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**Mandated Benefits Review by the  
Pennsylvania Health Care Cost Containment  
Council**

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**Senate Bill 636  
Colorectal Cancer Screening Mandate**

May 2002

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## EXECUTIVE SUMMARY

In conducting a review of this nature, the enabling legislation of the Pennsylvania Health Care Cost Containment Council clearly places the burden of providing scientific data and information regarding the proposed mandate on interested parties (e.g., proponents and opponents of the legislation). While the Council conducts its own research as appropriate (e.g., examining hospital admissions when relevant), the reviews rely almost entirely upon outside information as detailed in the enabling legislation. Ultimately, the Council's role in conducting a preliminary review is primarily to determine if sufficient evidence is available to proceed to the formal Mandated Benefits Review Panel as outlined in Act 34 of 1993 (i.e., contracting with a panel of outside experts to review the scientific validity of the studies submitted). In the case of Senate Bill 636, there was not sufficient information submitted to the Council to recommend the bill or to continue with the review process. The lack of supporting documentation submitted to the Council, however, should not detract from the medical community's general consensus on the efficacy of colorectal cancer screening.

Overall, the cost/savings figures submitted to the Council either varied greatly or were not substantiated with data. In particular, requisite scientific studies and cost figures were not submitted to determine (1) the impact increased insurance coverage would have on utilization and (2) the expected number or percent of identified colorectal cancer cases diagnosed at an early stage as a result. Without this information, an accurate cost/benefit analysis could not be prepared.

While insufficient evidence was available to the Council, there were nevertheless some points which may be of interest to the General Assembly.

- The medical community appears to agree on the general efficacy of colorectal cancer screening, and there is research to suggest that early identification of colorectal cancer leads to decreased treatment costs. However, insufficient information was submitted to quantify the potential increase in early detection.
- The Council notes the recommendations of the U.S. Preventive Services Task Force, an independent panel of experts convened by the Agency for Health Care Research and Quality in the U.S. Department of Health and Human Services. The U.S. Preventive Services Task Force recommends screening all persons aged 50 and older with annual fecal occult blood testing, or sigmoidoscopy (periodicity unspecified), or both. At the time their recommendation was released in 1996, they further stated there was (a) insufficient evidence to determine which screening method (fecal occult blood test or sigmoidoscopy) is preferable or whether the combination of fecal occult blood test and sigmoidoscopy produces greater benefits than does either test alone and (b) insufficient evidence to recommend for or against routine screening with barium enema or colonoscopy, although recommendations against such screening in average-risk persons may be made on other grounds (e.g., availability of alternate tests of proven effectiveness, costs and risks of colonoscopy).
- It appears that colorectal cancer screening tests are already widely covered by managed care plans. Medicare also covers periodic colorectal cancer screening. In some instances, traditional fee for service plans may also offer coverage for

screening (e.g., for high risk individuals or through a preventive services rider). In addition, all insurance products generally cover diagnostic colorectal cancer testing when medically necessary.

- While there is a general consensus about the medical efficacy of screening for colorectal cancer, there is disagreement about the need to mandate coverage and whether mandated coverage would bring about a desired increase in screening utilization.

In 1998, the Council reviewed a similar mandate as part of a larger cancer screening proposal. While there are minor differences in the drafting between the current bill and Senate Bill 39 reviewed in 1998, the intent with regard to colorectal cancer screening is similar. At that time, the Council noted that the potential increase in cost associated with screening may be offset by a decrease in the cost of treating this cancer if diagnosed at an earlier stage. At that time, the Council's cost/benefit analysis showed that while the cost for colorectal cancer screening may range between \$7.2 million and \$10.9 million annually, it could be offset by the \$10 million that might be saved *if* the percentage of colorectal cancer diagnosed at an early stage increases from 37 percent (the current rate at that time) to 50 percent. We were not able to verify those estimates, however, because no studies were submitted to indicate if this was a reasonable expectation.

## **Review of Senate Bill 636**

### **Overview of Senate Bill 636**

Senate Bill 636, PN 674 would require all group and individual health insurance policies to provide coverage for colorectal cancer screening examinations and laboratory tests for cancer for eligible nonsymptomatic individuals in accordance with the most recently published American Cancer Society guidelines for colorectal cancer screenings. Eligible individuals include: (1) individuals fifty years of age or older, and (2) individuals under fifty years of age who are at high risk for colorectal cancer (as identified by the most recently published guidelines of the American Cancer Society). Covered screenings include: 1) fecal-occult blood test, (2) flexible sigmoidoscopy, (3) colonoscopy, in the case of a high-risk individual, (4) barium enema, if medically necessary, as an alternative to flexible sigmoidoscopy or colonoscopy, and (5) such other procedures as the Department of Health deems appropriate.

### **The Mandated Benefits Review Process**

The Pennsylvania Health Care Cost Containment Council's enabling legislation, Act 89 of 1986 (as reauthorized by Act 34 of 1993), provides that the Council review proposed mandated health benefits when requested by the Secretary of Health or appropriate committee chairmen in the Pennsylvania Senate or the House of Representatives.

On October 9, 2001, Senator Edwin G. Holl, Chairman of the Senate Banking and Insurance Committee, requested that the Council review the provisions of Senate Bill 636, PN 674. Senator Allyson Schwartz (D, Philadelphia) is the prime sponsor of the bill.

Notification was published in the *Pennsylvania Bulletin* on October 27, 2001, requesting that interested parties submit documentation and information pertaining to the bill to the Council by December 27, 2001. Letters were also sent to potentially interested individuals and organizations informing them of the pending review and inviting them to submit documentation pursuant to the notice. The Pennsylvania Department of Health and the Pennsylvania Insurance Department were notified and received copies of the submissions. Following the initial comment period, an opportunity was provided for interested individuals and organizations to examine the responses received and submit additional comments through February 22, 2002 based on that review.

A list of the submissions received and a copy of the bill are attached.

Act 34 provides for a preliminary Council review to determine if documentation submitted is sufficient to proceed with the formal Mandated Benefits Review process outlined in the Act. This formal process involves another step beyond Council review by contracting with four additional experts to review the documentation submitted by proponents and opponents.

This report presents the results of the Council's preliminary review and the conclusions of the Council regarding whether the material is sufficient to proceed with the formal review process.

## **American Cancer Society's Guidelines for Colorectal Cancer Screening**

The mandated benefits and coverage proposed in Senate Bill 636 are dependent upon most recently published guidelines for colorectal cancer screening issued by the American Cancer Society. At this time, the American Cancer Society's guidelines are as follows<sup>1</sup>:

Beginning at age 50, both men and women should follow one of the five screening options below:

- Yearly fecal occult blood test (FOBT) (for FOBT, the take-home multiple sample method should be used)
- Flexible sigmoidoscopy every 5 years
- Yearly fecal occult blood test *plus* flexible sigmoidoscopy every 5 years (the combination of FOBT and flexible sigmoidoscopy is preferred over either of these two tests alone)
- Double contrast barium enema every 5 years
- Colonoscopy every 10 years

All positive tests should be followed up with colonoscopy.

Individuals should begin colorectal cancer screening earlier and/or undergo screening more often if they have any of the following colorectal cancer risk factors:

- A strong family history of colorectal cancer or polyps,
- A known family history of hereditary colorectal cancer syndromes,
- A personal history of colorectal cancer or adenomatous polyps, or
- A personal history of chronic inflammatory bowel disease.

## **Overview of Colorectal Cancer Screening Procedures**

The *fecal occult blood test* (FOBT) is used to find occult (hidden) blood in feces. Usually, a patient will receive a test kit with instructions that explain how to take a stool sample at home. The kit is then returned to the doctor's office or a medical laboratory for testing.

*Sigmoidoscopy* is an examination in which a physician uses a sigmoidoscope – a slender, flexible, hollow, lighted tube about the thickness of a finger – to examine the lower part of the colon. The sigmoidoscope is inserted through the rectum and is about 2 feet long, allowing the physician to see less than half of the colon.

*Colonoscopy* is an examination similar to a sigmoidoscopy which allows the physician to examine the entire colon. A colonoscope (a slender, flexible, hollow lighted tube similar to the sigmoidoscope) is inserted through the rectum up into the colon. Because a colonoscope is approximately twice as long as a sigmoidoscope, a physician can see much more, and in most cases all, of the colon. As with the sigmoidoscopy, the colonoscope is connected to a video camera and video display monitor so the physician

can closely examine the inside of the colon. If a polyp is found, the physician may remove it during the colonoscopy. A wire loop is passed through the colonoscope to cut the polyp from the wall of the colon with an electrical current. The polyp can then be sent to a lab to be checked under a microscope to see if it has any areas that have changed into cancer.

A *double contrast barium enema* is a procedure in which barium sulfate, a chalky substance, is used to partially fill and open up the colon. Once the colon is expanded, x-rays are taken to examine the colon.

### **Analysis of Documentation Submitted by Opponents and Proponents in Response to the Eight Categories Required by Act 34, Section 9**

Act 34 of 1993 provides that the documentation submitted to the Council by opponents and proponents of a proposed mandated benefit should address eight specific areas. In reviewing these eight points, determination is made whether the information received is sufficient to warrant the formal Mandated Benefits Review process outlined in the Act. Following are Council findings pertaining to the documentation received for Senate Bill 636 addressing each of these eight points.

- (i) The extent to which the proposed benefit and the services it would provide are needed by, available to and utilized by the population of the Commonwealth.**

#### Affected Population

According to 2000 Census, there are 1,928,007 men and women in the 50-64 age bracket who would potentially benefit from the mandates proposed in Senate Bill 636. The vast majority of people age 65 and over already have coverage for colorectal cancer screening through Medicare Part B. Information was not available to determine the number of people below age 50 who would benefit from Senate Bill 636 because they are at high risk for colorectal cancer according to the American Cancer Society. This analysis, therefore, focuses primarily on the 50-64 age group.

The Pennsylvania Department of Health reports there were 8,918 colorectal cancer cases diagnosed in Pennsylvania in 1999; 2,232 of these new cases were detected in those 64 years of age or younger. 3,484 Pennsylvanians died from colorectal cancer in 1999, with 514 (14.8%) of these deaths in the age 50-64 age group.

According to information from the Pennsylvania Department of Health, Pennsylvania's age-adjusted *incidence* rate for colorectal cancer has not changed much in the past several years. Overall, in 1999 the age-adjusted rate of 61.9 (per 100,000) was 3.1 percent lower than the 1990 rate of 63.9 (per 100,000). The state's age-adjusted *mortality* rate due to colorectal cancer (23.5 per 100,000 in 1999) has shown some decline since 1990 (when the rate was 28.0), for an overall decrease of 16.1 percent. According to the Department of Health, "Pennsylvania's age-adjusted incidence rates for invasive colorectal cancer were considerably higher than comparable United States rates." The Department also noted that "Pennsylvania's [age-adjusted] mortality rates

for colorectal cancer have consistently been higher than United States rates and are usually among some of the highest state rates in the country for both males and females.”<sup>2</sup> The Department of Health also reported that colorectal cancer is the fourth most common cause of cancer diagnosis and the second most common cause of cancer deaths among men and women in Pennsylvania.

### Utilization

According to the 1999 survey conducted by the Centers for Disease Control and Prevention’s (CDC) Behavioral Risk Factor Surveillance System (BRFSS), 24 percent of people in the 50-64 age group responded in the positive when asked if they had used a home blood stool test kit (i.e. fecal occult blood test) within the past two years to determine whether their stool contained blood. 33 percent of people in the age 50-64 age group responded in the positive when asked if they ever had a sigmoidoscopy or colonoscopy exam. (It is not known what insurance coverage, if any, these respondents may have had.)

In looking at utilization amongst people who already have coverage for the screening tests, Blue Cross of Northeastern Pennsylvania stated that, “despite the availability of the [screening] benefit and member education efforts, only 8.5 percent of [their HMO] members received a colonoscopy, 2.7 percent received a sigmoidoscopy and just less than 10 percent received a fecal occult blood test in 2000.”

### Availability

The availability of colorectal cancer screening tests is discussed in section (ii) below.

- (ii) The extent to which insurance coverage for the proposed benefit already exists, or if no such coverage exists, the extent to which this lack of coverage results in inadequate health care or financial hardship for the population of the Commonwealth.**

In general, it appears that colorectal cancer screening tests are already widely covered by managed care plans. In some instances, traditional fee-for-service plans may also offer coverage for screening (e.g., for high risk individuals or through a preventive services rider).

For example, Blue Cross of Northeastern Pennsylvania wrote that, “Like most managed care plans, First Priority Health [their managed care plan] currently covers colorectal cancer screenings for members as part of overall preventive health screenings.” First Priority Health covers an annual fecal occult blood test for members age 50 and over and has no limits on coverage of flexible sigmoidoscopies, colonoscopies or barium enemas.

In regard to their traditional indemnity insurance program, Blue Cross of Northeastern Pennsylvania (BCNEPA) states that like most traditional insurance programs, they do not specifically include preventive colorectal cancer screenings. However, in July 2000

they adopted a policy and criteria for covering *colonoscopy* procedures for all members. The policy states that BCNEPA, “shall provide coverage to all enrolled individuals who meet any of the following criteria:

- Personal history of colorectal cancer or colonic polyps.
- Personal history of Inflammatory Bowel Disease.
- Family history of one or more first-degree relatives with colorectal cancer. Such individuals may be screened every 3-5 years beginning 10 years earlier than the youngest affected relative.
- Individuals who are identified to have Familial Adenomatous Polyposis or Hereditary Non-Polyposis Colorectal Cancer Screening Syndrome.”

Highmark states that their benefits for colorectal cancer screening vary depending on the product. For example, their managed care plans already include coverage for colorectal cancer screening tests. Keystone Health Plan West’s preventive guidelines provide for an annual fecal occult blood test after age 50 and/or flexible sigmoidoscopy every 3-5 years. In addition, colonoscopies are currently covered for high-risk persons. Highmark notes, however, that this policy is under review in terms of its consistency with current literature and changes recommended by national health organizations. Keystone Health Plan Central’s preventive guidelines allow for an annual fecal occult blood test for persons age 50 and over as well as a flexible sigmoidoscopy every 4-5 years at age 50 and over. Colonoscopies are currently covered for persons every 10 years beginning at age 50. HealthGuard of Lancaster follows a similar regimen.

In Highmark’s traditional fee-for-service plan, however, the colorectal cancer screening exams are not considered a standard benefit unless the employer group purchases a preventive benefits rider. Under this option, covered nonsymptomatic individuals age 50 and over are eligible for an annual fecal occult blood test and an annual flexible sigmoidoscopy (screening colonoscopies and screening barium enemas are not included in the preventive benefits package or in the PPO products for asymptomatic members).

Highmark also stated that if a member exhibits symptoms of colorectal cancer, regardless of age, all of their plans, including the traditional fee-for-service and managed care products, would cover the tests outlined in Senate Bill 636 when prescribed by a physician for diagnostic purposes.

The Managed Care Association of Pennsylvania also suggested that many commercial managed care plans already provide coverage for colorectal screenings in accordance with the American Cancer Society’s guidelines. Information from the Insurance Federation supports this statement.

Public payers of health care provide similar benefits for colorectal cancer screening as do commercial insurers. For example, people enrolled in Medicare currently have coverage for colorectal cancer screening tests. Medicare supplement Part B provides coverage for all people with Medicare age 50 and older (there is no minimum age for colonoscopy) for the following:

- fecal occult blood test (once every 12 months),
- flexible sigmoidoscopy (once every 48 months),

- colonoscopy (once every 24 months for those at high risk for colon cancer or once every 10 years, but not within 48 months of a screening sigmoidoscopy, for those not at high risk), and
- barium enema which doctors may use in place of flexible sigmoidoscopy or colonoscopy.

Information supplied by the Pennsylvania Department of Public Welfare indicates the Medical Assistance program also provides coverage for colorectal cancer screening procedures, including fecal occult blood test, sigmoidoscopy, colonoscopy, and double barium contrast enema, based on medical necessity. Medical Assistance does not limit the frequency with which these tests are covered.

With regard to whether a lack of coverage results in inadequate health care, the American Cancer Society stated, “in one recent study of patient participation in colon cancer screening programs, nearly one quarter of the patients enrolled in the study reported ceasing colorectal screening because of a lack of insurance coverage for the procedure. In addition, surveys show that many health plans that do provide colon cancer screening only cover the most basic blood test and do not provide reimbursement for more comprehensive screening.”

Submissions did not specifically address the issue of financial hardship for patients in the *absence* of the proposed benefits for colorectal cancer screening. Several submissions touched upon the possibility that, if enacted, mandates such as Senate Bill 636 could in and of themselves cause a financial burden for some individuals and employers in the Commonwealth. By imposing additional costs associated with mandates, the total cost of health care will ultimately rise, therefore passing additional costs on to employers, or in the case where the employer does not absorb the cost increase, to employees. If the cost of health insurance becomes too high, employers may not be able to afford to provide or offer coverage or employees may not be able to afford coverage when it is offered due to high copayments for the premiums.

While general statements were made by both proponents and opponents, no specific data or studies regarding inadequate health care or financial hardship were submitted.

**(iii) The demand for the proposed benefit from the public and the source and extent of opposition to mandating the benefit.**

Demand for Senate Bill 636

The support for Senate Bill 636 comes from cancer advocacy groups and physicians who specialize in gastroenterology, an area of medicine that includes the diagnosis and treatment of colorectal cancer. The support stems primarily from the impact of colorectal cancer in terms of people affected and death rates and from the issue that colorectal cancer is one of the most preventable and treatable cancers. The impact of colorectal cancer was discussed in section (i) above. Proponents note that it is the third most common cause of both cancer diagnosis and cancer deaths among men and women in Pennsylvania.

In addressing the efficacy of the colorectal cancer screening and treatment options, the Colon Cancer Alliance states, “colorectal cancer is one of the most detectable, and if found early, most treatable forms of cancer. Over 90% of those diagnosed while the cancer is still localized survive more than five years. Currently, however, only 37% of colorectal cancers are detected while still localized. Regular screening will change that by identifying pre-cancerous polyps and finding colorectal cancers in their early stage when treatment is most effective.”

One substantial benefit of screening for colorectal cancer is that, as one physician wrote, “most cancers can only be detected once they are already established. ... In the colon, we have the opportunity to detect a precancerous lesion [i.e., polyp], remove it, and prevent the subsequent development of cancer.” While some polyps may be benign, if they are detected and removed in their benign or precancerous stages, later surgeries may be avoided. The American College of Gastroenterology estimates that up to 80% of colon cancer deaths can be prevented by timely removal of precancerous polyps.<sup>3</sup>

One physician wrote that, “except in a few high risk conditions, it is recognized that almost all colorectal cancers arise from polyps which if removed would have resulted in that patient not developing colorectal cancer.” She further stated that, “it is likely and hopeful in the future that it will be possible to identify people at risk and therefore to be able to screen a smaller population than the entire population over the age of 50. However, at the present time, this is the state of the art method of detecting lesions that potentially put the patient at risk for developing colorectal cancer...”

Finally, the American Cancer Society (ACS), “strongly believes that all persons over the age of 50, and those at increased risk under the age of 50, should have access to the full range of screening exams according to our guidelines. The final decision about which exam a person should use should be left to the patient and his or her physician. To ensure full access, individuals should have coverage for the screening options outlined in the ACS guidelines.” This position was supported by a physician who wrote, “patients and physicians should be allowed to choose which colorectal cancer screening tests they wish to follow.”

In addition to the submissions addressed above, the Council also notes the recommendations of the U.S. Preventive Services Task Force (USPSTF), an independent panel of experts in primary care and prevention convened by the Agency for Health Care Research and Quality in the U.S. Department of Health and Human Services. The USPSTF recommends screening all persons aged 50 and older with annual fecal occult blood testing (FOBT), or sigmoidoscopy (periodicity unspecified), or both. At the time their recommendation was released in 1996, they further stated there was (a) insufficient evidence to determine which screening method (FOBT or sigmoidoscopy) is preferable or whether the combination of FOBT and sigmoidoscopy produces greater benefits than does either test alone and (b) insufficient evidence to recommend for or against routine screening with barium enema or colonoscopy, although recommendations against such screening in average-risk persons may be made on other grounds (e.g., availability of alternate tests of proven effectiveness, costs and risks of colonoscopy).

## Opposition to Senate Bill 636

While the medical community appears to agree on the general efficacy of colorectal cancer screening, opponents point out that (1) there is some disagreement regarding the recommended screening method, (2) increased coverage may not necessarily lead to increased utilization, and (3) Senate Bill 636 gives other entities such as the American Cancer Society and the Pennsylvania Department of Health the ability to change and/or expand upon the mandated coverage without the benefit of legislative oversight.

In addressing the recommendations for screening, it should be recognized that at this time each of the screening methods has its drawbacks. While the FOBT is non-invasive and easily administered, it is designed to identify blood in the stool when in fact many cancers and polyps do not bleed at all. Sigmoidoscopy, which allows for examination of the lower half of the colon, cannot examine the upper portion of the colon. Colonoscopy, theoretically the best screening mechanism because it allows visualization of the entire colon, is not only expensive, but the rate of major complications (roughly estimated at 1 in 1,000) may also suggest a high number of adverse events if screening became universal. Barium enemas are only used to identify polyps, thereby necessitating a colonoscopy in patients with polyps, and may miss smaller cancers and precancerous lesions.

In their submission, Blue Cross of Northeastern Pennsylvania (BCNEPA) stated, "screening for hidden disease is not a risk-free activity," and submitted information which further discussed some of the concerns surrounding colorectal cancer screening methods. For example, one article noted that the FOBT is known to have a high rate of false positives. In one study where 10% of participants had positive FOBT results (and underwent a colonoscopy as a result), only 2% actually had cancer. To complicate matters further, sigmoidoscopy and colonoscopy may also produce false positive results in identifying polyps that are unlikely to become malignant in the patient's lifetime. While most colorectal cancer evolves from polyps and the removal of these polyps can prevent cancer, not all polyps will become cancerous if left untreated. For example, according to the U.S. Preventive Services Task Force, while 10-33% of older adults have colon polyps at death, only 2-3% have colorectal cancer.<sup>4</sup> While the submission included a general article discussing some of the studies, copies of the actual studies themselves were not submitted.

The Insurance Federation pointed out that their opposition to Senate Bill 636 centers less on colorectal cancer screening, but rather on the need to mandate coverage of it. They noted that many insurers already cover these tests and question whether a mandate is an appropriate way to encourage wider use of the procedures.

As discussed in question (ii) above, Blue Cross of Northeastern Pennsylvania (BCNEPA) stated that the, "availability of the benefit does not necessarily result in a high percentage of patients taking advantage of the benefit." In their experience, only 10 percent of Blue Cross of Northeastern Pennsylvania's HMO members who already have coverage for the screenings utilized a fecal occult blood test in 2000. The utilization rates for sigmoidoscopy and colonoscopy were even lower. As BCNEPA concluded, "Mandating coverage for colorectal cancer examinations does not necessarily mean that an increased number of individuals will be screened. Despite current availability of the benefit in various managed care insurance products and patient education efforts, relatively low percentages of those eligible receive such testing."

Highmark's submission supports the position taken by both BCNEPA and the Insurance Federation and writes that, ... "if lawmakers choose to mandate coverage for colorectal exams and testing, it does not necessarily mean more men and women will seek out these services – many people are actually fearful of the exams and avoid them even though they have insurance coverage for them. [Because] the majority of the insured population addressed in Senate Bill 636 already have access to the testing methods, it appears that the focus is misguided." Highmark suggests that the low utilization rates may stem from a lack of knowledge about colorectal cancer. As Highmark wrote, "... there is a low level of awareness about colorectal cancer risks as well as its symptoms. It is clear that more attention should be paid to public health campaigns that educate the public about various health initiatives, including regular visits to a physician. While the message of prevention and proactive health care has begun to make its way into the mainstream, more can be done by helping to change attitudes about the health care system in general."

Another concern raised in opposition to this bill surrounds the identification of the screenings to be covered. As the Managed Care Association noted, the colorectal cancer screening procedures defined in Senate Bill 636 include not only fecal occult blood test, sigmoidoscopy, colonoscopy, and barium enema, but also, "such other procedures as the Department of Health deems appropriate with this Act (page 3, lines 5-6, PN 674)." Opponents also noted a change in the mandated benefits would occur if the American Cancer Society were to change its recommendations for colorectal cancer screening. As the Insurance Federation (IFP) noted there is, "the possibility that if the American Cancer Society changes its policy on the frequency or nature of colorectal screening recommendations, the costs imposed could be significantly higher." In addition, the IFP noted that, "... the bill embeds the testing policies of a well intentioned, but nevertheless, single interest, national organization into Pennsylvania statutory law." As IFP further asserted, "the making of statutory standards should not be delegated to anyone else, especially single interest groups."

Finally, while not specifically opposing the mandates contained in Senate Bill 636, the American Family Life Assurance Company (AFLAC) suggests that supplemental insurance policies be excluded from the bill. AFLAC argues that, "the role of supplemental insurance benefits is to pay cash benefit to the insured to fill the gaps between what is covered by comprehensive insurance and the total financial impact of an illness or injury. ... They are not intended to be ... substitutes for comprehensive, major medical health insurance."

#### Opposition to mandates in general

Historically, the business community, organized labor, and the health insurance industry resist the passage of new mandates. They cite concerns about mandates' impact on the cost of health insurance and how they limit purchasers' ability to select benefit packages. The Insurance Federation noted that insurers create benefit packages based on market demands. This allows insurers to be flexible in the benefit design and meet the needs of the particular groups purchasing the benefits.

Highmark writes that their, "opposition to mandating benefits and/or reimbursement to provider groups has been longstanding. We believe that they restrict the ability of health

care consumers to tailor benefit programs, and they increase the cost of health insurance premiums, pricing many people out of the insurance market.”

While business, labor, and insurers are concerned about potential mandates, the timing of this particular mandate raised additional alarm. The Insurance Federation (IFP) stated that even in the absence of this particular mandate, employers are already struggling to afford health coverage in light of the current economy. To support this position, IFP notes that, “employer health care costs are in the third straight year of double digit inflation.” In particular, they provide figures that show that, “... large employer health care costs will rise by 14% in 2002. This follows a 12% increase in 2001 and a 10% increase in 2000. ... Moreover, the costs of health benefits in the Philadelphia region apparently outstripped the national average...” Highmark likewise agreed and wrote that they believe, “... mandating additional health insurance benefits at a time when health care costs are increasing at double-digit rates is imprudent.”

When discussing mandates in general, potential increases in the number of uninsured is also a concern of opponents. Several submissions – including those from the Pennsylvania Business Roundtable, the National Federation of Independent Business, the Insurance Federation of Pennsylvania, Blue Cross of Northeastern Pennsylvania, Highmark, and the Managed Care Association of Pennsylvania – reported that as health insurance costs rise, employers and individuals may drop coverage, thereby contributing to the increasing number of uninsured.

Opponents are also concerned about the cumulative, negative financial impact of all mandates imposed in Pennsylvania where there are approximately 30 benefit and provider reimbursement mandates in place—of which 11 were passed during the 1990’s. They noted that while one individual mandate may have minimal impact on costs, the cumulative impact of 30 or more mandates has a substantial impact on the affordability of insurance coverage.

Other insurers reported that large employers might become self-insured in order to control health care costs and to avoid state-mandated benefits. Small employers, who generally do not have the ability to self-insure, must choose between cost sharing with employees or eliminating health insurance coverage altogether. This position is argued by the National Federation of Independent Business (NFIB) in their opposition to mandates such as Senate Bill 636. They write that, “Studies have shown the mandated benefits raise the cost of health care insurance. As costs rise, small businesses, in particular, struggle to afford health care coverage for their employees. As a result, many small businesses are forced to drop coverage. In essence, enacting benefit mandates has the opposite effect than the intended purpose of covering more individuals. ... An NFIB study indicates that nearly 65 percent of the uninsured [individuals in the United States] either work for or own a small business. As states enact benefit mandates ... the number of ‘working uninsured’ will most certainly rise.”

The Insurance Federation of Pennsylvania suggests that the restrictions resulting from benefit mandates can affect the business environment and detract from the state retaining or attracting businesses. Indeed, one of their objections to mandates, “is based on interference with the insurance marketplace and the effect of the cumulative price increases resulting from the enactment of these requirements. ... In the long run it is a competitive issue for Pennsylvania business interests.”

As the Pennsylvania Business Roundtable writes, they have “a long-standing position against legislatively imposed mandates on health care coverage unless proven to be medically and cost effective... The greatest concern is that mandates will impose additional financial burdens on the payers of health insurance, whether they be private or public. Such burdens would be imposed on the very businesses that are providing good family-sustaining jobs that pay good wages and offer health care benefits.”

Highmark provided information which summarizes the concerns insurers and business have about mandates as follows:

- State benefit mandates increase premiums which may, in turn, cause more employers to drop health benefits for employees;
- A study has demonstrated that each new benefit increases by 1.5 percent the likelihood that a small business may not be able to afford or offer coverage;
- State benefit mandates may cause an increasing number of large employers to self-insure, thus avoiding the need to implement such mandates;
- State benefit mandates tend to disproportionately advantage specific provider groups;
- State mandates increase administrative costs of both insurers and employers, particularly for multi-state employers; and,
- Legislatively mandated benefits further escalate the cost of health care coverage.<sup>5</sup>

**(iv) All relevant findings bearing on the social impact of the lack of the proposed benefit.**

The impact of a lack of the proposed benefit is not clear since many insurers, such as HMOs and Medicare, already provide coverage for colorectal cancer screenings. In addition, traditional indemnity plans such as those provided by Highmark and Blue Cross of Northeastern Pennsylvania provide coverage for colorectal cancer testing if medically necessary or requested for diagnostic purposes when symptoms or risk factors are present.

Submissions suggested coverage for colorectal cancer screenings is already available through managed care plans, Medicare, Medical Assistance, and in some instances, traditional fee for service plans (e.g., for high risk individuals or through a preventive services rider). However, even when available, the cancer screening may not be widely utilized. As discussed in section (iii) above, a low level of awareness about colorectal cancer and the invasive nature of many of the screening tests may play a role in low utilization.

With the medical community generally agreeing on the efficacy of colorectal cancer screening, submissions suggest that additional public health campaigns may be a way to better educate the public and their families to the issue of colorectal cancer. Given that coverage is already available through managed care plans, Medicare, Medical Assistance, and in some instances, traditional fee for service plans, increased utilization of colorectal cancer screening may be better achieved by encouraging men and women to discuss colorectal cancer and screening options with their physicians. Ultimately,

increased education and awareness about colorectal cancer may be valuable regardless of whether or not this mandate is enacted.

- (v) Where the proposed benefit would mandate coverage of a particular therapy, the results of at least one professionally accepted, controlled trial comparing the medical consequences of the proposed therapy, alternative therapies and no therapy.**

As discussed earlier, Senate Bill 636 would mandate coverage of several types of colorectal cancer screening tests including fecal occult blood test (FOBT), sigmoidoscopy, colonoscopy, and double contrast barium enema.

Blue Cross of Northeastern Pennsylvania submitted information concerning a clinical trial to study the efficacy of FOBT screening. According to this information, the Journal of the National Cancer Institute recently published results from the longest running (18 years) clinical trial to track people randomly assigned to be tested or not.

The clinical trial, which began in Minnesota, involved more than 46,000 healthy men and women randomly assigned to a test group. After 18 years of follow-up, annual FOBT testing demonstrated the best results with study participants in this group having a 33% lower colorectal cancer death rate than the untested group. Members of a test group who had biennial FOBT testing showed a more modest 21% lower death rate.<sup>6</sup>

The same article submitted by Blue Cross of Northeastern Pennsylvania also discussed two ongoing clinical trials in Europe which have shown FOBT mortality reductions of 15% and 18%. The article notes that, "some research physicians believe that the European results more accurately reflect screening in the real world. People who volunteer for clinical trials tend to be more likely to comply with a referral to undergo sigmoidoscopy or colonoscopy, whereas a high percentage of people in the real world do not. Unlike the participants of the Minnesota trial, people did not volunteer for the European trials. They were chosen from health clinic rosters; and, most significantly, the untested group didn't even know they were in a study."<sup>7</sup> While copies of these studies (i.e., the Minnesota and European studies) were not submitted to the Council, they were published in the *Journal of the National Cancer Institute* and, as such, appear to be the results of professionally accepted trials.

Highmark submitted information concerning a series of articles published in the July 20, 2000 issue of the *New England Journal of Medicine* concerning the use of colonoscopy to screen for colorectal cancer. One cited a study concluding that screening by colonoscopy can detect advanced colorectal cancer in nonsymptomatic adults and that many of the cancers would not have been detected with sigmoidoscopy.<sup>8</sup> It should be recognized, however, that while this study generated significant interest in the media and medical community, it was not a controlled, clinical trial. Most significantly, the study did not have a control group (i.e., all participants underwent a colonoscopy) and participation was not entirely random (i.e., while some participants were randomly selected for inclusion, other participants had been referred for a sigmoidoscopy or responded to advertisements for patients with a family history of colorectal cancer). Because the study lacked a control group, the conclusions drawn about the effectiveness of colonoscopy versus sigmoidoscopy resulted from the location of the cancers found in the

participants (i.e., if the cancer was found in a part of the colon not accessible by sigmoidoscopy, it was determined it would have been missed by sigmoidoscopy). Further, the study did not estimate any potential reductions in death rates offered by screening with colonoscopy as compared to sigmoidoscopy. Therefore, while the study confirmed the prevailing knowledge that a colonoscopy can identify cancers which a sigmoidoscopy may miss (primarily because a colonoscopy examines the full colon while a sigmoidoscopy examines only a portion of the colon), it did not quantify any potential benefits in mortality reduction. Again, because the study results were published in the *New England Journal of Medicine*, they appear to be the results of a professionally accepted trial.

In one letter, a physician states that, "in the last 10 years we have seen a number of landmark studies which show quite convincingly that colorectal cancer screening works. ... This is an instance where a large body of work done by thousands of researchers in hundreds of thousands of patients have convincingly shown the benefits of these services." Another physician wrote that, "accumulated weight of data from numerous clinical studies have shown the effectiveness of colorectal cancer screening." Neither physician, however, provided copies of such studies or data to support these statements.

Submissions did not include information concerning clinical trials addressing the efficacy of screening with double contrast barium enema.

Finally, while not comparing the results of different screening tests, the submission from Blue Cross of Northeastern Pennsylvania noted that the Pennsylvania Department of Health, in cooperation with the University of Pittsburgh, is currently conducting a study in western Pennsylvania on *increasing the use* of the flexible sigmoidoscopy as a screening tool. "Specifically, the study is to determine if promoting the use of the flexible sigmoidoscopy as a screening tool for colorectal cancer increases its use among high-risk individuals. The study began with an initial survey of the public and health care professionals to determine current screening practices, knowledge of guidelines, and other pertinent information."

- (vi) Where the proposed benefit would mandate coverage of an additional class of practitioners, the results of at least one professionally accepted, controlled trial comparing the medical results achieved by the additional class of practitioners and those practitioners already covered by the benefits.**

Senate Bill 636 does not mandate coverage of an additional class of practitioners.

- (vii) The results of any other relevant research.**

Discussion of the research submitted to the Council is included elsewhere in this report.

**(viii) Evidence of the financial impact of the proposed legislation**

**(A) The extent to which the proposed benefit would increase or decrease the cost for treatment or service.**

According to information from the Centers for Disease Control and Prevention (CDC), as submitted by Highmark, the following costs are a typical range of rates for colorectal cancer screening tests. (Note: These cost estimates may not include the costs of all related services.)

- Fecal occult blood test (FOBT) - \$10 - \$25
- Flexible sigmoidoscopy - \$150 - \$300
- Combination flexible sigmoidoscopy and fecal occult blood test (see above)
- Colonoscopy - \$800 - \$1,600
- Double-contrast barium enema - \$250 - \$500

No other estimates of the cost of the screening tests were submitted. Further, no information was submitted to determine whether the costs of the tests would increase or decrease with enactment of the mandates in Senate Bill 636. Therefore, the extent to which Senate Bill 636 would increase or decrease the cost of colorectal cancer screening cannot be determined.

**(B) The extent to which similar mandated benefits in other states have affected charges, costs and payments for services.**

Highmark's submission stated that, "12 states currently have some form of a health insurance benefit mandate for colorectal cancer screening. ... The following states require health insurance plans to provide coverage for colorectal cancer screening: Connecticut, Delaware, Illinois, Indiana, Maryland, North Carolina, Rhode Island, Texas, Virginia, West Virginia, and Wyoming. Oklahoma's law requires health insurers to offer colorectal screening as a benefit option to purchasers." Highmark also noted that, "half of the laws on the books were passed in 2001."

Submissions did not address the financial impact similar legislation has had in these other states. Because almost all of other states enacted such mandates in either 2000 or 2001, it is likely that data is not yet available to discuss subsequent effects on improved detection, screening, treatment or morbidity levels or health insurance cost increases. Therefore, the extent to which similar mandates in other states have affected charges, costs or payments for services cannot be determined.

**(C) The extent to which the proposed benefit would increase the appropriate use of the treatment or service.**

It is unknown how many additional people will undergo colorectal cancer screening if the tests are covered by insurance. It may be reasonable to assume, however, that people who currently do not have coverage for colorectal cancer screening would follow similar utilization patterns to people who currently have coverage if coverage were extended to them.

**(D) The impact of the proposed benefit on administrative expenses of health care insurers.**

Highmark actuaries estimate that they will realize approximately \$1 million annually in administrative costs associated with the proposed mandate. According to Highmark, “mandates always present a series of challenges when it comes time for administration. Hundreds of man-hours are expended in preparation for adding a new benefit, i.e., claims processing system changes, revising benefit booklets and summary plan descriptions, communicating information to groups during the renewal process, etc.”

While no other insurer provided specific administrative cost estimates, other submissions – including Blue Cross of Northeastern Pennsylvania, the Insurance Federation, and the Managed Care Association – addressed the anticipated increase in administrative costs. Among the concerns they expressed were not only that insurers who do not currently offer the benefits would experience administrative costs, but also that even insurers who do currently offer coverage may incur additional administrative costs to incorporate some of the features of Senate Bill 636. For example, the provisions in the bill which tie the coverage to the most recent guidelines of the American Cancer Society and would allow the Department of Health to identify other colorectal cancer screening tests may necessitate administrative costs associated with the rewriting of policies to include these provisions. In addition, Senate Bill 636 has a provision which would allow the screenings to be administered by a non-participating provider in the event that a network does not have an appropriate provider that is not either “available” to or “accessible” to the patient. Because such non-network services would have to be provided to patients “at no additional cost” than what they would have paid for in-network services, the plan would have to assume the administrative costs of negotiating rates with non-participating providers.

The Managed Care Association of Pennsylvania expressed concern that the cost impact of any proposed mandate should be viewed along with the cost of existing mandates as well as the increasing cost of regulation.” The Association also notes that in June of 2001, “the Pennsylvania Department of Health finalized its Managed Care regulations. Health insurers have expended significant resources as they implement these regulations as well as those imposed by HIPAA and Gramm-Leach-Bliley. These requirements will critically impact the cost of health care.” The Managed Care Association did not provide specific figures as to the costs incurred by implementing these regulations.

**(E) The impact of the proposed benefits on benefits costs of purchasers.**

In general, the cost figures provided to the Council either varied greatly or were not substantiated with data.

The American Cancer Society stated that the cost of “offering coverage to the full range of colorectal cancer screening tools is actually very affordable.” Their submission states that, “When plans begin coverage of fecal occult blood testing, the benefit costs members about 47 cents per member per month. If a health plan is already offering FOBT, adding a colonoscopy benefit will cost only eight cents more per member per month. Plans can actually save 11 cents per member per month if beneficiaries have a colonoscopy every 10 years instead of the FOBT/flexible sigmoidoscopy combination.” Given these figures concerning a fecal occult blood testing benefit and a colonoscopy benefit, it can be estimated that the combination of the two benefits costs 55 cents per member per month or \$6.60 per member per year. (This estimate does not include benefits for sigmoidoscopy or double contrast barium enema which would also be mandated by Senate Bill 636.)

Highmark provided actuarial projections that indicate the cost of mandating the proposed benefits to its subscribers and members will exceed \$9 million annually; however, neither the American Cancer Society nor Highmark submitted any data to further explain or verify their cost estimates.

While recognizing that utilization may or may not change if Senate Bill 636 is enacted, one submission included information using varying utilization figures to estimate the potential costs if utilization does increase. Blue Cross of Northeastern PA theorized the following cost impacts for its members:

For the Screening Procedure...	If Utilization Increased by...	Costs would increase by...
Fecal Occult Blood Test	1%	\$4,076
	5%	\$20,380
	10%	\$40,759
	20%	\$81,518
Sigmoidoscopy	1%	\$118,583
	5%	\$592,141
	10%	\$1,184,281
	20%	\$2,368,562
Colonoscopy	1%	\$150,583
	5%	\$752,913
	10%	\$1,505,826
	20%	\$3,022,652

While the potential cost increase associated with the fecal occult blood test is relatively small, it should be recognized that these tests are most often recommended in conjunction with a sigmoidoscopy.

The Insurance Federation estimated that while there will be little or no financial impact for plans which already provide these benefits, “for plans taking this on for the first time something on the order of \$150 per person per year would have to be amortized for those number of individuals in the work force of the requisite age [i.e., those age 50 and over or those at high risk for colorectal cancer who would be eligible for benefits under Senate Bill 636].” The Federation continues that, “for small employer policies that [potential increase] could be significant.”

Several submissions stated that additional costs (including administrative costs) incurred by health insurers in response to Senate Bill 636 would be passed on to employers and purchasers in the form of higher insurance premiums. As discussed in section (iii) above, employers, in turn, would likely pass some of the costs along to their employees through increased employee cost-sharing and in the worst-case scenario, additional costs could force employers and/or individuals to drop health insurance coverage altogether.

**(F) The impact of the proposed benefits on the total cost of health care within the Commonwealth.**

Colorectal Cancer Screening Costs

**Population to be Affected.** According to 2000 Census, there are 1,928,007 people in the 50-64 age bracket who would be eligible for the benefits proposed in Senate Bill 636. The vast majority of people over age 65 already have coverage for the screening through Medicare Part B. Information is not available to determine the number of people below age 50 who may benefit from Senate Bill 636 because they are at high risk for colorectal cancer according to the American Cancer Society.

**Percentage of Population Already Covered.** Based on information submitted by the Insurance Federation, mandates such as this (i.e., those which apply to all private group plans and individually purchased policies) will cover only about 42 percent of the state’s population due to ERISA. Based on information on managed care penetration supplied by the Department of Health, it was further estimated that 45 percent of the eligible population already has coverage for the proposed screening through gatekeeper managed care plans (which are likely to already offer colorectal cancer screening tests as preventive screenings). It is also estimated that approximately 8.3 percent of the population does not have insurance coverage.<sup>9</sup> *The potential pool of beneficiaries between age 50 and 64, therefore, after accounting for ERISA exemptions, the uninsured and existing coverage, is approximately 408,404.* Again, the Council received insufficient information to estimate the number of people *under age 50* who may benefit from Senate Bill 636 because they are at high risk for colorectal cancer.

**Colorectal Cancer Screening Procedure Costs.** Based on information from the Centers for Disease Control and Prevention (CDC), as provided by Highmark, the following costs are a typical range of rates for colorectal cancer screening tests. The midpoint of each range (noted below) was used in the Council’s cost estimate. Insurer administrative expenses would add an additional 10 percent per year to the cost of the mandate.

- Fecal occult blood test (FOBT) - \$10 - \$25. Midpoint - \$17.50.
- Flexible sigmoidoscopy - \$150 - \$300. Midpoint - \$225.
- Combination flexible sigmoidoscopy and fecal occult blood test (see above).
- Colonoscopy - \$800 - \$1,600. Midpoint - \$1,200.
- Double-contrast barium enema - \$250 - \$500. Midpoint - \$375.

### **Projected Costs.**

In projecting costs, much will depend on utilization; however, the Council was not provided with information to determine the number of eligible individuals who would likely undergo colorectal cancer screening if the proposed mandate were enacted. While proponents hope that utilization will increase, they did not provide information to estimate the amount of change. On the other hand, some submissions pointed to the fact that when coverage is currently available, it is not widely used (for example due to the invasive nature of the tests, low level of awareness about colorectal cancer, etc.). It may be reasonable to assume, however, that utilization patterns among people gaining coverage for the tests under Senate Bill 636 would be similar to generalized utilization patterns.

The Council estimated the potential costs of colorectal cancer screening using both general utilization patterns and the goals for colorectal cancer screening put forth in Healthy People 2010.

### **Estimate based on current utilization rates**

Figures from the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS) estimated that 34 percent of Pennsylvanians between ages 50 and 64 have ever undergone fecal occult blood test (FOBT) screening in 1999; of those screened, 72 percent (representing 24.5 percent of the age 50-64 population) utilized an FOBT screening in the prior two years. (It is not known what insurance coverage, if any, these respondents may have had.) Based on this estimate, it was estimated that 12.5 percent of the eligible population (i.e., those age 50-64) would make use of FOBT in any given year.

Using the 1999 BRFSS again, the Council further estimated that 33 percent of Pennsylvanians between 50 and 64 have ever undergone a sigmoidoscopy or colonoscopy and that 72 percent of those (representing 24 percent of the age 50-64 population) utilized a sigmoidoscopy or colonoscopy in the past five years. Because the data did not indicate which procedure – sigmoidoscopy or colonoscopy – people underwent, it was assumed that they were equally utilized. It was therefore assumed that 12 percent of the eligible population (i.e., those age 50-64) will make use of a sigmoidoscopy every 5 years, with an equal portion of those (i.e., 2.4 percent) undergoing sigmoidoscopy in any given year, and 12 percent of the eligible population (i.e., those age 50-64) will make use of a colonoscopy every 10 years, with an equal portion of those (i.e., 1.2 percent) undergoing colonoscopy in any given year.

Because of the Council's understanding that double contrast barium enema (DCBE) is not used as often for colorectal cancer screening as are the other procedures, it was

assumed that the use of DCBE would be small enough not to have a significant impact on costs. The use of DCBE was therefore not included in this cost analysis.

Therefore, based on the above assumptions concerning the eligible population (i.e., 408,404 people), procedure costs (including administrative expenses), and utilization (i.e., 12.5% of the eligible population underwent FOBT screening in any given year, 2.4% of the eligible population underwent sigmoidoscopy in any given year, and 1.2% of the eligible population underwent colonoscopy in any given year), the Council estimated the benefits contained in Senate Bill 636 to cost \$9.9 million annually.

### **Estimate based on screening goals in Healthy People 2010**

Figures from the U.S. Department of Health and Human Services Healthy People 2010 Project set a target goal for 50 percent of adults aged 50 years and older to receive a fecal occult blood test (FOBT) screening within the preceding two years. Based on this target, it was estimated that 25 percent of the eligible population (i.e., those age 50-64) would make use of FOBT in any given year.

Healthy People 2010 also set a target that 50 percent of adults aged 50 years and older will have ever received a sigmoidoscopy. The Council assumed that it is hoped that the 50 percent of the population who received a sigmoidoscopy would continue to do so on a regular basis (currently recommend once every 5 years). It was therefore assumed that 50 percent of the eligible population (i.e., those age 50-64) will make use of a sigmoidoscopy every 5 years, with an equal portion of those (i.e., 10 percent) undergoing sigmoidoscopy in any given year.

Therefore, based on the above assumptions concerning the eligible population (i.e., 408,404 people), procedure costs (including administrative expenses), and utilization (i.e., 25% of the eligible population underwent FOBT screening in any given year and 10% of the eligible population underwent sigmoidoscopy in any given year), the Council estimated the benefits contained in Senate Bill 636 to cost \$12.1 million annually. Because Healthy People 2010 did not include targets for colonoscopy or double contrast barium enema, they were excluded from this analysis.

If, however, some of those people targeted to undergo a sigmoidoscopy instead underwent a colonoscopy, the costs could increase substantially since the cost of a colonoscopy is more than five times greater than the cost of a sigmoidoscopy. For example, the entire population targeted to undergo a sigmoidoscopy (50 percent of the population) may instead undergo a colonoscopy. Based on the estimate that 50 percent of the eligible population would make use of a sigmoidoscopy every 5 years (the recommended interval for sigmoidoscopy), it was estimated that 50 percent of the eligible population would make use of a colonoscopy every 10 years (the recommended interval for colonoscopy), with an equal portion of those (i.e., 5 percent) undergoing colonoscopy in any given year. Based upon this assumption, (i.e., 25% of the eligible population underwent FOBT screening in any given year, and 5% of the eligible population underwent colonoscopy in any given year), the Council estimated the benefits contained in Senate Bill 636 to cost \$28.9 million annually.

Neither of these cost estimates includes the costs associated with any follow-up or diagnostic testing.

It should also be recognizing that the costs of the mandate would be spread across a larger group than those who utilize the screening. For example, each insurer will have their own way of assessing costs and the costs may be spread across the entire insured population aged 50-64, the entire population with commercial insurance, or some combination thereof. The Council, therefore, did not assess how individual premiums would be affected by this mandate.

### **Potential Cost Savings.**

One physician, in her letter of support, referred to potential “cost savings based on not only the cost of surgeries that could be avoided but also the cost to families of losing family members at an early age and the cost of having to provide care for sick relatives.” No specific data, however, was provided.

According to the American Cancer Society, “a precancerous polyp can be removed during screening for about \$1,100 – this removal actually prevents the polyp from ever becoming cancer. However, if that polyp goes undetected and develops into stage four colorectal cancer – treatment costs can reach up to \$58,000.” ACS also states that, “the initial cost of treating rectal cancer that is detected early is about \$5,700. This is approximately 75% less than the estimated \$30,000 - \$40,000 that is costs to initially treat rectal cancer that is detected further in its development.”

While it is hoped that increased utilization of colorectal cancer screening procedures will lead to a shift in stage of diagnosis so that more cancers are detected at an early stage, no data was provided to estimate the extent to which this change would occur. Without such information, the Council was not able to determine the expected number of percent of identified colorectal cancer cases diagnosed in an early stage as a result of enactment of Senate Bill 636 and was therefore unable to accurately assess the potential cost savings associated with this bill.

## **Submissions for Senate Bill 636**

### AFLAC – The American Family Life Assurance Company of Columbus (Richard J. Gmerek)

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### Colon Cancer Alliance (Sandra White, Board Advocacy Liaison)

1. Letter supporting Senate Bill 636 dated February 21, 2002.

Highmark (Bruce R. Hironimus, Vice President of Government Affairs)

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Managed Care Association of Pennsylvania (Delores Hodgkiss, Executive Director)

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Thomas J. McGarrity, M.D. Graham H. Jeffries Professor of Medicine

1. Letter supporting Senate Bill 636 dated February 11, 2002.

Milton S. Hershey Medical Center, Penn State College of Medicine (Ann Ouyang, M.D. Professor of Medicine and Chief, Division of Gastroenterology & Hepatology)

1. Letter supporting Senate Bill 636 received February 19, 2002.

National Federation of Independent Business (Stephanie R. Larkin, Pennsylvania Assistant State Director)

1. Letter opposing Senate Bill 636 dated November 9, 2001

Pennsylvania Business Roundtable (Megan A. Milford, Vice President)

1. Letter opposing Senate Bill 636 dated December 26, 2001.

University of Pittsburgh Physicians (Robert E. Schoen, M.D., M.P.H., Associate Professor of Medicine and Epidemiology, Division of Gastroenterology, Hepatology, and Nutrition, University of Pittsburgh Medical Center)

1. Letter supporting Senate Bill 636 dated February 21, 2002.

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[http://www.cancer.org/eprise/main/docroot/CRI/content/CRI\\_2\\_4\\_3X\\_Can\\_colon\\_and\\_rectum\\_cancer\\_be\\_found\\_early?sitearea=CR](http://www.cancer.org/eprise/main/docroot/CRI/content/CRI_2_4_3X_Can_colon_and_rectum_cancer_be_found_early?sitearea=CR) as accessed on February 12, 2002.
- <sup>2</sup> Pennsylvania Department of Health Web site  
<http://webserver.health.state.pa.us/health/lib/health/colon.pdf> as accessed on March 26, 2002.
- <sup>3</sup> "Understanding Colorectal Cancer Screening: A Consumer Education Brochure."  
American College of Gastroenterology.
- <sup>4</sup> "Colorectal Cancer Screening Proven Effective – Few Informed of Its Downside." *HealthFacts*.  
April 1999. Accessed from the Web site  
[http://www.findarticles.com/cf\\_dls/m0815/1999\\_April/54425465/print.jhtml](http://www.findarticles.com/cf_dls/m0815/1999_April/54425465/print.jhtml) on November 8, 2001.
- <sup>5</sup> As quoted from the *Record of the Society of Actuaries*, Vol. 16, No. 1, in Highmark's *Mandated Benefit Submission to the Pennsylvania Health Care Cost Containment Council: Senate Bill 636: Colorectal Cancer Screening Mandate*. December 27, 2001
- <sup>6</sup> "Colorectal Cancer Screening Proven Effective – Few Informed of Its Downside." *HealthFacts*.  
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[http://www.findarticles.com/cf\\_dls/m0815/1999\\_April/54425465/print.jhtml](http://www.findarticles.com/cf_dls/m0815/1999_April/54425465/print.jhtml) on November 8, 2001.
- <sup>7</sup> "Colorectal Cancer Screening Proven Effective – Few Informed of Its Downside." *HealthFacts*.  
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[http://www.findarticles.com/cf\\_dls/m0815/1999\\_April/54425465/print.jhtml](http://www.findarticles.com/cf_dls/m0815/1999_April/54425465/print.jhtml) on November 8, 2001.
- <sup>8</sup> Lieberman D, Weiss D, Bond J et al. "Use of Colonoscopy to Screen Asymptomatic Adults for Colorectal Cancer." *New England Journal of Medicine*. Volume 343, Number 3. July 20, 2000. pp. 162-168.
- <sup>9</sup> *Health Insurance Coverage: 2000*. U.S. Census Bureau. September 2001.