REPORT OF THE
SPECIAL ADVISORY COMMISSION ON
MANDATED HEALTH INSURANCE BENEFITS

MANDATED COVERAGE FOR COLORECTAL CANCER SCREENING

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 31

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

COMMONWEALTH OF VIRGINIA

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SENATE

December 28, 1999

To: The Honorable James S. Gilmore, III
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 1285 regarding a proposed mandate of coverage for colorectal cancer screenings.

Respectfully submitted,

Stephen H. Martin
Chairman
Special Advisory Commission on
Mandated Health Insurance Benefits

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INTRODUCTION

The 1999 Senate Committee on Commerce and Labor referred Senate Bill 1285 to the Special Advisory Commission on Mandated Health Benefits (Advisory Commission) to be reviewed prior to the 2000 Session of the General Assembly. Senate Bill 1285 is patroned by Senator Emily Couric.

The Advisory Commission held a public hearing on July 28, 1999, in Richmond to receive public comments on Senate Bill 1285. In addition to the bill's chief patron, three interested parties spoke in favor of Senate Bill 1285. One speaker was a gastroenterologist, another was a registered gastroenterology nurse, and the third was a patient with colorectal cancer. Written comments supporting the bill were received from the American Cancer Society, and the Old Dominion Society of Gastroenterology Nurses and Associates. Representatives from the Virginia Association of Health Plans (VAHP) and the Health Insurance Association of America (HIAA) also addressed Senate Bill 1285 at the public hearing, but did not oppose the bill.

Written comments in opposition to Senate Bill 1285 were received from Trigon Blue Cross Blue Shield and the Virginia Manufacturers Association. No one spoke in opposition to Senate Bill 1285 at the public hearing.

SUMMARY OF PROPOSED LEGISLATION

Senate Bill 1285, as introduced, would amend the accident and sickness chapter of Title 38.2 of the Code of Virginia by adding §38.2-3418.8 to require insurers 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, corporations providing individual or group subscription contracts and health maintenance organizations (HMOs) to cover colorectal cancer screening under policy, contracts, or plans delivered, issued for delivery, or renewed on or after July 1, 1999.

The bill outlines guidelines for when the colorectal cancer screenings shall take place and what types of procedures are to be used during the screenings. The variables for screening guidelines are based on age, family history, personal history, and other factors. Many options are included for the several different types of screening tests to be performed. Most of the proposed screening guidelines are in accordance with guidelines set forth by the American Cancer Society and the American College of Gastroenterology.

The bill requires coverage for a person (i) less than 65 and not covered by Medicare and (ii) deemed high-risk for colon cancer because of colorectal or adenomatous polyps in first-degree relatives younger than 60, or in two first-

degree relatives of any age. Coverage must include colonoscopy beginning at age 40 or 10 years before the youngest case in the family, whichever is earlier. Coverage shall also be available to such person for other tests, indications and frequencies as defined for the Medicare population in the applicable medical statute. Coverage must be provided for those with a family history or hereditary nonpolyposis colon cancer or familial adenomatous for a colonoscopy every one to two years, and with other frequency deemed appropriate by the attending physician.

Amended language was presented on behalf of the patron prior to the August 24th meeting. New bill language outlined colorectal screenings to follow the most recently published guidelines of the American Cancer Society, the American College of Gastroenterology, the American Society of Gastrointestinal Endoscopy, the American Gastroenterologic Association, and the following criteria:

- For average risk individuals age 50 and older; a combination of a fecal occult blood test annually, and a flexible sigmoidoscopy every five years, or a colonoscopy every 10 years; or a double contrast barium enema every 5 to 10 years.

- For moderate risk individuals with personal or family history, a colonoscopy within 3 years after a polyp is found for those who are found with a single, small adenomatous polyp; or a colonoscopy within 3 years after a polyp is found for those with large or multiple adenomatous polyps; or a colonoscopy within 1 year after cancer is detected for those with a personal history of a curative-intent resection of colorectal cancer and, a follow-up exam within 3 years; or a colonoscopy at age 40, or ten years before the youngest case in the family for those who have a family history of relatives having colorectal cancer or adenomatous polyps in one first-degree relative younger than 60 years of age, or two or more first-degree relatives of any age; and a colonoscopy every 10 years, or a combination of fecal occult blood test annually and flexible sigmoidoscopy every five years, or a double contrast barium enema earlier than age 50 for all others.

- For high risk individuals with extreme personal and family history a surveillance with endoscopy beginning at puberty for those with a family history of familial adenomatous polyposis; or a colonoscopy beginning at age 21 and continuing every other year until age 40, then colonoscopy annually for those who have family history of hereditary non-polyposis colon cancer; and a colonoscopy every 1-2 years, which shall begin 8 years after the start of pancolitis; or 12-15 years after the start of left-sided colitis for those with inflammatory bowel disease.

COLORECTAL CANCER SCREENINGS

Colorectal cancer is defined as a malignancy in the intestine. It is also known as intestinal cancer, and cancer of the intestine. The American Cancer Society (ACS) reports that most cases of colorectal cancer start from a polyp. A polyp is tissue growth along the lining of the colon or rectum. The polyp is what may develop into cancer. If the polyps are found and removed, colorectal cancer may be prevented. If the polyps are not found and removed at an early stage, then colorectal cancer may be a life-threatening disease.

There are five different types of screening procedures that are cited by the American Cancer Society and the National Cancer Institute for detection of polyps and colorectal cancer. The first screening procedure is called the digital rectal exam (DRE), a procedure also used to detect prostate cancer. To conduct this test a physician inserts a lubricated, gloved finger into the rectum to feel for abnormalities. The procedure is not painful and is used to detect other rectal cancers. A second well-known screening test is the Fecal Occult Blood Test (FOBT). This test is performed by examining a stool sample for blood in the stool.

A third common type of colorectal cancer screening is known as a sigmoidoscopy. The sigmoidoscopy test is performed by inserting a "slender, flexible, hollow, lighted tube" (American Cancer Society), into the rectum. This test allows the doctor to see the rectum and part of the colon to detect polyps. The test may be uncomfortable, but is not painful.

The fourth type of screening procedure is known as a colonoscopy. The procedure is similar to the sigmoidoscopy procedure because it involves insertion of a tube to view the rectum and colon. This tube however, is about the width of a finger and allows the doctor to see the rectum and the entire colon. The tube is connected to a video camera and a display monitor to view the results. Another feature of the colonoscopy is that if polyps are found they can be removed while the colonoscope tube is inserted. A wire loop is passed through the end of the colonoscope and severs the polyps by using an electrical current in this procedure. The severed polyp can be used for further research to see if it is cancerous.

The final type of screening procedure used to detect colorectal cancer is the barium enema with air contrast (also known as a double contrast barium enema). This screening is conducted after a barium sulfate enema is administered. The barium enema is a white, chalky substance that outlines the colon and rectum. After the colon is filled with the barium, the patient is x-rayed to detect cancer.

CURRENT INDUSTRY PRACTICES

Staff surveyed fifty of the top writers of accident and sickness insurance in Virginia in March 1999, regarding the bills to be reviewed by the Advisory Commission this year. Twenty-eight companies responded to the survey by April 9, 1999. Four of the companies indicated that they have little to no applicable health insurance business in force in Virginia.

Of the 24 respondents that completed the survey, nine indicated that they currently provide the coverage required by Senate Bill 1285, under their standard benefit package. Eight of the companies do not provide the coverage. Two companies include coverage for group contracts. Two more include coverage for individual contracts. Two other companies offer coverage to group policyholders, and one company offers coverage to individual policyholders.

SOCIAL IMPACT

Senate Bill 1285 would require coverage for colorectal cancer screenings. In 1990, 2,557 people were diagnosed with colorectal cancer in Virginia. By 1996 this number had grown to 3,172 people being diagnosed with colorectal cancer in the Commonwealth of Virginia, as reported by the Virginia Cancer Registry. Between the years 1990 and 1996, the number of those diagnosed with colorectal cancer has increased in most years. From 1992 to 1993, the numbers went down by 7, and from 1993 to 1994, the numbers dropped by 135. Overall, the numbers have continually risen, increasing almost 15% from 1990 to 1996.

The Virginia Cancer Registry (Registry) reported that the rate of colorectal cancer increases with age, that males have a higher incidence rate than females, and that genetics may play a part of increased risk. The Registry also reported that research has shown that diets low in fat and high in fiber reduce the risk of colorectal cancer.

FINANCIAL IMPACT

Respondents to the Bureau of Insurance survey provided cost figures of between $.10 and $1.33 per month per standard individual policy. Cost figures were between $.08 and $7.42 per month per standard group certificate, to provide coverage for the benefits contemplated by Senate Bill 1285. Insurers providing coverage on an optional basis provided cost figures from $1.33 to $7.50 per month per standard individual policy, and between $.80 to $2.66 per month per standard group certificate.

Staff also surveyed local hospitals and medical laboratories to obtain the costs of colorectal cancer screenings. Most interviewees did not provide cost estimates for the barium enema procedure because they said it is not widely used. Costs for the fecal occult blood tests ranged from $5 to $32. Estimates for digital rectal examination were between $5-$6. Sigmoidoscopy cost ranged between $75 and $125. Finally, colonoscopy, the most expensive screening procedure, was reported to cost between $650 and $1,200.

MEDICAL EFFICACY

Information provided to the Advisory Commission indicates that colorectal cancer screenings check for symptoms before they cause long-term health problems or terminal illness. Detecting the symptoms at an early stage usually means cancer treatments will be more successful. This process of detecting colorectal cancer polyps is the key to treating colorectal cancer. All information provided also indicates that "survival is greatly enhanced when colorectal cancer is detected early and appropriate treatment provided" as stated by the Centers for Disease Control and Prevention. The Centers for Disease Control and Prevention also report that when colorectal cancer is diagnosed at a localized stage, death rates are low: about 9% will die within 5 years. However, when patients are diagnosed at an advanced stage, it is estimated that about 92% will die within 5 years.

SIMILAR LEGISLATION IN OTHER STATES

Staff surveyed other insurance departments and received information available from the National Association of Insurance Commissioners, the National Insurance Law Service, and the State Cancer Legislative Database to determine if requirements are imposed in other states that are similar to Senate Bill 1285. Two other states have laws requiring insurers to cover colorectal cancer screening. Illinois 215 ILCS 5/356x, mandates coverage of a sigmoidoscopy or fecal occult blood testing once every three years for those who are at least 50 years old. For those deemed high risks, coverage will apply to those who are at least 30 years old.

The State Cancer Legislative Database includes New Jersey as a state that mandates coverage of colorectal cancer screening by insurers. New Jersey § 17B: 27-46-1f mandates coverage every five years, for those 45 and older by a left-sided colon examination. The schedule of screening could be changed if medically appropriate and recommended by a physician.

SOCIAL IMPACT

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

The ACS estimates that there will be about 129,400 new cases of colorectal cancer diagnosed in 1999. The ACS also estimates that colorectal cancer will cause 56,600 deaths in 1999. Information from the Virginia Cancer Registry indicates that 2,557 people were diagnosed with colorectal cancer in Virginia in 1990. By 1996 this number had grown to 3,172 people being diagnosed with colorectal cancer in the state of Virginia.

Overall, in the United States colorectal cancer deaths have decreased during the past 20 years. The ACS and other organizations credit colorectal cancer screenings and the fact that treatments have become more efficient. In Virginia, the numbers have continually risen and increased almost 15% from 1990 to 1996.

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

Of the 24 respondents that completed the Bureau survey, nine indicated that they currently provide the coverage required by Senate Bill 1285, under their standard benefit package. Eight of the companies do not provide the coverage. Two companies include coverage for group policyholders. Two more include coverage for individual policyholders. Two other companies offer coverage to group policyholders, and one company offers coverage to individual policyholders

Two insurance representatives were present at the public hearing to discuss Senate Bill 1285. The representative from the Virginia Association of Health Plans (VAHP) stated that he represents HMOs and some managed care companies. He explained that most HMOs already provide this type of coverage because of an emphasis on preventive care. Most of the other companies in the VAHP also provide the coverage in Senate Bill 1285.

A representative from the Health Insurance Association of America (HIAA) also commented on the types of coverage HIAA member companies provide. HIAA members offer indemnity plans and managed care plans. Indemnity plans usually do not cover screenings as mandated in Senate Bill 1285, but this type of

coverage can be added to the indemnity plans by a separate rider. He noted that fewer people are enrolling in indemnity plans.

Neither representative from the VAHP or HIAA opposed this mandate.

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.*

Representatives from the VAHP and HIAA contend that coverage is available in almost all HMO and managed care plans. For indemnity plans, coverage may not be available in most cases, but can be obtained through a separate rider. Medicare also provides coverage for colorectal cancer for those who are qualified. Screening for colorectal cancer was a new benefit for Medicare recipients as of January of 1998.

Proponents testified that colorectal screening tests are not covered by basic insurance plans. If a test is considered medically necessary by a physician, then it is covered by basic insurance plans, but routine screenings are not deemed medically necessary.

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.*

Staff surveyed local hospitals and medical laboratories to obtain the costs of colorectal cancer screenings. Most interviewees did not provide cost estimates for the barium enema procedure because they said it is not widely used. Costs for the fecal occult blood tests ranged from $5 to $32. Estimates for digital rectal examination were between $5-$6. Sigmoidoscopies ranged between $75 and $125. Finally, colonoscopy, the most expensive screening procedure was reported to cost between $650 and $1,200.

If coverage is not available then some of the individuals needing screening would suffer financial hardship. Some of the tests cost as little as $5, however the range goes up to $1,200. The tests that cost between $5 and $125 are not as effective as the colonoscopy, which can cost upwards of $1,200. The least expensive tests cannot effectively screen the entire colon and are used for initial screenings. Also, screening guidelines may require the colonoscopy every year which is an out-of-pocket expense of $650-$1,200, every year.

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

The ACS estimates that there will be about 129,400 new cases of colorectal cancer diagnosed in the United States in 1999. The ACS also estimates that colorectal cancer will cause 56,600 deaths in the United States in 1999. In 1990, 2,557 people were diagnosed with colorectal cancer in Virginia. By 1996 this number had grown to 3,172 people being diagnosed with colorectal cancer in the state of Virginia, as reported by the Virginia Cancer Registry. Over that six-year period there was a 15% increase. The Virginia Cancer Registry also reported that the rate of colorectal cancer increases with age.

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

One gastroenterologist and one gastroenterology nurse spoke in favor of Senate Bill 1285. Many medical societies, including those specializing in gastroenterology, wrote letters endorsing Senate Bill 1285. They argued that the key to prevention of this disease is to detect it at an early stage. One doctor testified that more than 90% of the cases of colorectal cancer could be prevented or treated if caught at an early stage. They recognized that colorectal cancer treatments can be very expensive if not caught at an early stage. They explained that screenings serve as a preventive measure that is cost-effective because they detect the cancer before it spreads and expensive treatments are needed.

The proponents of the bill admitted that some of the screenings are expensive, yet they are efficient and are life-saving tools that are also cost-effective tools. They also testified that currently these screening tests are not covered by basic insurance plans. If a test is considered medically necessary by a physician, then it is covered by basic insurance plans, but routine screenings are not deemed medically necessary.

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

No information was received from collective bargaining organizations addressing potential interest in negotiating privately for inclusion of this coverage in group contracts.

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 relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of this 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.*

No information was provided by either proponents or opponents that would suggest that enactment of Senate Bill 1285 would either increase or decrease the cost of colorectal cancer screenings.

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

Proponents anticipate that the appropriate use of colorectal screening tests will increase with the enactment of the proposed mandate. Men and women would have coverage through their insurance companies to be screened for colorectal cancer by guidelines established in the proposed bill language. Proponents stated that the proposed mandate would decrease the cost of colorectal cancer treatments and surgery because the preventive screening tests will detect colorectal cancer at an early stage.

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

The alternative to the mandated screening test is for the cancer to go undetected. If the individual avoids the colorectal screening tests included in language in the bill, then they may develop cancerous polyps. The cancerous polyps spread the disease through other parts of the body. Without early detection many polyps will form, grow, and spread by the time symptoms are found. By this time colorectal cancer is a painful, deadly invasive disease.

The New England Journal of Medicine printed an article in October 1993 on research done by the National Cancer Institute (NCI). The National Cancer Institute found that for each dollar expended in colorectal cancer screenings, a reciprocated net return of $4.40 was gained. There was a net saving for a colorectal cancer screen of $15.40 per person per year, for the effort of colon

cancer screening. The article was presented by gastroenterologist David Johnson at the public hearing.

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.

Gastroenterologists are already performing the colorectal cancer screening tests. All of the tests in the bill language are presently being used, therefore the number and type of provider of the mandated services are not expected to increase over the next five years as result of this bill.

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.

Representatives from the Virginia Association of Health Plans (VAHP), and the Health Insurance Association of America (HIAA) were present at the Advisory Commission meetings to discuss this issue. Representatives from both groups reported that if the proposed mandate was enacted that it would be a cost-effective mandate, saving the insurers money in the long run.

Respondents to the Bureau of Insurance survey provided cost figures of between $.10 and $1.33 per month per standard individual policy. Cost figures were between $.08 and $7.42 per month per standard group certificate, to provide coverage for Senate Bill 1285. Insurers providing coverage on an optional basis provided cost figures from $1.33 to $7.50 per month per standard individual policy, and between $.80 and $2.66 per month per standard group certificate

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. Dr. David Johnson cited facts from a report by Dr. Peter McMenamin in 1996. Mr. McMenamin was commissioned by the American College of Gastroenterology to develop a framework to project colorectal screening costs. His report estimated that screening for colonoscopy (which is the most expensive colorectal screening test) cost $3.25 per person per year. The Congressional Budget Office did the same study in 1997 and concluded that a colonoscopy would cost $3.50 per person per year.

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.*

Information from the ACS indicates that colorectal cancer screenings check for symptoms before they cause long-term health problems or terminal illness. Detecting the symptoms at an early stage usually means cancer treatments will be more successful. Detecting colorectal cancer polyps is the key to treating colorectal cancer. If the symptoms go undetected, colorectal cancer becomes an invasive and painful deadly disease.

Information from the Centers for Disease Control and Prevention's Internet web site indicates that "survival is greatly enhanced when colorectal cancer is detected early and appropriate treatment provided." The Centers for Disease Control and Prevention also report that when colorectal cancer is diagnosed at a localized stage, death rates are low: about 9% will die within 5 years. However, when patients are diagnosed at an advanced stage, it is estimated that about 92% will die within 5 years.

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.*

Proponents of Senate Bill 1285 argued that the proposed coverage addresses a broad medical and social need. Medically, Senate Bill 1285 is consistent with the role of health insurance because it is a preventive measure that can save lives. They argue that screening is medically necessary because colorectal cancer is the second leading cause of cancer deaths in the United States and the screening will decrease the large number of deaths. The key to prevention is early intervention and removal of colorectal cancer polyps.

Colorectal cancer is expected to be diagnosed in 129,400 new patients in the U.S. in 1999, and cause death for about 55,000. Approximately 3,000 new patients will be diagnosed in Virginia, and approximately 1,300 will die in 1999. Therefore, this disease is affecting a significant portion of the population and has a substantial impact upon society. It is also proven to be a disease that is hereditary and it can affect many in a single family.

There were no opponents who indicated that the proposed coverage was inconsistent with the role of health insurance.

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

Respondents to the Bureau of Insurance survey provided cost figures of between $.10 and $1.33 per month per standard individual policy. Cost figures were between $.08 and $7.42 per month per standard group certificate, to provide coverage for Senate Bill 1285. Insurers providing coverage on an optional basis provided cost figures from $1.33 to $7.50 per month per standard individual policy, and between $.80 and $2.66 per month per standard group certificate.

Dr. David Johnson and other proponents argued that by providing this coverage, insurers would actually save money. They stated that by mandating colorectal screening guidelines, the cancer would be detected before spreading through the entire rectum and colon, as well as other parts of the body. The early detection and cure eliminates the cost of treatments and surgeries for colorectal cancer if it had spread.

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

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 insureds.

RECOMMENDATION

The Advisory Commission voted on September 21, 1999 to recommend that Senate Bill 1285 be enacted (Yes-9, No-1), with the amendments submitted on behalf of the patron.

CONCLUSION

The Advisory Commission found that treatment for colorectal cancer was generally covered, if deemed necessary by a physician. However, routine screenings for colorectal cancer are not categorized as a medical necessity. The Advisory Commission acknowledged that the key to survival of colorectal cancer was through screenings proposed by the guidelines and bill language. The Advisory Commission found that colorectal screening guidelines were beneficial to all of society as a preventive measure. The proposed mandated coverage is believed to be a preventive measure, and also a cost saving tool for insurers.

The Chairman of the Advisory Commission, Senator Stephen Martin asked the patron as well as the ACS, and insurance industry representatives to address some ambiguities in the revised language.

APPENDIX A

995099635

SENATE BILL NO. 1285

Offered January 21, 1999

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 38.2-3418.8, relating to accident and sickness insurance; coverage for colorectal cancer screening.

Patron—Couric

Referred to 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 38.2-3418.8 as follows:

§ 38.2-3418.8. Coverage for colorectal cancer screening.

A. Notwithstanding the provisions of § 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; and each health maintenance organization providing a health care plan for health care services shall provide coverage for colorectal cancer screening under any such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth, on and after July 1, 1999.

B.1. Colorectal cancer screening covered by this section shall include screening with annual fecal occult blood tests (three specimens) and flexible sigmoidoscopy every five years for persons who are at least fifty years of age.

2. For persons who are deemed at moderate risk for colorectal cancer because of colorectal cancer in a relative (who had the disease onset after sixty years of age), annual stool hemocculs and flexible sigmoidoscopy screening every five years will be covered for persons who are at least forty years of age.

3. For those persons less than sixty-five years of age and who are not covered by Medicare who are deemed at high risk for colon cancer (because of colorectal cancer or adenomatous polyps in first-degree relatives younger than sixty years of age or in two or more first-degree relatives of any age), colonoscopy will be covered beginning at age forty or ten years before the youngest case in the family, whichever is earlier, or alternatively, shall have available to them other tests, indications and frequencies as defined for the Medicare population in the applicable medical statute. In patients with a family history of hereditary nonpolyposis colon cancer or familial adenomatous polyposis, colonoscopy should be repeated every one to two years with possible alterations in frequency as deemed appropriate by the attending physician.

C. The provisions of this section shall not apply to (i) short-term travel, accident only, limited or specified disease policies other than cancer policies, (ii) short-term nonrenewable policies of not more than six months duration, or (iii) policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 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, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 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 38.2-1309, Articles 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 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, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3407.12, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1 through ~~38.2-3418.7~~ *38.2-3418.8*, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 58 (§ 38.2-5800 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.

APPENDIX B

SENATE BILL NO. 1285 - Patron - Couric

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 38.2-3418.8, relating to accident and sickness insurance; coverage for colorectal cancer screening.

§§38.2-3418.8. Coverage for colorectal cancer screening.

A. Notwithstanding the provisions of §§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; and each health maintenance organization providing a health care plan for health care services shall provide coverage for colorectal cancer screening under any such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth, on and after July 1, 2000 in accordance with the most recently published guidelines established by the American Cancer Society and by the national gastroenterology societies, i.e., the American College of Gastroenterology, the American Society of Gastrointestinal Endoscopy , and the American Gastroenterologic Association.

For purposes of this section, the most recently published guidelines established by the American Cancer Society and the national gastroenterology societies, shall hereinafter be referred to "the Guidelines."

Add to: 2.1-20.1 Health related insurance for state employees

Add to: 32.1-325 State Plan for Medical Assistance Services

B. Colorectal cancer screening shall be provided, in accordance with the Guidelines, (i) for persons fifty years of age and older, annual fecal occult blood tests (three specimens), flexible sigmoidoscopy every five years, or colonoscopy alone every ten years; and (ii) for persons who are at high risk for colorectal cancer, colonoscopy shall be provided as follows: (a) For patients with recognized genetic syndromes of colon cancer, colorectal cancer screening shall begin at age fifteen, with sigmoidoscopy being provided annually for patients with a history of familial polyposis and colonoscopy being provided at least every two years for patients with a history of nonpolyposis colon cancer beginning by twenty years of age, until age forty when colonoscopy shall be provided annually; (b) For patients with inflammatory bowel disease and a seven to ten-year-history of pancolitis and for those patients with a fifteen or more year history of left-sided colitis, colonoscopy shall be provided annually; (c) For patients age forty or older who have a family history in a first degree relative older than 60 of polyps, inflammatory bowel disease, breast, ovarian, endometrial or colon cancer, or another familial or lifestyle indicator, colonoscopy shall be offered at intervals no more frequently than every two years; and (d) For patients with the aforementioned indicators in a first degree relative younger than 60, colonoscopy shall begin at age forty or ten years before the youngest case in the family, whichever is earliest. These guidelines may be revised as changes are adopted by the above referenced organizations.

C. The benefits provided under this section shall be under the same terms and conditions as for any other medical condition covered by the insurance policy, service contract, indemnity or managed care health plan. Coverage shall neither be different nor separate from coverage for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

D. The provisions of this section shall not apply to (i) short-term travel, accident only, limited or specified disease policies other than cancer policies, (ii) short-term nonrenewable policies of not more than six months duration, or (iii) policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.