

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

**MANDATED COVERAGE  
FOR PAP SMEARS  
(SENATE BILL NO. 1028, 1995)**

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



**SENATE DOCUMENT NO. 7**

**COMMONWEALTH OF VIRGINIA  
RICHMOND  
1996**



COMMONWEALTH OF VIRGINIA



SENATE

November 6, 1995

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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 1028 (1995 Session) regarding a proposed mandated coverage for pap smears.

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 1028 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). Senate Bill 1028 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 1028. In addition to the patron, one speaker addressed the proposal. Dr. Randell West, Associate Professor of Obstetrics and Gynecology at the Medical College of Virginia, spoke in favor of the bill. Dr. West and Ms. Patti Fogg, of the American Cancer Society, submitted written comments to the Advisory Commission supporting the measure. 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 to the bill. The Virginia Association of Health Maintenance Organizations (VAHMO) filed written comments noting that HMOs cover pap smears routinely as basic health services. VAHMO also emphasized that it is critical that Virginia not enact legislation with requirements that differ from accepted national standards. VAHMO suggested that if the Advisory Commission determines that a mandate is appropriate, pap smears should be a mandated offer of coverage. 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 1028 on July 10, 1995.

## **SUMMARY OF PROPOSED LEGISLATION**

Senate Bill 1028 adds § 38.2-3418.1:2 and amends § 38.2-4319 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 individual and group policyholders for annual pap smears. The bill conflicts with federal requirements by including medicare supplement policies. As drafted, the legislation did not indicate whether the office visit in connection with the pap smear was to be included in the coverage required in the bill. The Advisory Commission determined that it was the patron's intent to include coverage for the cost of collecting the pap smear and the laboratory reading; not the entire office visit. Currently, coverage for pap smears is not mandated in Virginia.

## **PAP SMEARS**

As currently drafted, Senate Bill 1028 does not contain a clinical definition of a pap smear. The Dorland's Medical Dictionary, 27th Edition, defines a pap smear as

"an exfoliative cytological staining procedure for the detection and diagnosis of various conditions; particularly malignant and pre-malignant conditions of the female genital tract, in which cells which have been desquamated from the genital epithelium are obtained by smears; fixed and stained; and examined under the microscope for evidence of pathologic changes."

The American Cancer Society (ACS) states that the pap smear is highly effective in detecting early cancer of the uterine cervix. The five-year survival rate for cervical cancer is 67%. For women diagnosed with localized disease, the survival rate rises to 90%. Information provided by ACS's "Cancer Facts & Figures" estimates 1,100 women in Virginia will be diagnosed with uterine cancer in 1995. An estimated 250 will die from the disease in Virginia in 1995.

Dr. Randell West explained that the pap smear was designed to detect malignant and pre-malignant cervical lesions at a time when effective treatment may be offered. Dr. West noted that studies show a decrease of 50% to 70% in regional cancer in women that are participating in a screening program.

## **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 1028. 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 that completed the survey, twenty (76%) currently provide the coverage required by Senate Bill 1028 to their Virginia policyholders. Four companies make the proposed coverage available as an option to group policyholders.

Proponents of Senate Bill 1028 contend that since the introduction of the pap smear in 1943, the number of advanced lesions that are detected has decreased significantly. One proponent noted that no geographic area in the world has experienced a decrease in cervical cancer in the absence of an active screening program. Proponents encouraged the Advisory Commission to recommend mandatory coverage for pap smears to continue the successful results of early diagnosis and treatment of cervical cancer.

Opponents contend that the coverage specified in Senate Bill 1028 is routinely provided in health benefits programs. Trigon noted that it provides coverage for pap smears in the individual, small group and large group market. The VAHMO stated that this service is routinely included in all HMO basic benefits packages because pap smears have been proven to be highly effective in detecting as well as minimizing disease. Opponents also stated that additional mandates create cumulative costs that add to the overall expense of insurance programs.

**FINANCIAL IMPACT**

Respondents to the survey provided cost figures between \$0.05 and \$5.49 per month per group certificate holder and between \$0.05 and \$4.16 per month per individual policyholder to provide coverage for an annual pap smear. Trigon reports that its preventive care package of benefits, which includes pap smears, accounts for slightly less than 1% of the total policy premium. In its written comments on this subject, the Virginia Manufacturers Association maintained that mandated benefits force employers to offset increased health insurance costs through lower wages, pensions, and other benefits, or by reducing employment levels. The Health Insurance Association of America argued that mandates make insurance coverage less affordable, and, ultimately, less available to many Virginians, especially small employers. VAHMO, in its written comments to the Advisory Commission, stated that because HMOs already cover pap smears, there would be no additional cost associated with a mandate as long as any mandate is consistent with the schedule recommended in agreed upon national standards.

**SIMILAR LEGISLATION IN OTHER STATES**

According to information published by the National Association of Insurance Commissioners (NAIC), sixteen states currently require coverage for pap smears. One state requires that coverage be offered to policyholders. The NAIC reports that twelve states follow a schedule similar to the one recommended in Senate Bill 1028.

**Mandated Coverage**

California	Kansas	Nevada	Oregon
Delaware	Louisiana	New Mexico	Pennsylvania
District of Columbia	Massachusetts	New York	Rhode Island
Georgia	Minnesota	North Carolina	West Virginia

**Mandated Offer**

Ohio

## REVIEW CRITERIA

### SOCIAL IMPACT

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

Citing the Virginia Center for Health Statistics' Behavioral Surveillance Survey (BRFS), one proponent reported that 89% of white women and 94% of black women in Virginia under the age of 50 have had a pap test in the last two years. BRFS also reports that Virginia ranks 16th among all states for the percent of all women having a pap test within the last two years.

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

In a recent State Corporation Commission Bureau of Insurance survey of the top 50 writers of accident and sickness insurance in Virginia, twenty-six companies currently writing applicable business in Virginia responded. Of that number, twenty companies (76%) already provide the coverage required by Senate Bill 1028 to their Virginia policyholders. Four companies offer the coverage specified in Senate Bill 1028 to their group policyholders.

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 in basic benefits packages or through optional preventive care benefits packages. VAHMO noted that HMOs routinely include coverage for pap smears in all standard benefits packages in accordance with state regulations. Proponents indicated that 89% of white women under age 50 and 94% of black women under age 50 have had a pap test in the last two years. One proponent of the bill maintained that women who have health insurance are more likely to have a pap test.

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.*

Opponents argued in written comments that coverage is generally available. No information was submitted that indicated that a lack of coverage

resulted in unreasonable financial hardship on persons needing treatment. Trigon reports that the cost for a pap smear ranges from \$12 to \$25 per screening. One proponent contended that the success of effectively treating cervical lesions and cancer is directly related to the financial resources available to the patient.

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

According to information provided by the BRFS, 1,338,623 women between the ages of 18 and 44 years of age have pap tests annually. BRFS also reports that 696,992 women between the ages of 45 and 69; and 254,792 women 70 years and older have pap tests 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 patron stated that he submitted the bill because several members of the medical community expressed concern that insured patients were without coverage or uncertain whether their insurance coverage included pap smears.

*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 not known.

*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.*

In its written comments to the Advisory Commission, Trigon reported that the cost for a pap smear ranges from \$12 to \$25; however, Trigon pays from \$8.25 to \$18.00 per pap smear for its policyholders. The VAHMO stated that because HMOs already routinely cover pap smears, there would be no additional costs associated with a mandate as long as it was consistent 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.*

It is anticipated that the appropriate use of the treatment will increase with the proposed mandate. One proponent of the bill maintained that women who have health insurance are more likely to have a pap test.

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

According to information received from the American Cancer Society, the cost of cancer screening, including pap smears 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. The earlier uterine cancer is treated, the less expensive and the more effective the treatment. In written comments, Trigon stated that it promotes the value of prevention because it keeps individuals healthy and avoids more expensive care.

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 it appears that many insurers already provide such coverage and because the number of women having the pap test is relatively high.

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.*

An increase in the administrative expenses of insurance companies and the premiums and administrative expenses for policyholders is anticipated because of the expenses associated with such things as policy redesign, form filing, claims processing systems and marketing. One opponent of the bill pointed out that portioning out certain services currently contained in a package offering could increase administrative expenses slightly. HMOs are not expected to experience an increase in administrative expenses for their policyholders because pap smears are already covered.

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. The cost of screening should reduce the cost of treatment of cancer at advanced stages.

#### 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 acknowledged the medical efficacy of early detection of cervical cancer. The ACS reports that the rate of invasive cervical cancer has decreased steadily over the last several decades. Women diagnosed with localized cervical cancer have a five-year survival rate of 90%. Dr. Randell West stated that the pap test, unlike other screening tests, is used principally to diagnose pre-invasive lesions that, when treated, will result in a decrease in the incidence of deaths from invasive cancer. Dr. West credited the pap test with accomplishing this goal.

In its written comments, Trigon agreed that individuals can reduce their chances of developing certain diseases by adopting a healthy lifestyle and by participating in early detection programs, such as pap smears. While HMOs recognize the value of the pap smear, VAHMO noted that the screening schedule recommended in Senate Bill 1028 is inconsistent with other schedules found on the national level.

*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 contend that a considerable amount of indirect evidence suggests the effectiveness of the pap test. One proponent noted that screening studies indicate that since being introduced in 1943, the number of advanced lesions has decreased. The ACS reports that the five-year survival rate for localized cervical cancer is 90%; however, the survival rate drops to 67% if the cancer has spread. Dr. West maintained that the mortality rates relate to the stage of the disease at the time of diagnosis and treatment.

Opponents of the bill acknowledged that pap smears have been demonstrated to be effective in detecting and minimizing the spread of cervical cancer. In its written comments, Trigon noted that the quality of patient care and the health status of Virginians can benefit from the use of available screening and preventive care services. One proponent contended that the proposed mandate imposed an inflexibility on insurers that is inconsistent with changing medical guidelines.

*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 for an annual pap smear to range from \$0.05 to \$5.49 per month per group

certificate holder; and \$0.05 to \$4.19 per month per individual policyholder. Opponents of the bill assert that adequate coverage is currently available through optional preventive care packages and riders. In its written comments, VAHMO notes that HMOs already cover pap smears for their members; therefore, the cost of the proposed mandate would not affect HMO enrollees. VAHMO further noted that the cost to provide this service is believed to be insignificant when compared to the high cost of treating the effects of cancer.

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

One opponent recommended that, if the Advisory Commission determines there is a compelling need to enact legislation on this matter, the Advisory Commission should consider a mandated option.

It is expected that the cost of a mandated offer of coverage would be higher because the cost would rest on only those who select the coverage. In the case of group coverage, the decision whether to select the optional coverage or not would lie with the master contract holder and not the individual. Therefore, coverage may not reach some women who desire it.

#### **RECOMMENDATION**

To eliminate conflict with the federal requirements, the Advisory Commission agreed to a technical change that would strike language requiring insurers issuing medicare supplement policies to comply with the proposed mandate. As drafted, the bill does not indicate whether the office visit in connection with the pap smear is to be included in the coverage specified in Senate Bill 1028. The Advisory Commission determined that it was the patron's intent that the bill require insurers to provide coverage only for the costs for collection and laboratory reading of the pap smear and not the entire office visit.

The Advisory Commission acknowledges that early diagnosis and treatment of cervical cancer are important. However, the Advisory Commission feels that the schedule proposed in Senate Bill 1028 is inconsistent with other schedules accepted on the national level. The Advisory Commission voted to amend the bill and to add language indicating coverage should be consistent with the recommendations of the U.S. Preventive Services Task Force (Task Force). The schedule recommended by the Task Force currently includes regular pap tests for all women who are or have been sexually active to begin at the age when the woman first engages in sexual intercourse or, at age 18, and may discontinue at age 65, if previous smears have been consistently normal. The test should be performed every one to three years, as determined by the physician. It was suggested that language be included in the bill to exempt pap

smears 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 1028. The Advisory Commission voted to recommend Senate Bill 1028, as amended, on July 10, 1995 (7-Yes, 3-No).

#### **CONCLUSION**

All interested parties acknowledged the value of early detection in the treatment of cervical cancer. Since the introduction of the pap test in 1943, the number of advanced lesions has decreased significantly. However, the frequency and timing of screening remains controversial. Information provided to the Advisory Commission during its review indicated that estimates of the cost for providing coverage for this procedure, as recommended in Senate Bill 1028, varied widely. However, both proponents and opponents indicated that the cost for providing coverage for preventive care, such as the pap smear, was not significant when compared to the cost of treating cervical cancer. The Advisory Commission concluded, therefore, that Senate Bill 1028 should be recommended with the amendments proposed by the Advisory Commission.

LD6911739

SENATE BILL NO. 1028

Offered January 23, 1995

A BILL to amend and reenact § 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.1:2, relating to accident and sickness insurance; coverage for annual pap smears.

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

Referred to the Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3418.1:2 as follows:

§ 38.2-3418.1:2. Coverage for pap smears.

A. Notwithstanding the provisions § 38.2-3419, 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 provide coverage under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1995, for annual pap smears.

B. 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.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1310, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3411.2, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.1:2, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3525, 38.2-3542, and Chapter 53 (§ 38.2-5300 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

LD6911739

SB1028

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