

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

**MANDATED COVERAGE  
FOR MAMMOGRAMS  
(SENATE BILL NO. 1027, 1995)**

**TO THE GOVERNOR AND  
THE GENERAL ASSEMBLY OF VIRGINIA**



**SENATE DOCUMENT NO. 6**

**COMMONWEALTH OF VIRGINIA  
RICHMOND  
1996**



COMMONWEALTH OF VIRGINIA



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SENATE

November 6, 1995

To: The Honorable George Allen  
Governor of Virginia  
and  
The General Assembly of Virginia

The report contained herein has been prepared pursuant to §§ 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 Senate Bill 1027 (1995 Session) regarding a proposed mandated coverage for mammograms.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Clarence A. Holland".

Clarence A. Holland  
Chairman  
Special Advisory Commission on  
Mandated Health Insurance Benefits



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## **INTRODUCTION**

During the 1995 Session of the General Assembly, the Senate Committee on Commerce and Labor referred Senate Bill 1027 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). Senate Bill 1027 is patroned by Senator Kenneth W. Stolle.

The Advisory Commission held a hearing on May 8, 1995, in Richmond to receive public comments on Senate Bill 1027. In addition to the patron, one speaker addressed the proposal. Dr. Ellen De Prades, Director of the Imaging Center at the Medical College of Virginia and representative of the American Cancer Society, spoke in favor of the bill. Dr. De Prades also submitted written comments in support of the bill. Trigon BlueCross BlueShield of Virginia (Trigon), BlueCross BlueShield of the National Capital Area, the Virginia Manufacturers Association, and the Health Insurance Association of America submitted written comments in opposition of the bill. The Virginia Association of Health Maintenance Organizations (VAHMO) filed written comments noting that HMOs cover mammograms routinely as basic health services. VAHMO emphasized that it is critical that Virginia not enact legislation with requirements that differ from accepted national standards. In written comments, Advisory Commission member Dr. John T. Ashley, Associate Vice President of the University of Virginia Health Sciences Center, recommended that the bill be supported; however, the schedule for screening should be amended to reflect another schedule found on the national level. The Advisory Commission concluded its review of Senate Bill 1027 on July 10, 1995.

## **SUMMARY OF PROPOSED LEGISLATION**

Senate Bill 1027 amends § 38.2-3418.1 of the Code of Virginia, relating to accident and sickness insurance. The bill requires insurers, health services plans, health maintenance organizations (HMOs), and insurers issuing Medicare Supplement policies to provide coverage to Virginia policyholders for low-dose screening mammograms. Coverage would include one screening mammogram for women between the ages of thirty-five and thirty-nine; one mammogram every two years for women between the ages of forty through forty-nine; and one mammogram annually for women age fifty and older. Benefits may be limited to fifty dollars. The bill conflicts with federal requirements by including Medicare supplement policies. As drafted, Senate Bill 1027 indicates that the proposed legislation would amend and reenact § 38.2-4319 of the Code of Virginia. It was determined that this was a typographical error, and that the bill is intended to amend § 38.2-3419 of the Code of Virginia.

The current mandate requires the "offer" of coverage for mammography for individual and group policies.

## **MAMMOGRAPHY**

According to information provided by the American Cancer Society's (ACS) "Cancer Facts & Figures," there were 4,500 estimated cases of breast cancer in Virginia in 1995. It is estimated that 1,200 women in Virginia will die from breast cancer in 1995. The ACS states that mammography can help determine if there are lumps or lesions too small to be felt through a routine monthly self-examination. The five-year survival rate for localized breast cancer is 94%. If the cancer spreads regionally, the survival rate drops to 73%. Dr. Ellen De Prades stated that early and frequent screening is valuable. She noted that breast cancer is the most common cancer killer in women.

## **CURRENT INDUSTRY PRACTICES**

The State Corporation Commission's Bureau of Insurance recently surveyed 50 of the top writers of accident and sickness insurance in Virginia regarding Senate Bill 1027. Thirty-three companies responded by April 20, 1995. Seven of those responding to the survey indicated that they have little or no applicable health insurance business in force in Virginia and, therefore, could not provide the information requested. Of the twenty-six companies that were able to respond to the survey, twenty-four indicated that they currently provide coverage as specified in Senate Bill 1027 to their Virginia policyholders. Two currently offer the coverage specified in Senate Bill 1027.

Proponents of Senate Bill 1027 contend that the measure is needed because there is confusion among policyholders as to whether or not their policy provides this coverage. Proponents argued that women covered under group policies often are not certain if their employer or policyholder selected the optional mammography coverage until the need for the service arises. They further argued that the key barriers that women encounter when attempting to obtain a mammogram are cost and lack of coverage.

Opponents contended that the coverage specified in Senate Bill 1027 is already available through either standard policies or riders. BlueCross BlueShield of the National Capital Area stated that "mammograms...are routinely provided in health benefits programs. Legislative enactment of mandated benefits for these services is not necessary or appropriate." Opponents also stated that additional mandates create cumulative costs that add to the overall expense of insurance programs.

## **FINANCIAL IMPACT**

Respondents to the Bureau of Insurance survey provided cost figures of between \$0.02 and \$6.88 per month per group certificate holder. Respondents provided the same cost figures per month for an individual policyholder. In its written comments on the subject, Trigon stated that its preventive care package, which includes coverage for mammograms, accounts for slightly less than 1% of the total premium in small group and most individual plans. For the larger group market, Trigon stated that mammogram coverage would make up less than 0.5% of a premium increase. The Virginia Association of Health Maintenance Organizations, in its written comments to the Advisory Commission, stated that the cost to provide coverage for mammograms is believed to be very small as compared to the high cost of treating the effects of cancer. The VAHMO further stated that HMOs already cover mammograms in their preventive services. Therefore, HMOs would incur no additional cost associated with a mammography mandate as long as the screening schedule is consistent with national standards.

House Document No. 3 (1995), "The Financial Impact of Mandated Health Insurance Benefits and Providers Pursuant to Section 38.2-3419.1 of the Code of Virginia: 1993 Reporting Period," shows that mammography accounts for 0.50% of the policy premium in single coverage individual contracts and 0.49% of the policy premium in family coverage individual contracts. House Document No. 3 also indicates that mammography represents 0.61% of the policy premium in single coverage in group certificates and 0.54% in family coverage in group certificates.

## **SIMILAR LEGISLATION IN OTHER STATES**

According to information published by the National Association of Insurance Commissioners, forty-two states currently require coverage of mammography. Four states require that such coverage be offered to policyholders. The NAIC reports that of the forty-two states with mammography mandates, thirty-two states (including Virginia) currently require coverage on the following schedule: a baseline screening between the ages of 35-39; a biennial screening between the ages of 40-49; and an annual screening for women age 50 and older.

**Mandated Coverage**

Alaska	Kentucky	North Carolina
Arizona	Louisiana	North Dakota
California	Maine	Ohio
Colorado	Maryland	Oklahoma
Connecticut	Massachusetts	Oregon
Delaware	Minnesota	Pennsylvania
District of Columbia	Missouri	Rhode Island
Florida	Montana	South Dakota
Georgia	Nebraska	Tennessee
Hawaii	Nevada	Texas
Idaho	New Hampshire	Vermont
Illinois	New Jersey	Washington
Iowa	New Mexico	West Virginia
Kansas	New York	Wisconsin

**Mandated Offer**

Arkansas	Michigan
Indiana	Virginia

**REVIEW CRITERIA**

**SOCIAL IMPACT**

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

One proponent cited information supplied by the Virginia Center for Health Statistics that, in Virginia, 40% of white women and 46% of black women under the age of fifty have ever had a mammogram. The proponent also reported that Virginia ranks 40th among all states for the percentage of women over age 50 who received a mammogram in the last two years.

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

Of the thirty-three respondents to the Bureau's insurer survey, twenty-four (72.7%) reported that they currently provide the coverage required by Senate Bill 1027 to their Virginia policyholders. Seven respondents to the survey reported that they have little or no applicable health insurance business in force in Virginia and, therefore, could not provide the information requested.

- 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.*

According to written comments received from opponents to the bill, adequate coverage is already available as a mandated offering in § 38.2-3418.1. Proponents of the bill cited a March 1995 *Journal of the National Cancer Institute* article stating that the reasons women give for not obtaining mammograms are cost, accessibility and fear.

- 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.*

One proponent noted that one-third to one-half of her patients do not have coverage for mammography screening. She explained that most patients are unaware that they do not have mammography coverage until they come in for a screening. The American College of Radiology reports that the cost for a mammogram ranges from \$65 to \$125 per screening.

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

The Virginia Center for Health Statistics' Behavioral Risk Factor Surveillance Survey reports that an estimated 380,214 women between ages 35-49 years of age obtain mammograms annually; and 524,813 women age 50 and older are screened annually in Virginia.

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

The level of public demand for individual and group insurance coverage for this service is not known. One proponent of the bill estimated that between one-third and one-half of the patients she sees in her office are insured by group policies, but are not covered for mammography. Proponents of the bill noted that cost was the number one reason women forego screening.

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

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

- 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 information or findings of the state health planning agency or the appropriate health system agency regarding the social impact of the mandated benefit was presented during this review.

#### FINANCIAL IMPACT

- a. The extent to which the proposed insurance coverage would increase or decrease the cost of treatment or service over the next five years.*

Proponents of the bill, citing the American College of Radiology, report that the average cost for a screening mammogram ranges from \$65 to \$125 per screening. In its written comments, Trigon stated that it allows from \$21.25 to \$64.50 for mammograms. The VAHMO stated that because HMOs already cover mammograms routinely, there would be no additional costs associated with a mandate so long as any mandate would not be inconsistent with the schedule recommended by agreed upon national standards.

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

One proponent of the bill explained that more patients with coverage utilized mammography screening than those without coverage. She noted that the two reasons women give for not seeking mammography screening are cost and accessibility. It is anticipated that the appropriate use of the treatment will increase with the proposed mandate.

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

In its written comments, VAHMO stated that the cost to provide preventive services, such as mammography, are believed to be much less expensive when compared to the high cost of treating the ill effects of breast cancer. The American Cancer Society estimates that, nationally, \$6 billion annually in direct medical costs are due to treatment of breast cancer. According to information received from the American Cancer Society, the cost of cancer screening, including mammograms and other screening mechanisms, adds \$3 to \$4 billion to overall cancer costs nationwide, but reduces suffering and saves lives if cancer is detected at an earlier, treatable stage.

- 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.*

It is unlikely that this proposed coverage would significantly affect the number and types of providers of the mandated treatments because currently all insurers must offer this level of coverage in their policies.

- 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.*

It is unlikely that the proposed coverage will significantly affect the administrative expenses of the insurance companies and the premium and administrative expenses of policyholders because it would apply to all policyholders equally.

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

The total cost of health care is not expected to be significantly affected.

#### 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.*

Both proponents and opponents acknowledge the medical efficacy of early detection of breast cancer. The American Cancer Society states that the five-year survival rate for localized breast cancer is 94%. If the cancer has spread regionally, the survival rate drops to 73%. Mammography screening detects lumps and lesions that are too small to be felt during a routine monthly self-examination. One opponent noted that the health status of Virginians can benefit from use of available screening and preventive care services. Several comments were submitted regarding the necessity of the proposed screening schedule. Dr. John T. Ashley noted that the national schedule recommended by the U.S. Preventive Services Task Force endorses an annual screening to begin at age 50, unless the woman falls into a high risk category. Others supported the continuance of the existing schedule in the mandate. Opponents argued that including a specified time and age schedule in legislation is inappropriate and troublesome to revise should the schedule be revised.

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.*

It is recognized that the benefit addresses a medical need and is consistent with the role of health insurance. Proponents of the bill make the argument that the medical efficacy of mammography screening is clearly proven in a number of studies. Studies show that women who have routine screening mammography at regular intervals have 30% fewer deaths from breast cancer. The American Cancer Society reports that the five-year survival rate for localized breast cancer is 94%. However, if the cancer spreads regionally, the five-year survival rate drops to 73%. Due in part to the rise in the use of mammography, proponents noted that mortality rates have flattened in recent years. Proponents contend that the bill eliminates confusion and ensures coverage for those women currently insured.

Opponents of the bill acknowledged that mammograms have been demonstrated to be highly effective in detecting as well as minimizing breast cancer. One opponent emphasized that early detection of diseases, such as breast cancer, minimizes cost and increases wellness. Opponents argued that it is the role of insurers to put health care components together in response to market demand for quality and affordable coverage. In its written comments to the Advisory Commission, one opponent contended that insurers may be limited in their ability to respond to the desire of consumers for choice in the marketplace, if the mandate is adopted.



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

Insurers responding to a Bureau survey projected the cost of coverage to range from \$0.02 to \$6.88 per month per group certificate holder. The cost is similar for individual policyholders. The American Cancer Society reports that breast cancer costs this country more than \$6 billion each year in medical costs and lost productivity. Opponents asserted that adequate coverage is currently available with the mandated offering, therefore, there is no need for a new mandate or a revision to the current mandate. Another opponent noted that mandates increase health insurance costs, providing a disincentive to both individuals and employers to obtain or retain health insurance.

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

Mammography is currently required as a mandated offer of coverage.

#### **RECOMMENDATION**

To eliminate the conflict with federal requirements, the Advisory Commission agreed to a technical change that would strike language requiring insurers issuing Medicare supplemental policies to comply with the proposed mandate. The Advisory Commission agreed that diagnosing breast cancer in its earliest state is crucial. However, the Advisory Commission did not feel that the schedule proposed in Senate Bill 1027 was consistent with the schedule recommended in the appropriate national standards. The Advisory Commission voted to amend the bill and to add the schedule recommended by the U.S. Preventive Services Task Force (Task Force). The schedule recommended by the Task Force currently includes annual mammography screenings to begin at age 50 and conclude at age 75 unless pathology has been detected. It was suggested that language be included in the bill to exempt mammograms from copayments and deductibles. Senator Holland commented that copayments and deductibles represent the insured's responsibility in meeting the cost of coverage. He expressed concern that insurers would raise premiums to offset the loss of revenue normally collected through copayments and deductibles. With the exception of the child health supervision mandate, no other mandate includes such an exemption; therefore, the Advisory Commission did not include the proposed exemption in its recommendation of Senate Bill 1027. The Advisory Commission voted unanimously (10-Yes, 0-No) to recommend Senate Bill 1027, as amended, on July 10, 1995.

## **CONCLUSION**

Both proponents and opponents of the bill recognize the value of early diagnosis of breast cancer. While incidence of breast cancer has increased steadily over the last decade (due in part to increased use of mammography screening), mortality rates have remained stable. Information provided to the Advisory Commission during its review indicated that the estimated cost of providing coverage for this procedure varied widely. Regardless of the actual cost, proponents and opponents indicated that the cost for providing coverage was not significant when compared to the cost of treatment for breast cancer. The Advisory Commission concluded, therefore, that Senate Bill 1027 should be recommended with the amendments proposed by the Advisory Commission.

LD3374739

## SENATE BILL NO. 1027

Offered January 23, 1995

1  
2  
3 A BILL to amend and reenact § 38.2-3418.1 of the Code of Virginia, relating to accident and sickness  
4 insurance; coverage for mammograms.

5  
6 Patrons—Stolle, Earley, Howell, Potts, Quayle, Robb, Stosch, Trumbo and Woods; Delegates:  
7 Callahan, Croshaw, Forbes, Purkey, Rhodes, Tata, Wagner and Wardrup

8  
9 Referred to the Committee on Commerce and Labor

10  
11 Be it enacted by the General Assembly of Virginia:

12 1. That § 38.2-3418.1 of the Code of Virginia is amended and reenacted as follows:

13 § 38.2-3418.1. Coverage for mammograms.

14 A. 1. ~~Each~~ Notwithstanding the provisions of § 38.2-4319, each insurer proposing to issue  
15 individual or group accident and sickness insurance policies providing hospital, medical and surgical  
16 or major medical coverage on an expense incurred basis, each corporation providing individual or  
17 group accident and sickness subscription contracts, each health maintenance organization providing a  
18 health care plan for health care services and each insurer proposing to issue individual or group  
19 Medicare supplement policies shall ~~offer and make available~~ provide coverage under such policy,  
20 contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after January  
21 1, 1990 1996, for low-dose screening mammograms for determining the presence of occult breast  
22 cancer. Such coverage shall make available one screening mammogram to persons age thirty-five  
23 through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, one  
24 such mammogram annually to persons age fifty and over and may be limited to a benefit of fifty  
25 dollars per mammogram subject to such dollar limits, deductibles and coinsurance factors as are no  
26 less favorable than for physical illness generally.

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

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

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

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

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

44 C. The provisions of this section shall not apply to short-term travel, accident only, limited or  
45 specified disease policies, or to short-term nonrenewable policies of not more than six months  
46 duration.

