

California Health Benefits Review Program

Analysis of California Assembly Bill (AB) 1763 Colorectal Cancer Screening

A Report to the 2015-2016 California State Legislature

April 7, 2016



Key Findings:

Analysis of California Assembly Bill AB 1763 Colorectal Cancer Screening

Summary to the 2015-2016 California State Legislature, April 2016



AT A GLANCE

Assembly Bill (AB) 1763 would require plans or policies to provide coverage for colorectal cancer (CRC) screenings and tests.

- **Enrollees covered.** CHBRP estimates that in 2016, 25.2 million Californians have state-regulated coverage that would be subject to Assembly Bill (AB) 1763.
- **Impact on expenditures** (AB) 1763 would increase total net annual expenditures by \$5.63 million or 0.004% for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a 25.92 million increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, partially offset by a decrease in enrollee expenditures for previously noncovered benefits (\$20.29 million).
- **EHBs.** AB 1763 impacts the terms and conditions of coverage for CRC screenings and tests, but does not change coverage itself. AB 1763 does not exceed EHBs.
- **Medical effectiveness.** There is a preponderance of evidence that USPSTF-recommended CRC screening modalities are medically effective for the detection and prevention of CRC among average- and high-risk individuals.
- **Benefit coverage.** CHBRP estimates the percentage of enrollees with coverage for CRC screening exams and lab tests assigned a grade of A or B by the USPSTF and additional screening and tests recommended by a physician will remain to be 100%. However, AB 1763 would eliminate cost sharing on CRC screenings and lab tests for enrollees aged 50 and older including colonoscopies with the removal of polyps if the enrollee has a positive result on any fecal test. CHBRP estimates 5% of their enrollees aged 50 and older in high-deductible plans would be exempted from waving cost sharing. Accordingly, CHBRP estimates that the percent of enrollees aged 50 and older with coverage for CRC screening services listed in AB 1763 without cost sharing would increase from 78% to 95%.
- **Utilization.** CHBRP assumes that the overall utilization of CRC screening and lab tests is going to increase by 0.3% (1,764 users), which is mainly due to the increase in use among enrollees aged 50 and older after the removal of cost-sharing requirements for CRC screening and lab tests.
- **Public Health.** CHBRP projects no measurable public health impact on the diagnosis or prevention of colorectal cancer at the population level due to the small number (1,764) of additional enrollees who would avail themselves of CRC screening. At the individual level, AB 1763 would likely yield health and quality of life improvements, such as reduced screening-related financial burden and identification of CRC at earlier, and therefore more treatable, stages.
- **Long-term impacts.** To the extent that AB 1763 would eliminate cost sharing for medically necessary additional colorectal cancer screenings and all events along the stepwise "continuum of screening", including follow-up colonoscopies to positive fecal tests and polyp removal during colonoscopies, it would be reasonable to assume that this reduction in financial burden would promote greater adherence to physician-recommended screenings beyond those projected for the first 12 months following implementation of the mandate.

BILL SUMMARY

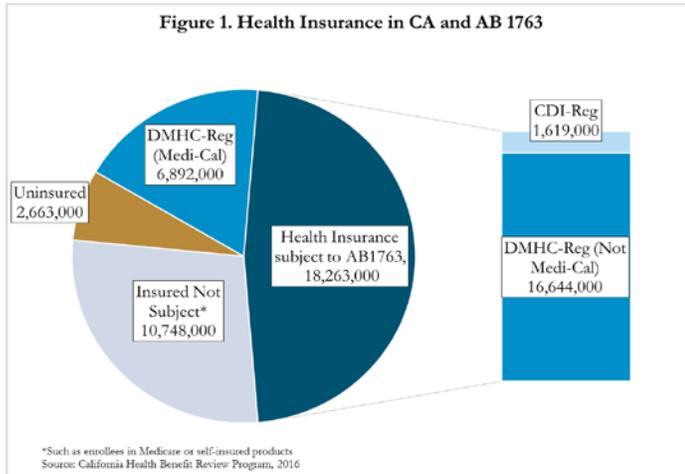
Assembly Bill 1763 (introduced February 2016) would require health care plans and insurance policies to provide coverage for colorectal cancer screenings and tests with a grade of A or B by the U.S. Preventive Services Task Force (USPSTF), provide coverage for additional screenings and tests for high-risk individuals, and remove cost-sharing for enrollees aged 50 and over.

INCREMENTAL IMPACT OF ASSEMBLY BILL (AB) 1763

Benefit Coverage, Utilization, and Cost

Coverage Impacts

If AB 1763 were enacted, CHBRP estimates the percentage of enrollees with coverage for colorectal cancer screening exams and lab tests assigned a grade of A or B by the USPSTF and additional screening and tests recommended by a physician would remain to be 100%. However, AB 1763 would eliminate cost sharing on CRC screenings and lab tests for enrollees aged 50 and older including colonoscopies with the removal of polyps if the enrollee has a positive result on any fecal test. As AB 1763 does not apply to high-deductible plans, CHBRP estimates 5% of enrollees aged 50 and older would be exempted from waving cost sharing. Accordingly, CHBRP estimates that the percent of enrollees aged 50 and older with coverage for CRC screening services listed in AB 1763 without cost sharing would increase from 78% to 95%.

Figure 1. Health Insurance in CA and AB 1763

Utilization Impacts

CHBRP assumes that the overall utilization of CRC screening and lab tests is going to increase by 0.3% (1,764 users), which is mainly due to the increase in use among enrollees aged 50 and older after the removal of cost-sharing requirements. The improved access will be beneficial to those enrollees at average risk who were discouraged from seeking CRC screening services due to the cost-sharing requirements.

Cost Impacts

CHBRP estimates that (AB) 1763 would increase total net annual expenditures by \$5.63 million or 0.004% for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a \$25.92 million increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, partially offset by a decrease in enrollee expenditures for previously noncovered benefits (\$20.29 million).

Public Health

Colorectal Cancer (CRC) Rates

Measurable health outcomes relevant to AB 1763 include reduced incidence of colorectal cancer and CRC-associated morbidity and mortality, improved quality of life, and reduction in financial barriers to screening. However, CHBRP projects no measurable public health impact on the diagnosis or prevention of colorectal cancer at the population level due to the small number (2,358) of

additional enrollees who would avail themselves of CRC screening.

CHBRP estimates that AB 1763 would modify coverage and reduce the net financial burden by \$3.2 million in the first year, postmandate, for covered enrollees aged 50 and older utilizing the 2,358 additional screenings beyond USPSTF recommendations, on the basis of high-risk status.

Medical Effectiveness

There is a moderate preponderance of evidence that USPSTF-recommended screenings are effective for persons with a family history of CRC, persons with prior CRC, persons with a precursor neoplastic polyp, and persons with inflammatory bowel disease.

Evidence of the impact of expanded insurance coverage on screening utilization is limited to observational studies. The impact of insurance coverage for CRC screening and utilization among high-risk populations has not been assessed by these studies.

For average-risk individuals, evidence exists suggesting a small but positive impact of insurance coverage for CRC screening and utilization (Cokkinides, 2011), and that low socioeconomic status individuals may benefit from the elimination of barriers to screening utilization (Fedewa, 2015a).

Long-Term Impacts

Adherence to Recommended Screenings

To the extent that AB 1763 would eliminate cost sharing for medically necessary additional colorectal cancer screenings and all events along the stepwise "continuum of screening," including follow-up colonoscopies to positive fecal tests and polyp removal during colonoscopies, it would be reasonable to assume that this reduction in financial burden would promote greater adherence to physician-recommended screenings beyond those projected for the first 12 months following implementation of the mandate.

CONTEXT FOR BILL CONSIDERATION

Essential Health Benefits and the Affordable Care Act

SB 1763's requirements regarding coverage of CRC screenings and tests given a grade of A or B by the USPSTF and coverage for tests recommended by treating physicians for high-risk individuals is consistent with ACA requirements that health plans that started on or after September 23, 2010, to cover CRC screening tests.

Therefore, (AB) 1763 does not exceed EHBs, and therefore would not trigger the ACA requirement that the state defray the cost of additional benefit coverage for enrollees in qualified health plans (QHPs) in Covered California.