State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

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Senator Russ Decker
Senate Majority Leader
Room 211 South
State Capitol
P.O. Box 7882
Madison, WI 53707-7882

Representative Michael Sheridan
Speaker of the Assembly
Room 211 West
State Capitol
P.O. Box 7882
Madison, WI 53707-7882

Dear Senator Decker and Representative Sheridan,

Pursuant to s. 601.423, Wis. Stat., I am submitting a social and financial report on 2009 Senate Bill 163, currently 2009 Wisconsin Act 346, relating to health insurance coverage of colorectal cancer screening.

2009 Wisconsin Act 346 (Senate Bill 163)

Prior to the enactment of 2009 Wisconsin Act 246 (2009 Senate Bill 163) neither Wisconsin nor federal law required disability insurance policies or governmental self-insured health plans to cover screening for colorectal cancer. Senate Bill 163, as amended by Senate amendment 1 and Assembly amendment 1, creates Sec. 632.895 (16) Wis. Stat., which requires disability insurance policies, with some exceptions, and self-insured health plans of the state, or a county, city, town, village, or school district that offer coverage of diagnostic or surgical procedures to provide coverage of colorectal examinations and laboratory tests. The coverage must be provided for all insureds or enrollees age 50 or older as well as those under 50 at high risk for colorectal cancer. The coverage required may be subject to any limitations, exclusions and cost-sharing provisions that apply generally under the disability insurance policy or self-insured governmental or school district plan.

Wisconsin Act 346 calls for the commissioner of insurance to promulgate rules, using nationally validated guidelines, including those issued by the American Cancer Society, to further define which examinations and tests must be covered as well as which factors to consider when determining if an individual is at high risk for colorectal cancer. The bill also requires the commissioner to periodically update these rules.

Administrative Rule Ins 3.35

Wisconsin Act 346 requires the commissioner to promulgate rules that specify guidelines for the coverage of colorectal cancer screening, and to specify the factors determining whether an individual is at high risk. These guidelines and factors are contained in Ins 3.35, Adm. Code, which:

- Allows insurers and self-insured governmental plans to select from among the U.S Preventive Services Task Force, the National Cancer Institute, or the American Cancer Society guidelines for colorectal cancer screening intervals and specific tests and procedures;

- Requires insurers and self-funded governmental plans to provide coverage of at least three of four screening tools: flexible sigmoidoscopy, colonoscopy, fecal occult blood test, and computerized tomographic colonography;
- Sets forth guidance on determination of whether an individual is high risk for colorectal cancer based on the American Cancer Society's guidelines;
- Requires insurers to comply with preventive services provisions of the Affordable Care Act (discussed below); and
- Requires insurers and self-funded governmental plans to annually review the selected guidelines and comply with updates in the subsequent policy year.

Federal Law

Section 2713 of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, collectively referred to as the Affordable Care Act (ACA), requires both group and individual major medical plans to cover preventive services without cost-sharing. Rule guidance relating to the section was published on July 19, 2010 which specified all plans subject to the provision are required to cover services which are rated either "A" or "B" by the United State Preventive Services Task Force (USPSTF) without cost-sharing. Colorectal cancer screening has received an "A" rating from the USPSTF. These requirements will be in effect for plans issued or renewed after September 23, 2010. Congress has also required Medicare to cover colorectal cancer screening since 1998.[1]

Social Impact Factors

Prevalence and Screening

Colorectal cancers develop in the colon (the longest part of the large intestine connecting to the small intestine) or the rectum (the last several inches of the large intestine). In both cases cancers occur when cells divide abnormally, creating tumors. Cancerous tumors may interfere with the function of the digestive tract and can spread, impacting other tissues and organs.[2] Tumors of the colon and rectum develop slowly and are usually preceded by precancerous masses called polyps.[3] Colorectal cancer incidence is highly linked to age, with over 90 percent of cancers occurring in individuals over 50 according to the American Cancer Society.

In 2009, the Wisconsin Department of Health Services (DHS) released a report analyzing cancer statistics in Wisconsin from 2002-2006. The analysis found colorectal cancer to be the third most frequently diagnosed cancer in Wisconsin for both males and females with an average of 2,891 cases diagnosed per year. The disease is more prevalent among men and incidence increases with age. The study also found colorectal cancers were the third leading cause of cancer deaths in Wisconsin from 2002-2006, resulting in an average of 1,023 deaths annually. Again, mortality rates were markedly higher for men and increased with age.[4]

Screening has been shown to decrease the number of deaths due to colorectal cancer by discovering cancers sooner, allowing for more successful treatment. When colorectal cancers are found at an early stage, before the cancer has spread beyond the intestinal wall, the survival rate is very high—around 90 percent.[5]

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[1] Matthews, B.A., Ruric C. Anderson, and Ann B. Nattinger. "Colorectal Cancer Screening Behavior and Health Insurance Status." *Cancer Causes & Control* 16, no. 6 (2005): 735-742.
[2] "Colorectal Cancer Screening Fact Sheet." National Cancer Institute. Available at http://www.cancer.gov/cancertopics/factsheet/Detection/colorectal-screening
[3] "Cancer Facts and Figures 2009." American Cancer Society. 2009.
[4] "Wisconsin Cancer Incidence and Mortality." Wisconsin Department of Health Services. 2009.
[5] "Cancer Facts and Figures 2009." American Cancer Society. 2009.

Below is a table from the Wisconsin Comprehensive Cancer Control Plan summarizing the three major commonly accepted national standards for testing: those of the USPSTF, the National Cancer Institute (NCI), and the American Cancer Society (ACS). The table includes recommendations relating to only the three most commonly recommended tests.

	USPSTF	NCI	ACS
General	Recommends screening for colorectal cancer in adults, beginning at age 50 years and continuing until age 75 years.	Strongly recommends discussing with health care provider to determine the start of screening and what screening test is best for the patient.	Average risk: Begin screening at age 50. Higher risk (*personal history of colorectal cancer or chronic inflammatory bowel disease, strong family history of colorectal cancer or polyps, family history of hereditary colorectal cancer syndromes*): Discuss appropriate screening tests/schedule with MD.
Fecal Occult Blood Test (FOBT)	Annual screening for adults age 50 to 75.	Annual or biennial testing in people 50-80 decreases mortality.	Annual screening.
Sigmoidoscopy	Sigmoidoscopy every 5 years, with high-sensitivity fecal occult blood testing every 3 years.	Regular use in people over 50 may decrease mortality.	Every five years.
Colonoscopy	Every 10 years	Good evidence of detecting early-stage cancer polyps, but evidence of mortality reduction is inadequate.	Every ten years.

Source: DHS, "Wisconsin's Comprehensive cancer Control Plan 2005-2010."

It is important to note that the recommendations for each test are independent, that is, if one follows the ACS guidelines he or she need not receive an FOBT annually, a sigmoidoscopy every five years, *and* a colonoscopy every ten years. One of the three tests can be chosen if the tests are performed at the recommended interval.

The percentage of adults in Wisconsin receiving screening for colorectal cancer has been increasing in recent years, contributing to a decline in mortality. According to the Centers for Disease Control and Prevention, the number of Wisconsin adults over age 50 who report ever having undergone screening has been rising steadily, from 56.4 percent in 2002 to 64.0 percent in 2006.[6] During this same time period the rate of colorectal cancer in the state declined from 63.1 to 54.1 per 100,000.[7] These data suggest a strong correlation between increased screening and decreased deaths from colorectal cancer in our state. The ACS has estimated following the guidance they have issued on screening would result in a 50 percent reduction in mortality from colorectal cancer.[8]

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[6] "BRFSS Prevalence and Trends Data," Centers for Disease Control and Prevention. Available at http://apps.nccd.cdc.gov/brfss/display.asp?cat=CC&yr=2002&qkey=4425&state=WI

[7] "United States Cancer Statistics (USCS) Data – 2006 Cancers Grouped by State and Region." Centers for Disease Control and Prevention. Available at http://apps.nccd.cdc.gov/uscs/cancersbystateandregion.aspx?Year=2006&Variable1=Wisconsin

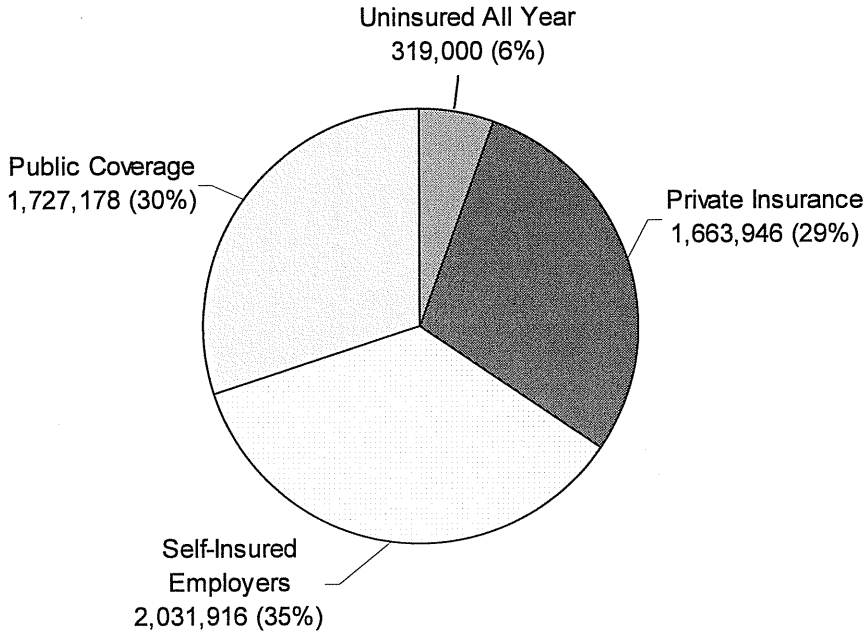
[8] Byers, Tim, Judy Mouchawar, James Marks, Blake Cady, and Nancy Lins. "The American Cancer Society Challenge Goals: How Far Can Cancer Rates Decline in the U.S. by the Year 2015?." *Cancer* 86, no. 4 (1999): 715-727.

Private Insurance

Fully insured health insurance products cover approximately 1.66 million Wisconsin residents, or about 29 percent of the population. Wisconsin Act 346 expands coverage for those individuals. Individuals who are members of groups whose benefit plans are self-funded are exempt from state regulation by the Employee Retirement and Income Security Act of 1974 (ERISA) and will not be directly effected by the mandate. Indirect effects may influence the coverage provided by self-funded plans, but these impacts are indeterminate. For example, market pressures may result in a company choosing to provide the mandated coverage in order to continue offering a competitive benefits package. Self-funded plans cover approximately 35 percent of Wisconsin's population.

The exemption from state regulation does not apply to self-funded plans provided by a governmental entity other than the federal government. The law does require self-funded plans provided by the state or a county, city, village, town or school district to provide the mandated coverage.

Wisconsin Health Insurance Coverage (2008)



Source: OCI, DHS, DOA, CMS, U.S. Census Bureau

An informal survey of seven large Wisconsin health insurers, covering approximately half of the group and individual markets, indicates most plans follow one of three nationally recognized guidelines or are more generous than all current guidelines. For individuals with health insurance coverage that did not cover colorectal cancer screening prior to enactment of Wis. Act 346, this law will offer a new preventive health tool.

Insurance coverage is a critical factor contributing to screening behavior. A 2005 study by the Medical College of Wisconsin found that insured individuals are more likely to be aware of

screening options, to have received a referral for screening, and to have undergone screening. In the study, insured persons were much more likely to have received screening in compliance with nationally accepted standards, 62 percent, versus 17 percent for uninsured individuals.[9] A recognition of the important role that insurance coverage plays in colorectal cancer screening has led 28 states other than Wisconsin, as well as Washington, D.C., to enact insurance mandates requiring the coverage of colorectal cancer screening tests.[10]

Financial Impact

Cost to Insurers

Wisconsin has long benefited from a healthy and competitive insurance market. The state currently has one of the lowest uninsured rates in the country, with 6 percent of residents having no health insurance coverage in 2008.[11] Insurers and business groups argue that mandated coverage for specific benefits can increase the cost of health insurance products, making it difficult for businesses to afford coverage for their employees. Wisconsin currently mandates coverage for 29 health related benefits.

Advocates for colorectal cancer screening stress the importance of screening in lowering both incidence of and mortality from colorectal cancer. Testing costs for colorectal cancer vary, depending on the type of testing covered and the frequency recommended. Below is a table with estimates by the ACS showing the approximate costs for the most common types of covered tests.

Test	Cost
Flexible Sigmoidoscopy	$150-$300
Colonoscopy	$1,000
Double Contrast Barium Enema	$300-$400
Computed Tomographic Colonography	$1,000
FOBT	$30
Stool DNA Test	$350

Source: American Cancer Society, *Colorectal Cancer Facts & Figures 2008-2010.*

Additionally, although there are most likely some health plans which were not offering the newly required coverage prior to enactment, the informal survey conducted by OCI found all surveyed insurers believed their plans would be in compliance with the rules which have now been promulgated by this office. These insurers compromise just below 50 percent of the market and, although it cannot be definitively determined, are unlikely to experience increased costs due to the mandate.

Companies providing coverage for colorectal cancer screening may face a lower cost in treating the disease, especially as certain types of screening can catch polyps early, effectively preventing cancers. One study published in the Journal of the American Medical Association found while colorectal cancers caught at a localized (early) stage cost $22,000 to treat, regional (middle stage) cancers cost $43,900 and distant (late stage) cancers cost $58,300.[12] As newer treatments for colorectal cancer are released, the cost for treatment climbs, making screening a

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[9] Matthews, B.A., Ruric C. Anderson, and Ann B. Nattinger. "Colorectal Cancer Screening Behavior and Health Insurance Status." *Cancer Causes & Control* 16, no. 6 (2005): 735-742.

[10] "Colorectal Cancer Screening Laws by State 2010." National Conference of State Legislatures. Available at http://www.ncsl.org/default.aspx?tabid=14328

[11] Wisconsin Office of the Commissioner of Insurance. "Wisconsin Insurance Report." 2009.

[12] Data in 1998 dollars. Frazier, A. L., Graham A. Colditz, Charles S. Fuchs, and Karen M. Kuntz. "Cost-effectiveness of Screening for Colorectal Cancer in the General Population." JAMA 284, no. 15 (2000): 1954-1961. http://jama.ama-assn.org/cgi/reprint/284/15/1954 (19 February 2010).

more cost-effective option. One recent chemotherapy clinical trial which resulted in a 50 percent survival improvement for late-stage cancer also involved a 340-fold increase in treatment cost. Larger costs for later-stage treatments make screening a more attractive option for insurer who both save money and lives by covering colorectal cancer screening. An analysis of the overall costs found screening resulted in a net savings using most testing strategies. In the one strategy which did not result in a net savings, colonoscopy screening, the overall cost was reduced to $300 per patient. The cost-effectiveness of screening may be one of the reasons most Wisconsin insurers surveyed were already providing coverage for screening.

Prior to passage of Senate Bill 163, both DHS and the Department of Employee Trust Funds (ETF) prepared fiscal estimates. DHS noted that the state's Medicaid program already provided the mandated coverage, and so expected no fiscal impact. ETF noted that the bill would be expected to have no material fiscal effect because health plans in ETF's program already provide coverage that is not materially different from the required coverage.

Please contact Eileen Mallow at (608) 266-7843 if you have any questions regarding this report.

Sincerely,

Sean Dilweg
Commissioner