Hawaii Pacific Health

55 Merchant Street • Honolulu, Hawaii 96813 • hawaiipacifichealth.org

Friday – January 22, 2010
Conference Room 329
11:00 am

LATE TESTIMONY

The House Committee on Health

To: Representative Ryan H. Yamane, Chair
Representative Scott Y. Nishimoto, Vice Chair

From: Virginia Pressler, MD, MBA
Executive Vice President

Re: Testimony in Strong Support HB 823, Relating to Health Insurance

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My name is Virginia Pressler, Executive Vice President for Hawaii Pacific Health (HPH). For more than a century, families in Hawaii and the Pacific Region have relied on the hospitals, clinics, physicians and staff of Hawaii Pacific Health as trusted healthcare providers. Our non-profit integrated healthcare system is the state's largest healthcare provider and is committed to improving the health and well-being of the people of Hawaii and the Pacific Region through its four hospitals -- Kapi`olani Medical Center for Women & Children, Kapiolani Medical Center at Pali Momi, Straub Clinic & Hospital and Wilcox Memorial Hospital -- 18 outpatient centers and a team of 1,100 physicians on the islands of Oahu, Kauai and Lanai.

We are in strong support of HB 823, which mandates health insurance coverage for colorectal cancer screening and requires insurers to provide the insured with information about the risks of undiagnosed colorectal cancer.

While there are many reasons for low rates of colorectal cancer screening, insurance coverage is certainly a contributing factor. Limits on covered benefits impede an individual's access to the benefits of early detection of/or screening for cancer. The cost for providing colorectal cancer screening is extremely low when compared to the cost of treatment. We support HB 823 since for only few cents per individual per month as Hawai'i colon cancer death incident rates as well as medical costs will be reduced.

We are in strong support of HB 823.

American Cancer Society

LATE TESTIMONY

The Official Sponsor of Birthdays

January 21, 2010

Committee on Health
Representative Ryan Yamane, Chair
Representative Scott Nishimoto, Vice Chair

Hearing:
11:00 A.M. Friday, January 22, 2010
Hawaii State Capitol, Room 329

RE: HB823-Relating to Health Insurance

Testimony in Strong Support

Chair Yamane, Vice Chair Nishimoto, and members of the Committee on Health. Thank you for the opportunity to once again testify in strong support of HB823, which will require health insurance coverage for colorectal cancer screening including the use of colonoscopy.

As the Chair is aware, last year the American Cancer Society offered extensive testimony on the benefits of early detection and treatment of colorectal cancer. Colorectal cancer is the third most common cancer in the United States. 154,000 new cases were diagnosed in 2007. With almost 50,000 deaths a year, it is the second leading cause of cancer deaths among men and women. In Hawaii, over 700 of our residents will develop colon cancer and approximately 210 will die.

When colorectal cancer is diagnosed at the earliest stage, the five year survival rate is 90%. However, after the cancer spreads, the five year survival rate plunges to 10%. **When detected early, the pain and suffering due to cancer diagnosis can be completely prevented through early identification and removal of pre-cancerous polyps, detectable only through colorectal cancer screenings.**

The cost of colonoscopy as a screening option is literally pennies a day compared to the cost of treating colorectal cancer which greatly varies. When detected early the cost is between $30,000 and $35,000. If detected late, the average cost is in excess of $100,000. Clearly the cost for providing colorectal cancer screening is extremely low when compared to the cost of treatment.

In Hawaii, only 53.7% of our residents over the age of 50 reported having a colorectal cancer screening exam. One of the reasons for this low screening rate was health insurance coverage. From studies conduced across the nation it has been shown that limits on covered benefits are a factor on an individual's decision to request colonoscopy as a screening option, **and primary care physicians often do not refer people for tests if they believe those tests will not be covered by health insurance.**

American Cancer Society Hawai'i Pacific, Inc., 2370 Nu'uanu Avenue, Honolulu, Hawaii 96817-1714
•Phone: (808) 595-7500 •Fax: (808) 595-7502 •24-Hour Cancer Info: (800) 227-2345 •http://www.cancer.org

HB823 is unique in that it incorporates the latest colorectal screening guidelines which were developed collaboratively between the American Cancer Society, the American College of Radiology, and the U.S. Multi-Society Task Force on Colorectal Cancer which includes the American College of Gastroenterology and the American College of Physicians.

These colorectal screening guidelines emphasize **"options"** because:

- Individuals differ in their preferences for one test or another. It is a fact that not everyone will elect to have a colonoscopy.
- Colonoscopy access is uneven geographically in Hawaii, however other tests are available.
- Primary care physicians differ in their ability to offer, explain, or refer patients to all options equally.
- The utilization of colonoscopy in Hawaii is still low, with only 53.7% of all adults reporting a FOBT/sigmoidoscopy or colonoscopy.
- Providing a wide range of test will enhance screening rates.

We offer a comment on SECTION 1 ""**§431:10A- Colon cancer screening coverage.** (b) Beginning January 1, 2010, a health care coverage provider shall include information in the policy about the risk associated with undiagnosed colorectal cancer and encourage the insured to consult with the insured's physician about available screening options. For the purposes of section 432D-23, the requirement under this subsection shall be considered one of the benefits of coverage.""

HB823 is a good bill. For only a few cents per insured individual per month, it will dramatically reduce colon cancer death and incidents rates in Hawaii. As everyone on the committee knows, cancer does not distinguish between Democrats or Republicans, rich or poor, young or old, insured or uninsured, male or female. It is an equal opportunity disease impacting victims, caregivers, and love ones. HB823, if enacted, can lead to the defeat of the second deadliest cancer in Hawaii.

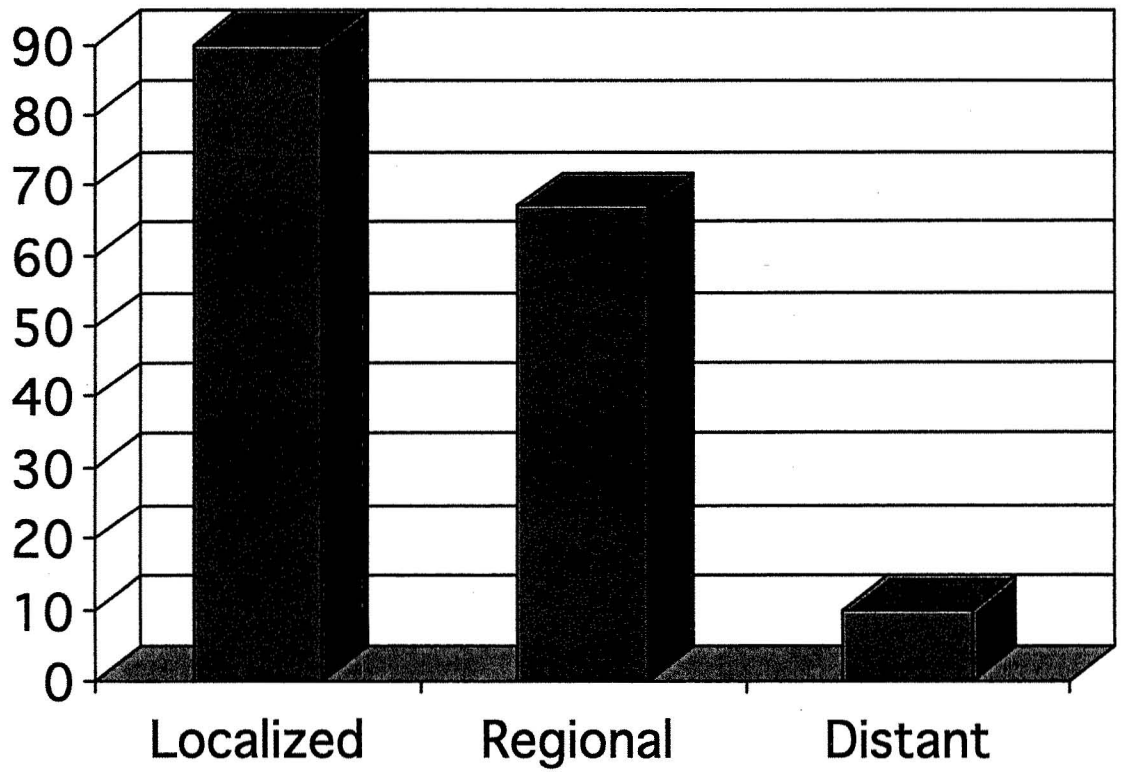
Mahalo once again for the opportunity to provide testimony in very strong support this measure.

Sincerely,

George S. Massengale, JD
Director of Government Relations

Early Detection Improves Survival

Five-Year Relative Survival Rates for CRC Cancer by Stage at Diagnosis, 1995-2000



Results:
Short Term Costs of Colorectal Cancer Screening

ANNUAL FOBT/FLEX SIG	
Per Member Per Month Costs	$.66
COLONOSCOPY@10 years	
Per Member Per Month Costs	$.55

Colonoscopy is a less costly screening strategy than Annual FOBT/Flex Sig every 5 years by *11 cents PMPM*.

For the majority of insurers who are already covering Annual FOBT/Flex Sig, colonoscopy screening coverage can be added for little or no cost.

In order to ensure that these costs, which are intuitively low, are affordable for insurers, it was necessary to compare this data with a high volume screening test already covered by insurers.

January 22, 2010

The Honorable Ryan Yamane, Chair
The Honorable Scott Nishimoto, Vice Chair
House Committee on Health

Re: HB 823 – Relating to Health Insurance

Dear Chair Yamane, Vice Chair Nishimoto and Members of the Committee:

My name is Howard Lee and I am President of the Hawaii Association of Health Plans ("HAHP"). HAHP is a non-profit organization consisting of seven (7) member organizations:

AlohaCare
Hawaii Medical Assurance Association
HMSA
Hawaii-Western Management Group, Inc.
MDX Hawai'i
University Health Alliance
UnitedHealthcare

Our mission is to promote initiatives aimed at improving the overall health of Hawaii. We are also active participants in the legislative process. Before providing any testimony at a Legislative hearing, all HAHP member organizations must be in unanimous agreement of the statement or position.

HAHP appreciates the opportunity to testify in opposition to HB 823 which would require health plans provide colon cancer screenings which follow guidelines supported by American Cancer Society (ACS), the U.S. Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology, which include the following: colonoscopy, flexible sigmoidoscopy, double contrast barium enema, CT colonoscopy (virtual colonoscopy), fecal occult blood test (FOBT), fecal immunochemical test (FIT), and stool DNA test (sDNA). While HAHP supports ensuring medically appropriate colon cancer screenings are available for our members, we are unable to support this measure and oppose the language contained in HB 823.

There are three main reasons why HAHP member organizations do not support the expanded set of screening guidelines being proposed by ACS.

First, two of the screening methods listed in the mandate (CT colonography and fecal DNA testing) are not recommended by the U.S. Preventive Services Task Force (USPSTF) in their report of November 4, 2008. "The USPSTF concludes that the current evidence is

insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined." The USPSTF also recommends that screening be done for individuals aged 50 to 75 years, and states in their guidelines that risks outweigh benefits for patients who are older than age 75. Colorectal screening guidelines are not uniformly "settled science."

Second, we believe that with an expanded set of screening guidelines, Hawaii providers already in short supply (i.e. gastroenterologists) will be further stretched. Although we cannot state this with certainty, HAHP is concerned that Hawaii does not have the capacity to fulfill this mandate successfully. HAHP member organizations are concerned that individuals who truly are in a high-risk category will be forced to wait longer for a medically appropriate invasive colorectal screening (i.e. colonoscopy) and may face worse medical outcomes as a result.

Finally, it is also important to remember that Hawaii's employers bear the cost of any mandated benefit. With the exception of FOBT, none of the tests listed in the mandate are inexpensive; if enacted, this mandate will be costly. With the economic downturn continuing to have no end in sight, we believe that any legislation that would increase health care costs should be closely scrutinized prior to passage.

One final thought: passage of health care reform on the national level has implications for Hawai'i which are currently unknown to both providers and insurers. While reform is necessary throughout the health care system, it may be prudent to delay making these types of changes at this time.

Thank you for the opportunity to offer comments today.

Sincerely,

Howard K F Lee

Howard Lee
President

Points to make:

- Health Plans does not oppose preventive screenings, in fact we promote it. Example includes UHA's booklet and HMSA's health pass. To mandate that we promote it is not necessary.
- Mandating what should be covered leads to unintended consequences. Again, we support and pay for preventive screening, but to mandate this benefit can lead to unintended consequences of higher cost, including fraud and abuse, and potential harm to the patient. In addition, you mandating a 2008 standard (not the gold standard), which if it becomes law may be already outdated. Our testimony explains what the current USPTF (the gold standard of practice) says, so I won't reiterate that. But let me read to you what the American College of Gastroenterology says about CT Colonography.

The next 7 pages were added to the HAHP testimony.

AMERICAN COLLEGE OF GASTROENTEROLOGY

Virtual Colonoscopy: Frequently Asked Questions about CT Colonography

1. What is CT colonography?

   CT colonography, often referred to as "virtual colonoscopy," is a CT scan x-ray test designed to simulate colonoscopy to look for large colon polyps and cancers. This test has been recommended in people without symptoms to screen for colon polyps and cancers.

2. What happens during a CT colonography?

   First, a radiology technician inserts a tube into your rectum and gas is pumped into the colon until it is fully expanded. Then you are asked to hold your breath while lying on your back and a CT scan is performed. You then turn over onto your stomach and again hold your breath while a second CT scan of the abdomen and pelvis is performed.

3. Does it require bowel cleansing (laxatives)?

   Yes. The bowel-cleansing regimen is the same as that for colonoscopy. On the day before the procedure, you stay on clear liquids all day and on the evening before and the morning of the procedure, laxatives are taken to flush waste from the colon.

4. Is CT colonography painful?

   Because no sedation is used, the expansion of the colon with gas can be painful. In some studies, patients reported more pain and discomfort with CT colonography than with a colonoscopy. Colonoscopy may be more comfortable because sedatives are given during the examination.

5. What happens after the test?

   The radiologist will examine the colon and other structures within the pelvis and abdomen and generate a report for the physician who ordered the test. Sometimes information about polyps in the colon is known immediately. If so, some radiology centers and endoscopy units are equipped to perform colonoscopy and remove the polyp on the same day without having to repeat the bowel preparation. If not, colonoscopy will need to be performed another day after the bowel is cleansed.

6. What are the advantages of CT colonography?

   CT colonography is less invasive than colonoscopy. It has a lower risk of perforation of the colon. CT colonography is typically performed without sedation, so no driver is needed. CT colonography occasionally identifies an important abnormality outside of the colon, such as a large abdominal aortic aneurysm or a possible cancer.

7. How accurate is CT colonography?

   According to the most recent large study performed in the United States, CT colonography is 90% sensitive for the detection of patients with a polyp 1cm or larger in size. These large polyps constitute about 10% of all colorectal polyps and are the most likely to develop into cancer. For polyps less than 1cm in size, the sensitivity of CT colonography falls off rapidly. For polyps 6 to 9mm in size the sensitivity of CT colonography is well below 90%. For polyps 5mm and smaller, which constitute about 80% of all precancerous polyps in the colon, CT colonography is unreliable. Radiologists are currently advised to not attempt interpretation of polyps 5mm and smaller in size. CT colonography also produces a considerable number of "false positives." This means that if a radiologist finds a polyp on CT colonography, there is a less than 50% chance that a polyp is actually present at the colonoscopy.

8. How often is a colonoscopy needed to remove polyps?

   The older the patient, the greater the chance that a polyp will be detected that requires a complete colonoscopy. In the hands of the best CT colonographers, about 12% of patients undergoing CT colonography will require colonoscopy and polypectomy, but in older populations this number increases to 20 to 25%.

9. Is CT colonography paid for by insurance?

   Currently, CT colonography is usually paid for if a colonoscopy is unable to be completed, or when cancer is detected by colonoscopy and the cancer blocks passage of the colonoscope. The Center for Medicare and Medicaid Services recently decided to not cover CT colonography for screening for Medicare patients. Some private insurers currently cover CT colonography for screening, so you should check with your insurer.

10. How often should CT colonography be repeated?

    CT colonography is currently recommended at 5 year intervals if the study is normal. Colonoscopy is recommended at 10 year intervals. The difference in intervals between the two tests is accounted for CT colonography's lack of efficacy at detecting small colon polyps, and current uncertainty about how often these polyps will turn into cancer.

11. Are there risks to CT colonography?

    The immediate risks of CTC include a small rate of perforation related to gas distension, which is lower than the risk from colonoscopy. Potential long-term risks include missing small polyps that could develop into cancer. The risk from radiation exposure is uncertain. The radiation dose from a CT colonography is equivalent to several hundred chest x-rays. One expert estimated that a 50 year old patient undergoing CT colonography would have a 1 in 714 chance of developing a solid tumor from radiation. This risk is substantially higher than the risk of perforation from colonoscopy. The U.S. Preventative Services Task Force cited radiation risk as one of the factors underlying their decision to not endorse CT colonography as a colorectal cancer screening test. The final risk pertains to findings seen on CT scan outside the colon, which usually are incidental and of no significance. However, they often lead to the significant inconvenience, cost, and risk of additional follow-up x-ray tests to further characterize these incidental findings.

SCREENING FOR COLORECTAL CANCER
CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

Population	Adults Age 50 to 75 Years*	Adults Age 76 to 85 Years*	Adults Older Than 85 Years*
Recommendation	Screen with high-sensitivity FOBT, sigmoidoscopy, or colonoscopy Grade: A	Do not screen routinely Grade: C	Do not screen Grade: D
	For all populations, evidence is insufficient to assess the benefits and harms of screening with computed tomographic colonography and fecal DNA testing. Grade: I (insufficient evidence)		

Screening tests	High-sensitivity FOBT, sigmoidoscopy with FOBT, and colonoscopy are effective in decreasing colorectal cancer mortality. The risks and benefits of these screening methods vary. Colonoscopy and flexible sigmoidoscopy do a lesser degree entail possible serious complications.	
Screening test intervals	**Intervals for recommended screening strategies:** • Annual screening with high-sensitivity FOBT • Sigmoidoscopy every 5 years with high-sensitivity FOBT every 3 years • Screening colonoscopy every 10 years	
Balance of Harms and Benefits	The benefits of screening outweigh the potential harms for 50- to 75-year-olds.	The likelihood that detection and early intervention will yield a mortality benefit declines after age 75 because of the long average time between adenoma development and cancer diagnosis.
Implementation	Focus on strategies that maximize the number of individuals who get screened. Practice diverse decision making; discussions with patients should incorporate information on test quality and availability. Individuals with a personal history of cancer or adenomatous polyps are followed by a surveillance regimen; and screening guidelines are not applicable.	
Relevant USPSTF Recommendations	The USPSTF recommends against the use of aspirin or nonsteroidal anti-inflammatory drugs for the primary prevention of colorectal cancer. This recommendation is available at www.preventiveservices.ahrq.gov.	

U.S. Preventive Services Task Force

About USPSTF

The U.S. Preventive Services Task Force (USPSTF), first convened by the U.S. Public Health Service in 1984, and since 1998 sponsored by the Agency for Healthcare Research and Quality (AHRQ), is the leading independent panel of private-sector experts in prevention and primary care. The USPSTF conducts rigorous, impartial assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications. Its recommendations are considered the "gold standard" for clinical preventive services.

The mission of the USPSTF is to evaluate the benefits of individual services based on age, gender, and risk factors for disease; make recommendations about which preventive services should be incorporated routinely into primary medical care and for which populations; and identify a research agenda for clinical preventive care.

Background and Mission

Public Law Section 915 mandates that AHRQ convene the USPSTF to conduct scientific evidence reviews of a broad array of clinical preventive services, develop recommendations for the health care community, and provide ongoing administrative, research, technical, and dissemination support.

The Task Force's pioneering efforts began with the 1989 *Guide to Clinical Preventive Services*. A second edition of the *Guide* was published in 1996. The current *Guide to Clinical Preventive Services* is available on the Web.

Return to Contents

Process

The Task Force makes its recommendations on the basis of explicit criteria. Recommendations issued by the USPSTF are intended for use in the primary care setting. The USPSTF recommendation statements present health care providers with information about the evidence behind each recommendation, allowing clinicians to make informed decisions about implementation.*

The USPSTF is supported by an Evidence-based Practice Center (EPC). Under contract to AHRQ, the EPC conducts systematic reviews of the evidence on specific topics in clinical prevention that serve as the scientific basis for USPSTF recommendations.

The USPSTF reviews the evidence, estimates the magnitude of benefits and harms for each preventive service, reaches consensus about the net benefit for each preventive service, and issues a recommendation.

The Task Force grades the strength of the evidence from "A" (strongly recommends), "B" (recommends), "C" (no recommendation for or against), "D" (recommends against), or "I" (insufficient evidence to recommend for or against).

*From: Harris RP, Helfand M, Woolf SH, et al. Current methods of the U.S. Preventive Services Task Force: a review of the process. *Am J Prev Med* 2001;20(suppl 3):21-35.

Return to Contents

Members of the USPSTF

The USPSTF comprises primary care clinicians (e.g., internists, pediatricians, family physicians, gynecologists/obstetricians, and nurses). Individual members' interests include: decision modeling and evaluation; effectiveness in clinical preventive medicine; clinical epidemiology; the prevention of high-risk behaviors in adolescents; geriatrics; and the prevention of disability in the elderly.

Current members of the Task Force are listed below. They have recognized expertise in prevention, evidence-based medicine, and primary care.

Bruce N. Calonge, M.D., M.P.H. (Chair)
Chief Medical Officer and State Epidemiologist
Colorado Department of Public Health and Environment, Denver, CO

Susan Curry, Ph.D.
Dean, College of Public Health
Distinguished Professor
University of Iowa, Iowa City, IA

Allen J. Dietrich, M.D.
Professor, Community and Family Medicine
Dartmouth Medical School, Hanover, NH

David Grossman, M.D., M.P.H.
Medical Director, Preventive Care and Senior Investigator, Center for Health Studies, Group Health Cooperative
Professor of Health Services and Adjunct Professor of Pediatrics
University of Washington, Seattle, WA

George Isham, M.D., M.S.
Medical Director and Chief Health Officer
HealthPartners, Minneapolis, MN

Michael L. LeFevre, M.D., M.S.P.H.
Professor, Department of Family and Community Medicine
University of Missouri School of Medicine, Columbia, MO

Rosanne Leipzig, M.D., Ph.D
Professor, Geriatrics and Adult Development, Medicine, Health Policy
Mount Sinai School of Medicine, New York, NY

Joy Melnikow, M.D., M.P.H.
Professor, Department of Family and Community Medicine
Associate Director, Center for Healthcare Policy and Research
University of California Davis, Sacramento, CA

Bernadette Melnyk, Ph.D., R.N., C.P.N.P./N.P.P.
Dean and Distinguished Foundation Professor in Nursing
College of Nursing & Healthcare Innovation
Arizona State University, Phoenix, AZ

Wanda Nicholson, M.D., M.P.H., M.B.A.
Associate Professor
Johns Hopkins School of Medicine and Bloomberg School of Public Health, Baltimore, MD

J. Sanford (Sandy) Schwartz, M.D.
Leon Hess Professor of Medicine, Health Management, and Economics

University of Pennsylvania School of Medicine and Wharton School, Philadelphia, PA

Timothy Wilt, M.D., M.P.H.
Professor, Department of Medicine, Minneapolis VA Medical Center
University of Minnesota, Minneapolis, MN

Role of AHRQ Staff

It is AHRQ's mission to improve the safety, quality, efficiency, and effectiveness of health care for all Americans. The USPSTF is a prime example of the Agency's efforts to translate research on preventive medicine into practice.

In keeping with its mission and the importance of prevention, AHRQ has augmented its support staff for the USPSTF and for its prevention programs in general. The AHRQ Center for Primary Care, Prevention, and Clinical Partnerships oversees operation of the USPSTF, and provides administrative, programmatic, and technical support for the USPSTF program.

Return to Contents

Role of Partners

Partners to the U.S. Preventive Services Task Force are drawn from the fields of primary care, public health, health promotion, policy, and quality improvement. Liaisons from these groups and from Federal health agencies contribute their expertise in the peer review of draft USPSTF documents and help disseminate the work of the USPSTF to their members.

Primary care partners include:

- American Academy of Family Physicians (AAFP)
- American Academy of Nurse Practitioners (AANP)
- American Academy of Pediatrics(AAP)
- American Academy of Physician Assistants (AAPA)
- American College of Obstetricians and Gynecologists (ACOG)
- American College of Physicians (ACP)
- American College of Preventive Medicine (ACPM)
- American Osteopathic Association (AOA)
- National Association of Pediatric Nurse Practitioners (NAPNAP)

Policy, population, and quality improvement partners include:

- America's Health Insurance Plans (AHIP)
- AARP
- National Committee for Quality Assurance (NCQA)

Federal partners include:

- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- U.S. Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Veteran's Health Administration (VHA)
- Department of Defense/Military Health System (DoD/MHS)
- Office of Disease Prevention and Health Promotion (ODPHP)
- Office of the Surgeon General

Return to Contents

Impact of the USPSTF

USPSTF recommendations have formed the basis of the clinical standards for many professional societies, health organizations, and medical quality review groups. Previous editions of the Guide to Clinical Preventive Services have been used widely in undergraduate and post-graduate medical and nursing education as a key reference for teaching preventive care.

The work of the USPSTF has helped establish the importance of including prevention in primary health care, ensuring insurance coverage for effective preventive services, and holding providers and health care systems accountable for delivering effective care.

USPSTF recommendations highlight the opportunities for improving delivery of effective services and have helped others in narrowing gaps in the provision of preventive care in different populations.

Return to Contents

For More Information

Go to http://www.ahrq.gov/clinic/uspstfix.htm:

- To access recommendations made by the USPSTF and the articles that summarize the evidence on which the recommendations are based.
- To find out how to receive CD-ROM and print publications of USPSTF recommendations.
- And, to sign up for AHRQ's Prevention Program LISTSERV®.

To download the Electronic Preventive Services Selector (ePSS), a searchable PDA and online tool of USPSTF recommendations, go to: http://pda.ahrq.gov.

For more information, contact:

Therese Miller, Dr.P.H.
Project Coordinator
Center for Primary Care, Prevention, & Clinical Partnerships
Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850
Phone: (301) 427-1585
Fax: (301) 427-1597
E-mail: Therese.Miller@ahrq.hhs.gov

The recommendations of the USPSTF are made for asymptomatic populations; the recommendations made by the Task Force are not disease—or individual—specific. If you have concerns about your health, contact your medical care provider.

Return to Contents

Current as of January 2010

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About USPSTF. U.S. Preventive Services Task Force. January 2010. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/uspstfab.htm

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