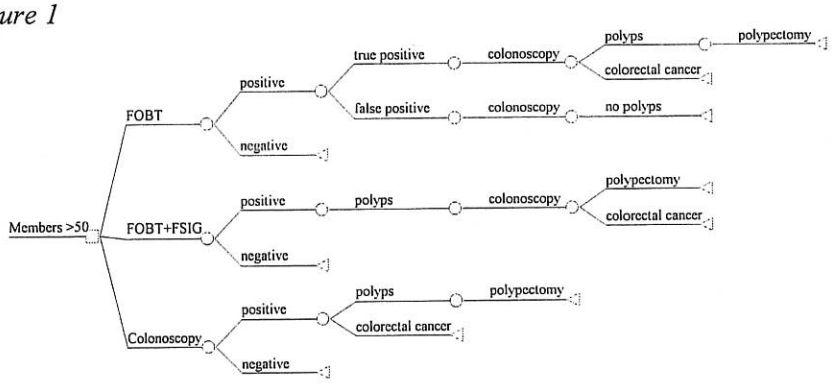
method. Total direct medical costs of screening included – costs of all tests performed, follow up, complications, treatment, etc. Total costs were then divided by the population of the plan in order to calculate the PMPM costs.

Decision Tree:

Figure 1



Data Collection:

Data for key variables were obtained from a combination of national databases, published peer-reviewed literature and expert opinion. Information was collected on the following parameters:

- Disease incidence and prevalence
- Screening and treatment utilization (i.e., compliance)
- Sensitivity and specificity of screening tests
- Screening outcomes
- Screening and treatment costs

Assumptions:

Plan demographics were drawn from four managed care organizations, creating a sample member population of 81,565 with 14,941 members over the age of 50. It was also assumed that 41% percent of plan members over 50 would comply with screening recommendations – a figure that is consistent with 1999 Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System survey (BRFSS). These assumptions helped to simulate real life scenarios with respect to a given health plan population.

Furthermore, the model assumed that:

- Screening begins at the age of 50 years
- One-fifth and one-tenth of eligible plan members receive a flexible sigmoidoscopy and colonoscopy, respectively, in a given year because flexible sigmoidoscopy is recommended once every 5 years and colonoscopy once every

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10 years

- Cost estimates reflect current national private insurance costs and the Medicare Fee Schedule
- Costs associated with physician visits are included in the screening and treatment cost estimates

At age 65, Medicare assumes 80% of all screening and follow-up costs – Remaining 20% of screening and follow-up costs are covered by private insurance

- All screening methods are included as a new health benefit and costs passed through to plan members accordingly

Figure 2 – Assumptions

SCREENING COMPLIANCE		DATA SOURCE
ANNUAL FOBT/FLEXIBLE SIGMOIDOSCOPY@ 5YRS	41%	Palitz et al. The Colon Cancer Prevention Program (CoCaP): Rationale, Implementation, and Preliminary Results, *HMO Practice*, 1997.
COLONOSCOPY@ 10-YRS	41%	
FOLLOW UP COLONOSCOPY	80%	Frazier et al. Cost-effectiveness of Screening for Colorectal Cancer in the General Population. *Journal of the American Medical Association*, 2000.
SCREENING COMPLICATION RATE		**DATA SOURCE**
FLEXIBLE SIGMOIDOSCOPY	4 per 100,000 screens	Anderson et al. Endoscopic Perforation of the Colon: Lessons from 10 year Study. *American Journal of Gastroenterology*, 2000.
COLONOSCOPY	1.9 per 1,000 screens	

Figure 3 - Assumptions

SCREENING AND TREATMENT COSTS (in 1998 US Dollars)*		DATA SOURCE
FOBT SCREEN	$12.64	Khandker et al. A Decision Model and Cost Effectiveness Analysis of colorectal cancer Screening and Surveillance Guidelines for Average Risk Adults. *International Journal of Technology Assessment in Health Care*, 2000.
FLEXIBLE SIGMOIDOSCOPY SCREEN	$201.89	
FLEXIBLE SIGMOIDOSCOPY+BIOPSY	$342.60	
COLONOSCOPY SCREEN	$768.38	
POLYPECTOMY/PATHOLOGY	$357.03	
COLONOSCOPY+POLYPECTOMY	$1,125.41	
SCREENING COMPLICATIONS	$32,356.49	

*Khandker et al. cost estimates in 1994 US dollars were inflated to 1998 US dollars using Statistical Abstract of the United States, The National Data Book, 1999.

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Results:

*Figure 4 – Short term costs of Colorectal Cancer Screening**

ANNUAL FOBT	
PMPM	$0.47
Cost per Member per Year	$5.70
ANNUAL FOBT/FLEXIBLE SIGMOIDOSCOPY@5-YEARS	
PMPM	$0.66
Cost per Member per Year	$7.92
COLONOSCOPY@ 10-YEARS	
PMPM	$0.55
Cost per Member per Year	$6.64

*Analysis employed base case compliance values for initial and follow-up screenings (FOBT-39%, Flexible Sigmoidoscopy and Colonoscopy-41%, and follow-up Colonoscopy-80%). Analysis included initial colorectal cancer treatment costs of $18,100 per case.

Conclusions:

- Over the short term, all colorectal cancer screening strategies are an acceptable cost, hovering around 50 cents PMPM.
- If a plan's colorectal cancer screening coverage consists of only FOBT, colonoscopy coverage can be added for 8 cents more PMPM.
- Colonoscopy is less costly than FOBT combined with flexible sigmoidoscopy by 11 cents PMPM. If a plan is already covering FOBT combined with flexible sigmoidoscopy, plans can expand coverage to include colonoscopy for little or no additional cost.

Discussion:

The data establish that all three colorectal cancer screening strategies can be provided at a reasonable cost to insurers and their plan members, at approximately 50¢ PMPM. While there is agreement among health care economists that services costing under $1 PMPM are considered acceptable to insurers, PMPM costs equal to or less than $1.00 is admittedly arbitrary. For the sake of comparison, we calculated the short term PMPM costs for breast cancer screening at a comparable screening compliance rate. Annual mammography, a widely covered screening exam, costs 75¢ PMPM, revealing that colorectal cancer screening compares favorably with a well-established and commonly provided preventive health test.

The study also challenges the assumption that colonoscopy would be the most expensive screening option for insurers, and instead demonstrates that FOBT combined with flexible sigmoidoscopy is a more expensive strategy. The data show that colonoscopy costs *11 cents*

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less than 5-year flexible sigmoidoscopy combined with annual FOBT. When the results of this study are coupled with the fact that insurers seem to be widely covering FOBT and flexible sigmoidoscopy, but only covering colonoscopy to a lesser degree, the results have significant ramifications. If a plan is already covering the FOBT/flexible sigmoidoscopy screening strategy, there is no economic reason for a plan not to extend coverage to colonoscopy screening.

Our finding that colonoscopy costs less than 5-year flexible sigmoidoscopy/annual FOBT may seem counter-intuitive, but colonoscopy is less expensive for four main reasons:

- Screening colonoscopy only needs to be done once every 10 years.
- Screening colonoscopy can biopsy a suspicious lesion or remove a polyp *during the actual screening exam.* Both FOBT and flexible sigmoidoscopy need to be followed by a colonoscopy when these tests come back positive, adding additional costs to these two screening tests.
- Screening colonoscopy prevents more cancers and saves more lives than the other two tests, thus reducing treatment costs to a greater extent.
- Finally, colonoscopy is a more accurate test. It has the ability to more accurately or precisely detect polyps or cancer compared to all other colorectal cancer screening modalities.

The report does not conclude that screening colonoscopy should be the only test covered. Rather, it is important that the full range of screening tests be offered to address such issues as screening capacity, patient preference, patient health, and physician judgement. Because screening rates are low, and at a time when screening capacity is building, it is prudent to offer the full range of screening options in order to ensure the greatest number of adults have access to screening -- this is especially the case since all options can be covered at reasonable cost.

This analysis demonstrates that the full range of colorectal cancer screening tests, including colonoscopy, can be covered with little or no impact on member costs, similar to other accepted medical tests. When the costs of these screening strategies are spread across a plan's membership base, costs are only increased – at most – by pennies a month and could potentially be reduced. Offering colorectal cancer screening is a wise use of health dollars since the potential to save lives, prevent disease, and reduce suffering and premature mortality is so great. These data show that plans could offer coverage for the full range of colorectal cancer tests – thus removing one barrier to screening – and could do so at minimal cost.

Key Sources:

Frazier et al. Cost-effectiveness of screening for colorectal cancer in the general population. *Journal of the American Medical Association*, 2000.

Imperiale, et al. Risk of advanced proximal neoplasms in asymptomatic adults according to the distal colorectal findings. *The New England Journal of Medicine*, 2000.

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Khandker et al. Cost-effectiveness analysis of colorectal cancer screening and surveillance guidelines. *U.S. Department of Health and Human Services, Public Health Service, Agency for Healthcare Research and Quality*, 2000.

Lieberman. Cost-effectiveness model for colon cancer screening. *Gastroenterology*, 1995.

Loeve et al. Endoscopic colorectal cancer screening: A cost-saving analysis. *Journal of the National Cancer Institute*, 2000.

Smith RA, von Eschenbach AC, Wender R, et al. American Cancer Society Guidelines for the Early Detection of Cancer: Update of Early Detection Guidelines for Prostate, Colorectal, and Endometrial cancers. Also: Update 2001--Testing for Early Lung Cancer Detection. *CA Cancer J Clin.* Jan-Feb 2001

Winawer et al. Colorectal Cancer Screening: Clinical Guidelines and Rationale. *Gastroenterology,* 1997.

Testimony before the House Insurance Committee

In Favor of HB 2075

February 5, 2009

Chairman Schultz and Committee Members,

Thank you for the opportunity to speak in favor of **HB 2075.**

Prior to being a member in this astute body, I lobbied for the American Cancer Society. An issue that is very important to ACS is that of making sure everyone can be afforded the luxury of getting a preventive colorectal cancer screening without having to forego the procedure due to cost. Colon cancer is one cancer that can be prevented with proactive action. If, through screenings, pre-cancerous polyps can be removed, cancer will not materialize. It is suggested all men and women get a screening, beginning at age 50, as that is the age where risk is the greatest.

The ACS concludes there are several accepted tests to screen for colorectal cancer. The choice is up to the individual as to which screening is best for him/her.

There are two points I wish to make:

1) Insurance companies state they cover these screenings. If that is the case, having a mandate in place will not affect the way they currently do business. Some companies may cover colon cancer screenings, but I heard from doctor's offices some insurance companies only cover FOBT (every year) and flexible sigmoidoscopies (every 5 years), but not the colonoscopy (to be conducted every 10 years). Considering the results from the Lewin Group study, it is apparent that expanding coverage to include colonoscopies in their coverage would certainly save lives at little or no costs to insurers. There is no compelling reason not to offer **all** screenings for colorectal cancer.
2) And, most importantly, this cancer is very unforgiving. It can be extremely painful and difficult to cure. If caught by a screening-before symptoms occur-there is about a 90% survival rate. If it is detected due to symptoms, it is often too late in the stage to survive. The survival rate is by far, much less.

A state policy assuring comprehensive coverage for colorectal cancer can be part of the effort to increase screening rates and save lives—at a minimal costs to insurance companies and ultimately to our state.

I am happy to stand for questions at the appropriate time.

Representative Lisa Benlon

House Insurance
Date: 2-05-09
Attachment # 4

KANSAS
DEPARTMENT OF HEALTH
AND ENVIRONMENT

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Colorectal Cancer Screening Insurance Coverage, HB 2075

Presented to
House Insurance Committee

By
Richard Morrissey, Interim Director of Health
Kansas Department of Health and Environment

February 5, 2009
Room 784, DSOB

Chairman Schultz and members of the committee, I am Richard Morrissey, Interim Director of Health for the Kansas Department of Health and Environment and am pleased to be here today to discuss insurance coverage for colorectal cancer screening.

One of the most powerful weapons in preventing colorectal cancer is regular screening or testing. Colorectal cancer begins as small polyps or growths in the lining of the colon or rectum. When detected early, through a colonoscopy test, the polyps are removed before they develop into cancer. Regular colorectal cancer screening can, in many cases, prevent colorectal cancer. This is because from the first time the abnormal cells start to grow, it may take 10-15 years for them to develop into colorectal cancer. When polyps are found at an early stage and removed, colorectal cancer is highly curable.

Of the approximately 13,000 new cases of cancer diagnosed in Kansas each year, only 11 percent are colorectal cancer. However, it is the second leading cause of cancer death in men and women, second only to lung cancer. In 2007, 531 Kansans died from the disease according to statistics from the Kansas Cancer Registry.

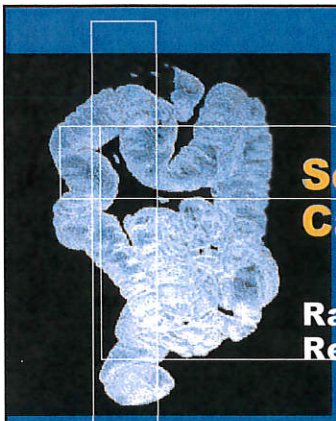
The Behavioral Risk Factor Surveillance System survey conducted by KDHE indicates that 54 percent of Kansans 50 years and older report they have never had a Fecal Occult Blood Test, the simplest of testing methods to indicate colorectal

problems (BRFS, 2006). Nearly 44 percent of Kansans in this 50+ age group indicated they had never had a colonoscopy or sigmoidoscopy, a more advanced testing methods to screen for colorectal cancer. The United States Preventive Services Task Force recommendation that adults over the age of 50 be screened is based on convincing evidence that screening reduces cancer mortality. The Task Force reports that current levels of cancer screening in this country lag behind those of other effective cancer screening tests.

The cost per life-year saved for colorectal cancer screening is estimated at $10,000 to $25,000 and compares favorably with other commonly endorsed preventive health care interventions. For example, it is comparable to the effectiveness of mammography screening for women older than forty years of age or to treatment of moderate hypertension. (Annuals of Internal Medicine, 2002).

When colorectal cancer is diagnosed at an early stage, before it has spread, the five-year survival rate is 90 percent, according to the American Cancer Society. Once the cancer has spread to distant organs such as the lungs, liver or lymph nodes, the five-year survival rate drops to about 10 percent.

Evidence-based public health practices and cancer prevention methods indicate that colorectal cancer screening reduces future health care costs and disease incidence. Thank you for the opportunity to appear before the committee today. I will now stand for questions.



Screening for Colorectal Cancer

Rationale for Current ACS Recommendations

House Insurance Committee

February 5, 2009

Testimony on HB 2075

James J. Hamilton, Jr. , MD, FACS

Kansas State Chair, Commission on Cancer

Volunteer Legislative Advisor, American Cancer Society

Thank You...

For passing a resolution in both the Kansas House and Senate commending those insurers who provide preventive colon cancer screenings!

We agree!

House Insurance
Date: 2-05-09
Attachment # 6

PLEASE...

Support **House Bill 2075** to assure colon and rectal cancer screening for all insured Kansans. This bill has been referred to the House Insurance Committee.

We agree!

Colon and Rectal Cancer Facts

108,070 new cases of colon cancer each year

53760 men

54310 women

40,740 new cases of rectal cancer each year

23,490 in men

17,250 in women

Lifetime risk of about 1 in 19

- American Cancer Society, 3/5/08

Colon and Rectal Cancer Facts

Colorectal cancer is the third leading cause of cancer-related deaths in the United States

49,960 deaths predicted in 2008

24,260 men

25,700 women

- American Cancer Society, 3/5/08

Who's At Risk?

Average Risk

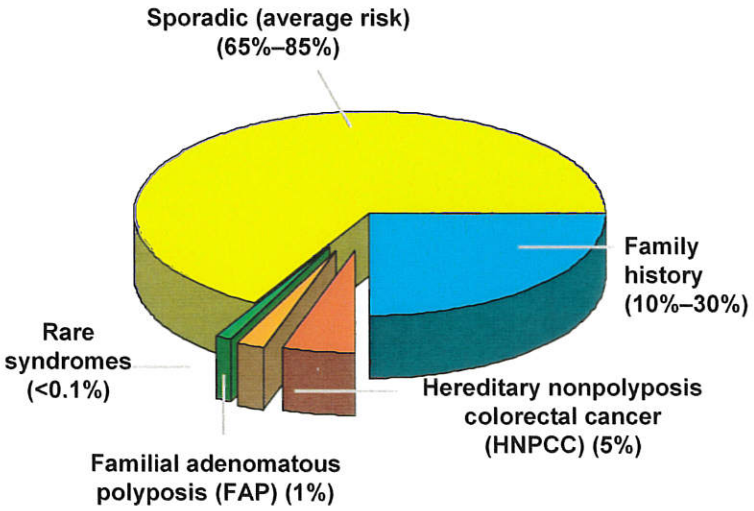
All adults 50 years and older

Increased Risk

Personal history of inflammatory bowel disease, adenomatous polyps or colon ca

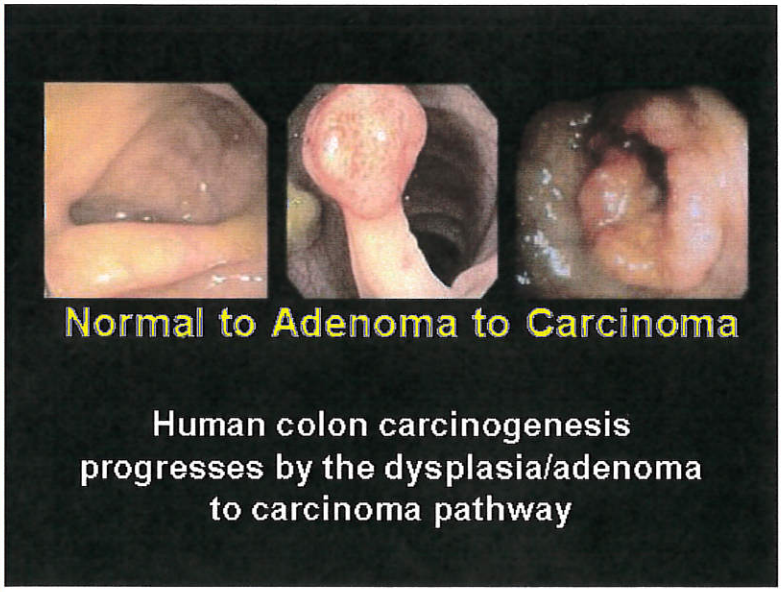
Family history of adenomatous polyps, colon cancer, other conditions

Colorectal Cancer



CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

American Cancer Society



Research suggests that this progression usually takes *5 to 15 years*

American Cancer Society

Benefits of Screening

- **Cancer Prevention**

  Removal of pre-cancerous polyps *prevent* cancer (unique aspect of colon cancer screening)

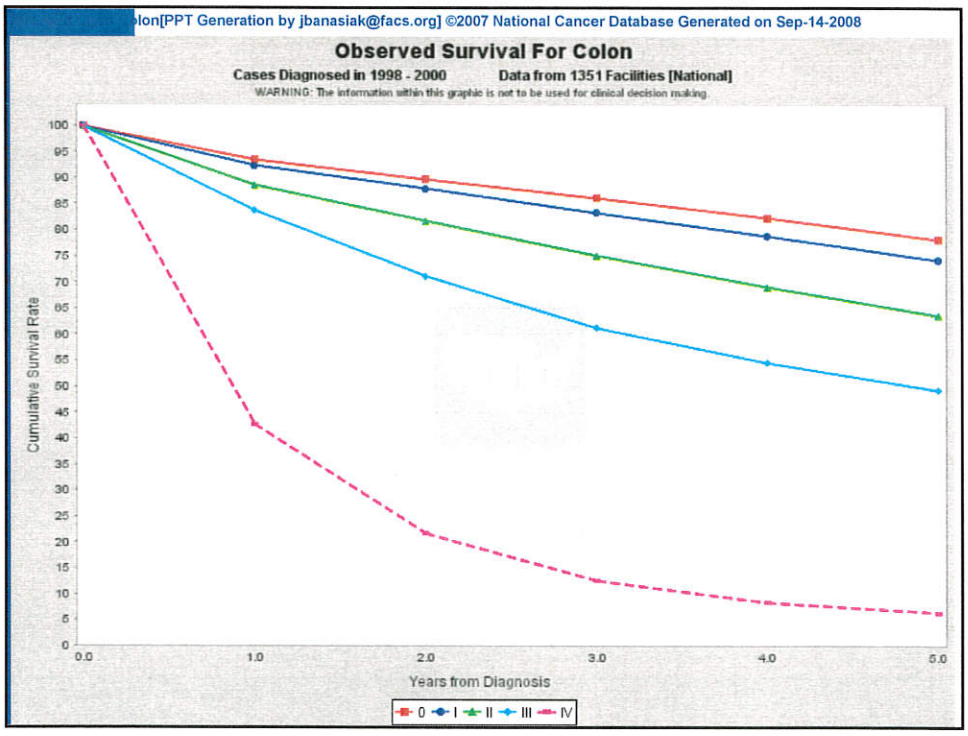
- **Improved survival**

  Early detection markedly improves chances of long term survival

Colorectal Screening Rates are Low

Just 39% of colorectal cancers are detected at the earliest stage.

Less than half of Americans over age 50 report having had a recent colorectal cancer screening test.



CRC Screening Methods

Fecal Occult Blood Testing (FOBT)
- *Guaiac
- *Immunochemical

Flexible Sigmoidoscopy (FSIG)

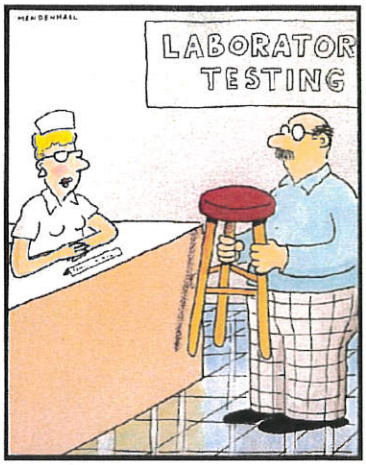
Fecal Occult Blood Testing + Flexible Sigmoidoscopy (FSIG)

Colonoscopy

Double Contrast Barium Enema (DCBE)

All of the above methods have evidence to support their use

Fecal Occult Blood Test (FOBT)



That's not quite the stool sample we had in mind

Fecal Occult Blood Test (FOBT)

Rationale

- Detects blood in the stool
- Cancers tend to bleed
- Large polyps also may bleed (although less likely to bleed than cancers)

Fecal Occult Blood Test (FOBT)

Two different methods

- Guaiac
- Immunochemical

Sensitivity of Take Home & In-Office FOBT *

FOBT method	Sensitivity	
	All Advanced Lesions	Cancer
3 card, take-home	23.9 %	43.9 %
Single sample, in-office	4.9 %	9.5 %

**Guaiac test*

Fecal Occult Blood Test

In-office FOBT is essentially worthless as a screening tool for CRC and must be ***strongly discouraged***

However;

In a recent national survey, nearly *30%* of physicians reported using single-sample, in-office FOBT at the time of rectal exam as their primary method of screening for colorectal cancer

Nadel et al, Annals of Int Med Jan 2005

Fecal Occult Blood Test

Inadequate follow up of positive FOBT

Approximately 30% of patients who were told they had a positive FOBT reported that this test was either followed up with a repeat FOBT, or no diagnostic work up.

Nadel et al, Annals of Int Med Jan 2005

Fecal Occult Blood Test (FOBT)

Advantages

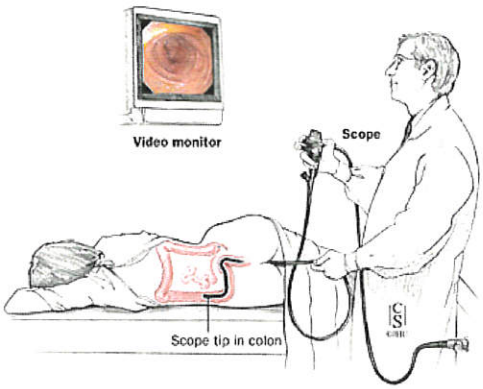
- Strongest Evidence
- Non-invasive
- Convenient
- Widely available
- No special provider skills or equipment required
- Inexpensive

Fecal Occult Blood Test (FOBT)

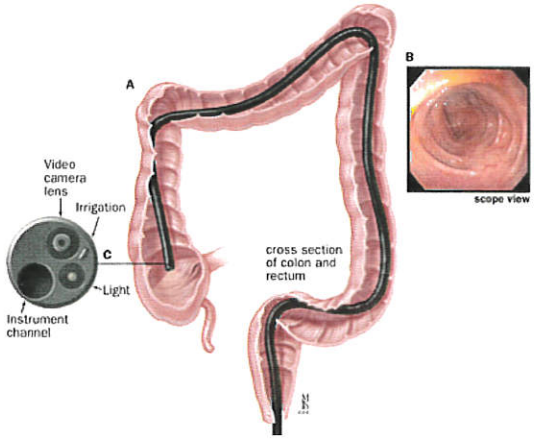
Limitations

- Lowest sensitivity of all recommended tests
- Requires annual testing
- Inappropriate testing and follow-up are common
- Poor patient acceptance
- Many providers lack belief in test utility

Colonoscopy



Colonoscopy



Evidence for CRC Screening

Colonoscopy

Studies as screening modality currently underway

Best method for diagnostic evaluation after abnormalities identified by other screening techniques

Proven superior to FSIG and DCBE for surveillance after polypectomy

ACS 2001 Guidelines for Screening and Early Detection of CRC

in Average Risk Individuals

FOBT* annually + Flex Sigmoidoscopyevery 5 years

(preferred compared with FOBT or FSIG alone)

Flexible sigmoidoscopyevery 5 years

Fecal occult blood testing annually

Colonoscopy every 10 years

Dilute contrast barium enema every 5 years

All positive tests should be followed up with colonoscopy

*FOBT = guaiac-based or immunochemical

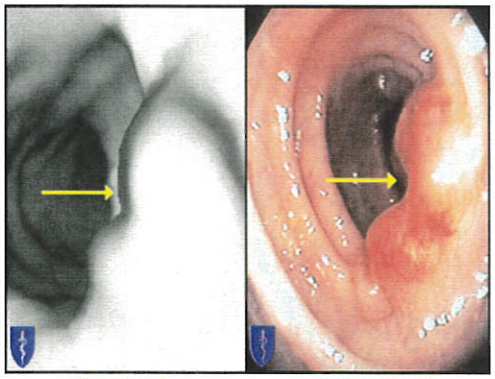
CRC Screening Methods

Guidelines emphasize *options* because:

- Individuals differ in their preferences among these choices
- Physicians vary in their ability or readiness to refer patients to all options equally
- Access is uneven geographically, and in terms of insurance coverage
- There still is considerably uncertainty about *program* performance in terms of benefits, harms, and costs

Future Directions in CRC Screening

CT Colonography (Virtual Colonoscopy)



virtual colonoscopy | traditional colonoscopy

Existing Cancer Benefits Provided to Insureds in Kansas

- Mammograms
- Prostate
- Breast reconstruction after cancer surgery

Cost of Screening: The Lewin Study

ANNUAL FOBT	
Cost per Member per Year	$5.70
PMPM	$0.47
ANNUAL FOBT/FSIG@ 5-YEARS	
Cost per Member per Year	$7.92
PMPM	$0.66
COLONOSCOPY@ 10-YEARS	
Cost per Member per Year	$6.64
PMPM	$0.55
ANNUAL SCREENING MAMMOGRAPHY	
Cost per Member per Year	$8.99
PMPM	$0.75

Analysis employed base case compliance values for initial and follow-up screenings (FOBT-39%, FSIG and colonoscopy-41%, follow-up colonoscopy-80%, and mammogrpahy 41%). Analysis included initial CRC treatment costs of $18,100 per case, and initial BC treatment costs of $6,169.11 per case.

Case for Prevention is Stronger than Ever

- New colorectal cancer drugs, such as bevacizumab (Avastin) and cetuximab (Erbitux), are much more costly.
- Avastin has been hailed as one of several "significant new improvements" in physicians' weapons for fighting colon cancer.

Case for Prevention is Stronger than Ever

Table. Estimated Drug Costs for Eight Weeks of Treatment for Metastatic Colorectal Cancer.

Regimen	Drugs and Schedule of Administration	Drug Costs*
		$
Regimens containing fluorouracil		
Mayo Clinic	Monthly bolus of fluorouracil plus leucovorin	63
Roswell Park	Weekly bolus of fluorouracil plus leucovorin	304
LV5FU2	Biweekly fluorouracil plus leucovorin in a 48-hr infusion	263
Regimens containing irinotecan or oxaliplatin		
Irinotecan alone	Weekly bolus	9,497
IFL	Weekly bolus of fluorouracil plus irinotecan	9,539
FOLFIRI	LV5FU2 with biweekly irinotecan	9,381
FOLFOX	LV5FU2 with biweekly oxaliplatin	11,889
Regimens containing bevacizumab or cetuximab		
FOLFIRI with bevacizumab	FOLFIRI with fortnightly bevacizumab	21,399
FOLFOX with bevacizumab	FOLFOX with biweekly bevacizumab	21,033
Irinotecan with cetuximab	Weekly irinotecan plus cetuximab	30,790
FOLFIRI with cetuximab	FOLFIRI and weekly cetuximab	30,675

* Costs represent 95 percent of the average wholesale price in May 2004.

Schrag, D. N Engl J Med 2004;351:317-319

Case for Prevention is Stronger than Ever

Wholesale Drug Costs (AWP)

- 1995 – 4.5 months 5FU/LV
  - Approximately $500 per patient
- 2004 – 11 months FOLFOX/bevacizumab
  - 4.5 months of irinotecan
  - 4.5 months irinotecan/cetuximab
  - **Approximately $250,000 per patient!**

Screening presents the opportunity to reduce the high cost of treatment for advanced disease

Thank you

American Cancer Society®

Coordinating health & health care for a thriving Kansas

KHPA™

KANSAS HEALTH POLICY AUTHORITY

House Insurance Committee:
HB 2075 – Coverage for Colorectal Cancer Screening

February 5, 2009

Doug Farmer, Director
State Employee Health Benefits Plan

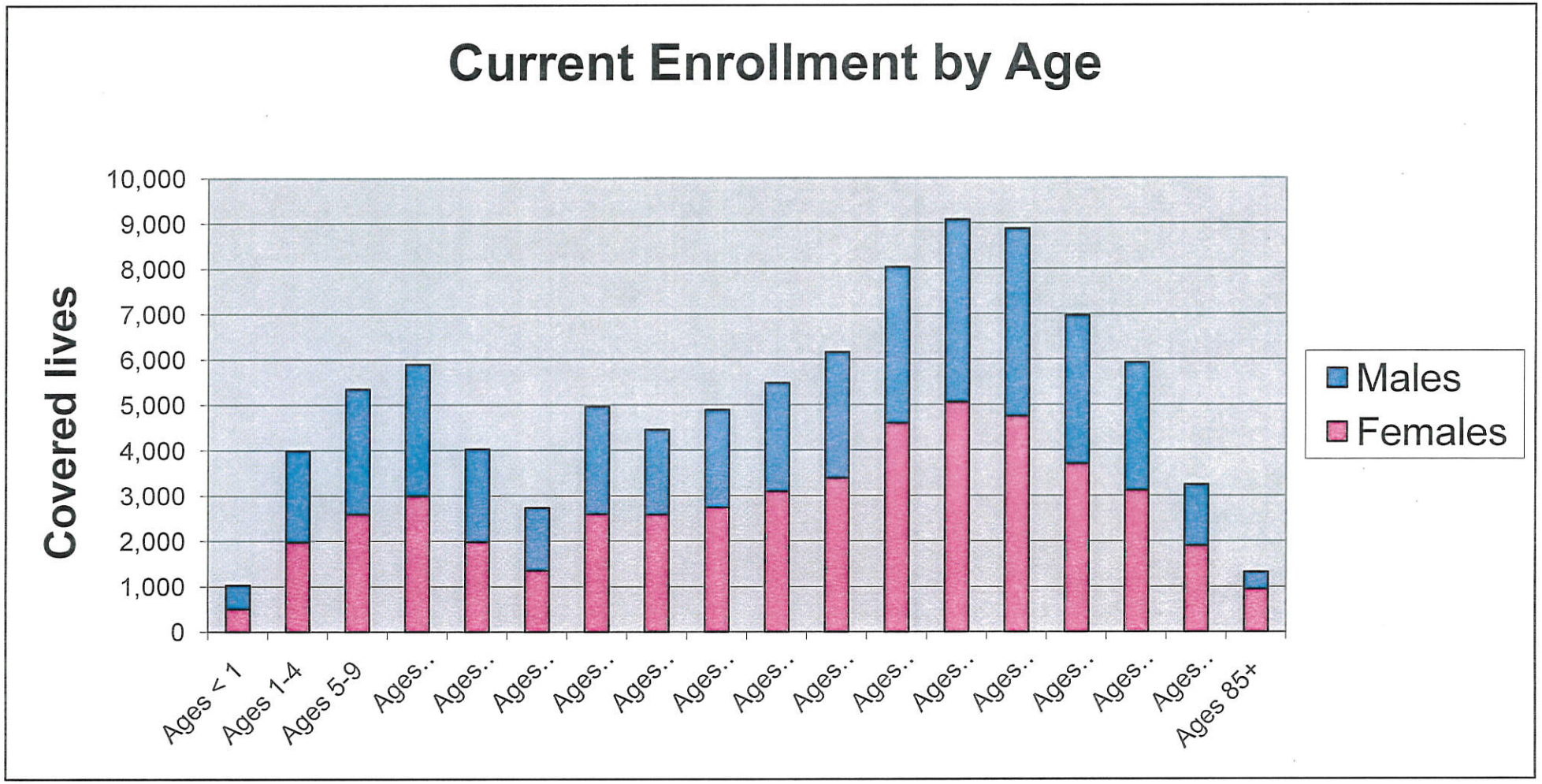
The State Employee Health Plan (SEHP) currently covers colorectal cancer screenings at 100%. Colonoscopies and related procedures have always been covered under the SEHP, but the move toward 100% coverage was made in 2006. At that time the State Employees Health Care Commission (HCC) approved coverage of one medically necessary routine colonoscopy per member per lifetime, to begin in Plan Year 2007. Additional colonoscopies were also covered, but were subject to coinsurance. What we learned during Plan Year 2007 is that most colonoscopies were not coded by the medical provider as "routine," which prevented our members from receiving the enhanced preventive benefit.

In 2007, the HCC approved major plan design changes to move the plan toward a more robust value-based benefit design. One of the changes was to remove the requirement that colonoscopies be "routine" and to remove the limit of one procedure under the preventive benefit per lifetime. Members now have coverage for colonoscopies at 100% when they use a network provider. The plan offers the 100% coverage benefit to members over the age of 50, or a member of any age who has a family history of colorectal cancer.

In terms of the demographics of the SEHP, we cover an average of about 90,000 lives at any given time. Of that amount, 74.0 % are active employees, 11.9% are retirees, 13.9% are part of our non-state group, and .2% are COBRA. The current average age of our enrolled employees is 46, and the overall covered population is 39.5 years of age.

Plan Year 2008 was the SHEP's first year of being completely self-insured. In Plan year 2008, the SEHP spent $6.3 million on claims related to colorectal cancer screening. Of that amount, $4.6 million (73.3%) was for the population age 50 and over, and $1.7 million (26.6%) for the population under age 50. Of the costs for the 50 and older population: colonoscopy accounted for 94.6% of all costs related to colorectal screening; sigmoidoscopy accounted for .5% of all costs related to colorectal screening; and nearly 5% of all costs were attributable to "other" procedures.

Because billing decisions are made at the discretion of physicians' offices, it is impossible to say how much of our current spend for colorectal procedures is related to the screening mandated in HB 2075, and how much is purely diagnostic.


Current Enrollment by Age
Covered lives
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
Ages < 1
Ages 1-4
Ages 5-9
Ages..
Ages..
Ages..
Ages..
Ages..
Ages..
Ages..
Ages..
Ages..
Ages..
Ages..
Ages..
Ages..
Ages 85+
Males
Females

STATE OF KANSAS

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TOPEKA

HOUSE OF REPRESENTATIVES

COMMITTEE ASSIGNMENTS

Member
APPROPRIATIONS
GENERAL GOVERNMENT BUDGET
ELECTIONS AND GOVERNMENTAL ORGANIZATION
JOINT COMMITTEE ON STATE BUILDING CONSTRUCTION

Testimony for HB 2075

Colorectal cancer is the second leading cause of cancer deaths in the United States. It is a cancer that is just as common for women as for men. In many cases colon cancer can be prevented. The cancer almost always starts with a small growth called a polyp. If the polyp is found early, doctors can remove it and stop colon cancer before it starts.

Early colon cancer usually has no symptoms. Signs and symptoms occur when the cancer is more advanced. The absence of symptoms should never be a reason to delay or ignore colon cancer testing. The reason I am supportive of colon cancer screening is because my husband and I both had colon cancer. We were fortunate to have the cancer detected early through screening. I believe coverage should be provided for everyone over 50 years of age to have colorectal cancer examinations and laboratory tests as specified in the American cancer society guidelines.

Jo Ann Pottorff

Jo Ann Pottorff
State Representative
83rd District

House Insurance
Date: 2-05-09
Attachment # 8

Kansas Association of Health Plans

815 SW Topeka Boulevard, Suite 2C
Topeka, Kansas 66612

(785) 213-0185
marlee@brightcarpenter.com

February 5, 2009

HB 2075
Before the House Insurance Insurance Committee
Marlee Carpenter, Executive Director

Chairman Shultz and members of the Committee;

The Kansas Association of Health Plans (KAHP) is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and other entities that are associated with managed care. KAHP members serve the majority of Kansans enrolled in private health insurance. KAHP members also serve the Kansans enrolled in HealthWave and Medicaid managed care.

KAHP is here today to oppose HB 2075 and would like to provide you with information about colon screening coverage in the state. KAHP believes that all health insurance plans operating in the state of Kansas offer coverage for colon screenings. Since all Kansas plans cover this procedure, KAHP believes that passage of HB 2075 is unnecessary.

We believe that the real issue surrounding colon screenings is that individuals are not seeking this service. KAHP members support preventative care and believe that this procedure helps in early detection of cancer, saving costs in the long term. KAHP members not only support colon screenings but promote screening by encouraging tests through newsletters and other communications.

In addition, approximately 60% of Kansans covered by a group health insurance plan are covered through an employer who self-insures. That means that the employer makes all coverage decisions. These plans are also exempt from state health insurance mandates.

Health insurance companies in Kansas offer this coverage. The Kansas Legislature has been discussing this issue for more than 10 years and we have never been given the name of a single Kansan who has been denied coverage; a single doctor who hasn't been paid for this procedure or the name of any offending health insurance carrier. We ask once again, if you know of anyone who has been denied this test, please give us the information and we will ask the Kansas Insurance Department to investigate the situation

Thank you for your time and consideration of this issue. I will be happy to stand for questions

House Insurance
Date: 2-05-09
Attachment # 9

Legislative Testimony

achieve more

HB 2075

February 4, 2009

House Insurance Committee

Rachelle Colombo, Senior Director of Legislative Affairs

Chairman Shultz, members of the Committee:

We appreciate the opportunity to provide testimony in opposition to HB 2075 which mandates the provision of coverage for colorectal cancer screening. While this is an emotional subject that impacts a growing percentage of our population, it behooves the legislature to first consider the effectiveness and financial impact of mandating such coverage.

The Kansas Chamber and its members believe that before we impose higher premiums on employers, additional mandates should meet the financial impact requirements laid out in statute so that their cost can be accurately determined.

Studies show that mandates increase the cost of health care and drive up premium price. Increasing premium price makes health care less affordable and results in a growing number of uninsured. In a recent study, the Pacific Research Institute found that if the cost of insurance premiums rises by 1 percent, the number of uninsured people increases by 0.5 percent. This illustrates the detrimental impact of even minor increases in premium price on the uninsured population.

Managing health care costs remains one of the top three issues affecting profitability as identified by Kansas CEOs surveyed in the Chamber's annual CEO poll. Kansas business owners tell us that they want to provide health insurance and remain competitive, but the cost is too high. Already the cost of health care put business owners at a competitive disadvantage. Until statutory financial impact studies are conducted additional coverage should not be mandated.

The Kansas Chamber opposes HB 2075 because the exact cost of implementing the coverage required has not yet been determined, but we do know that mandates increase the cost of health care. Before employers are burdened with increasing premium costs fattened by mandates and forced to shoulder the cost of an even heftier health care bill, we should study the financial and physical impact of new mandates on the market and the health of individuals.

Thank you for the opportunity to offer these comments today.

The Kansas Chamber, with headquarters in Topeka, is the leading statewide pro-business advocacy group moving Kansas towards becoming the best state in America to do business. The Chamber represents small, medium and large employers all across Kansas.

THE KANSAS CHAMBER

835 SW Topeka Blvd. **Topeka, KS** 66612 785.357.6321

House Insurance
Date: 2-05-09
Attachment # 10