REPORT OF THE
SPECIAL ADVISORY COMMISSION
ON MANDATED HEALTH INSURANCE BENEFITS ON

THE MANDATED OFFER OF COVERAGE FOR MAMMOGRAMS PURSUANT TO SECTION 38.2-3418.1 OF THE CODE OF VIRGINIA

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 26

COMMONWEALTH OF VIRGINIA
RICHMOND
1994

SENATE OF VIRGINIA

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December 29, 1993

To: The Honorable L. Douglas Wilder
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein has been prepared pursuant to Sections 9-298 and 9-299 of the Code of Virginia.

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits to assess the social and financial impact and the medical efficacy of the mandated offer of coverage for mammograms pursuant to § 38.2-3418.1 of the Code of Virginia.

Respectfully submitted,

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Special Advisory Commission on
Mandated Health Insurance Benefits

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INTRODUCTION

Section 38.2-3418.1 of the Code of Virginia requires insurers to offer and make available coverage for low-dose screening mammograms for determining the presence of occult breast cancer. The coverage must include one screening mammogram for persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over. The benefit may be limited to $50 per mammogram and be subject to such dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally.

The term "mammogram" is defined in the statute to mean:

> an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

In addition, the mammogram must be ordered by a health care practitioner, performed by a registered technologist, interpreted by a qualified radiologist, and performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body. The equipment used must meet the standards of the Virginia Department of Health as set forth in its radiation protection regulations. A copy of the mammogram report must also be sent to the health care practitioner who ordered it. Section 38.2-3418.1 was enacted in 1989.

The Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) held a public hearing during its October 4, 1993 meeting to receive comments regarding the mandated offer of coverage for mammograms. Two speakers were heard and written comments were received from three interested parties.

BREAST CANCER AND MAMMOGRAPHY

Mammography is used to detect breast cancer. Cancer is defined in layman's terms as a group of diseases characterized by the spread and uncontrolled growth of abnormal cells. It is estimated that Virginia will have 4,400 new cases of female breast cancer in 1993 and 1,100 breast cancer deaths in that year.

Approximately one of every nine women will develop breast cancer by age 85. Nationwide, in 1993, 1,000 new cases of breast

cancer will be diagnosed in men. According to information from the American Cancer Society (the ACS), breast cancer rates have increased by about two percent a year since the 1970's and have leveled off since 1987 at a rate of 107 occurrences per 100,000. Some of the rise in rates is believed to be due to the increase in the utilization of mammograms, which allows the detection of early stage cancers often before they would be clinically apparent.

The Virginia mandate is consistent with the recommendations of the ACS for mammograms. The ACS recommends a screening mammogram for all women by age 40; a mammogram every one to two years for women age 40 to 49; and mammograms every year for asymptomatic women age 50 and over. In addition to being an effective screening procedure for asymptomatic women, mammography is considered by the ACS to be a valuable diagnostic technique for women with conditions that are suggestive of breast cancer.

The ACS also recommends a clinical physical examination of the breast every three years for women 20 to 40 years old, and every year for those over 40. Monthly breast self-examination is also recommended for women 20 years or older.

The use of mammography in women under age 50 has been criticized by some as being ineffective. At least one study has found a false negative rate of 13% in women over 50. Women under 50 had a false negative rate of 38% in the same study. Some opponents of mammograms before age 50 point to the monetary costs of screenings, unnecessary biopsies, diagnostic delays that result from false negative reports, and the radiation exposure when the mammogram does not meet the requirements.

Those who support mammography for women under age 50 recognize that it is not 100% effective, but believe that it is currently the best technology available. Supporters believe that the benefits of mammograms prior to age 50 outweigh the drawbacks.

COSTS ASSOCIATED WITH § 38.2-3418.1

In 1992, the State Corporation Commission (SCC) issued its first annual report on the financial impact of mandated benefits and mandated providers pursuant to § 38.2-3419.1 of the Code of Virginia (1993 House Document No. 9). Insurers were only required to submit data for the fourth quarter of 1991 for this initial report. Therefore, the results reported in 1993 House Document No. 9 may not be truly representative of insurer experience. Subsequent reports, however, will cover full calendar years. The results printed in the SCC's initial report are as follows:

Portion of Premium Attributable to the Mammography Mandate

INDIVIDUAL		GROUP	
Single	*Family*	*Single*	*Family*
0.37%	*0.30%*	*0.41%*	*0.50%*

Portion of Claims Attributable to the Mammography Mandate

INDIVIDUAL	GROUP
0.03%	*0.09%*

LEGISLATION IN OTHER STATES

According to the National Association of Insurance Commissioners, at least 43 states mandate some form of coverage for screening mammography. Four of those states, including Virginia, only require that such coverage be offered and made available to policyholders.

REVIEW CRITERIA

Social Impact

a. The extent to which the treatment or service is generally utilized by a significant portion of the population.

The ACS recommends that all women have a screening mammogram by age 40. The mandated offer of coverage provides for one screening for those age 35-39. Virginia's population in 1990 was approximately 6.2 million people. 1,502,802 women over the age of 35 are included in those 6.2 million Virginians.

b. The extent to which insurance coverage for the treatment or service is already available.

Insurance coverage for mammograms must be offered and made available to individuals and groups. The requirement has been in effect since January 1, 1990. Mammography would not be covered for members of a group if the employer or other group policyholder declined the coverage. Some insurers, including Blue Cross and Blue Shield of Virginia, have included mammography in their standard contracts for individuals.

c. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatments.

Coverage is generally available for women age 35 or older because of the mandate. However, proponents cited the example of a 32 year old "at risk" woman in need of diagnostic assistance (including mammography) who had no coverage for the diagnostic tools currently available to detect breast cancer.

d. If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment.

Coverage is generally available because of the mandated offer of coverage. Nationally, the cost of mammograms was cited as ranging from $25 to $200 in 1988 in a study used in the article "The Value of Mammography Screening in Women Under Age 50 Years." Lack of insurance coverage for the procedure could possibly result in financial discomfort for some individuals.

e. The level of public demand for the treatment or service.

Information regarding the number of people utilizing mammography was not presented to the Advisory Commission.

f. The level of public demand and the level of demand from providers for individual and group insurance coverage of the treatment or service.

Members of the public spoke in favor of the continuance of this mandate. No information was presented to the Advisory Commission from providers.

g. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.

The Advisory Commission did not receive any information regarding the interest of collective bargaining organizations in negotiating privately for inclusion of coverage for mammography in group contracts during the course of its review.

h. Any relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.

No findings from state agencies were presented to the Advisory Commission.

Financial Impact

a. The extent to which the proposed insurance coverage would increase or decrease premiums or the cost of services over the next five years.

The current mandate statute allows a limit of $50 per mammogram. It is not expected to increase or decrease the cost of mammograms in the next five years.

b. The extent to which the proposed insurance coverage might increase the appropriate or inappropriate use of the treatment or service.

Testimony about limited inappropriate use of mammograms was presented to the Advisory Commission. However, the statutory wording of the mandate allows coverage to be limited to one screening mammogram for those 35-39, one every two years for those 40-49 and one each year for people over 50. The language of the mandate limits the insurance coverage of mammography to what is considered appropriate use by the ACS.

c. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.

Although other diagnostic tools are currently available to assist in the detection of breast cancer, none are as effective as mammography for the majority of the women covered by this mandated offer.

d. The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.

The mandated offer of coverage for mammograms went into effect almost four years ago. The mandate requires that the mammogram be performed by a registered technologist and that the equipment used must meet the standards of the Virginia Health Department. It is not anticipated that the coverage will greatly affect the number of providers of mammograms over the next five years because of the restrictions in the language.

e. The extent to which insurance coverage might be expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.

The greatest expenses associated with mandates are generally

incurred when a mandate is initially enacted. The ongoing cost for the offer of coverage for mammograms is not expected to be substantial.

f. The impact of coverage on the total cost of health care.

Proponents of the mandate take the position that mammograms may actually reduce the total cost of health care because they reduce the need for costly treatment modalities as a result of early intervention.

Medical Efficacy

a. The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.

The medical efficacy of mammograms was not questioned in written or oral comments to the Advisory Commission. The language of the mandate is consistent with the recommendations of the ACS. The use of mammograms for women over 50 is widely encouraged.

b. If the legislation seeks to mandate coverage of an additional class of practitioners:

1) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered.

Not applicable.

2) The methods of the appropriate professional organization that assure clinical proficiency.

Not applicable.

Effects of Balancing the Social, Financial and Medical Efficacy Considerations

a. The extent to which the benefit addresses a medical or a broader social need and whether it is consistent with the role of health insurance.

The offer of coverage for mammograms addresses a medical need, is consistent with the role of health insurance, and also

addresses a social need by providing for earlier intervention and less intrusive treatment.

b. The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders.

Proponents make the argument that the cost of mandating that coverage for mammograms be offered is not significant because (i) the cost reported by insurers for this mandate has a small impact on premiums and (ii) earlier detection of cancer results in the use of less expensive treatments. And, as a mandated offer, coverage for mammograms can be rejected by policyholders that do not desire it.

c. The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policyholders.

Coverage for mammograms is required to be offered. Insureds have the option of refusing the coverage.

RECOMMENDATIONS

It is the recommendation of the Special Advisory Commission on Mandated Health Insurance Benefits that the mandated offer of coverage for mammograms contained in § 38.2-3418.1 of the Code of Virginia be maintained in its current form. The Advisory Commission adopted this position at its October 4, 1993 meeting (7-Yes, 0-No).

CONCLUSION

In reviewing the mandated offer of coverage for mammograms, the Advisory Commission examined social, financial, and medical efficacy considerations. During the course of its review, no interested party recommended to the Advisory Commission, either orally or in writing, that the mandated offer be repealed. Evidence and testimony provided to the Advisory Commission during the course of its review indicates that the benefits of the offer of coverage for mammograms favorably outweigh the cost associated with the requirement.

APPENDIX

§ 38.2-3418.1. Coverage for mammograms. --- A.1. Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing individual or group accident and sickness subscription contracts, each health maintenance organization providing a health care plan for health care services and each insurer proposing to issue individual or group Medicare supplement policies shall offer and make available coverage under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after January 1, 1990, for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mam-mogram biennially to persons age forty through forty-nine, one such mammo-gram annually to persons age fifty and over and may be limited to a benefit of fifty dollars per mammogram subject to such dollar limits, deductibles and coinsurance factors as are no less favorable than for physical illness generally.

2. The term "*mammogram*" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

B. In order to be considered a screening mammogram for which coverage shall be made available under this section:

1. the mammogram must be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization physician, (ii) performed by a registered technologist, (iii) interpreted by a qualified radiologist, (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body and (v) a copy of the mammogram report must be sent or delivered to the health care practitioner who ordered it;

2. The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

3. The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

C. The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease policies, or to short-term nonrenewable policies of not more than six months duration. (1989, c. 646; 1990, c. 284.)