April 14, 2008

The Honorable Sally Lieber
Speaker pro Tempore, California Assembly
State Capitol, Room 3013
10th and L Streets
Sacramento, CA 94249-0022

Dear Assemblymember Lieber:

I write in response to the request of Barry N. Steinhart, of your office, who requested clarification of the cost impact analysis provided in the California Health Benefits Review Program (CHBRP) Analysis of Assembly Bill 1774: Health Care Coverage: Gynecological Cancer Screening Tests, submitted on April 7, 2008.

The projected cost impact of $2.7 billion for AB 1774 is attributable to the number of screening tests that potentially would be ordered by a health provider once health plans and insurers are prohibited from applying their medical necessity criteria for their decisions with regard to these tests.

The basis of this projected cost impact is set forth in detail in the Utilization, Cost and Coverage Impact section of the report. However, a few points may be useful to re-state here.

- **Screening versus diagnostic tests:** Screening tests are not the same as diagnostic tests. Screening tests are performed on people who have no symptoms or findings suggestive of a cancer. A screening test is done on people who have do not have symptoms (asymptomatic) to find hidden disease. If the person has symptoms or findings that could be due to a cancer then diagnostic tests have to be conducted. Abnormal results on screening tests indicate a potential problem that must be resolved by diagnostic tests. Health plans and insurers currently cover diagnostic tests and screening tests that are in accordance with evidence-based guidelines. Therefore, the CHBRP cost impact focused on screening tests for “well” women; that is, women who are asymptomatic and at low risk for cancer (i.e., few risk factors for the disease).

- **Available effective screening tests for endometrial and ovarian cancers and genetic testing:** There is insufficient evidence in the medical literature to determine the effectiveness of screening asymptomatic women for endometrial or ovarian cancer. In addition, no national medical organization recommends screening “well” women for endometrial or ovarian cancer. The few tests that might be ordered (in particular, tests to determine genetic predisposition to certain cancers) are relatively expensive (about $3,000) and could be ordered for a substantial number of women; consequently, over half of the projected increase in costs, as presented in our current analysis, can be attributed to the increased use of such genetic testing.
For endometrial cancer, for example, the CHBRP cost model includes the assumption that a significant portion of “well” women would be tested for the genetic mutation associated with increased risk of endometrial cancer (hereditary nonpolyposis colorectal cancer [HNPCC]). Our report estimates that approximately 244,000 more genetic tests would be ordered in the first year following enactment than is presently ordered.

For ovarian cancer, our cost model includes the assumption that a significant portion of women who are not currently considered “high risk,” (those with less than three symptoms of ovarian cancer), would be tested for the BRCA 1 or 2 genetic mutation. This translates into about 232,000 more women receiving BRCA 1/2 genetic testing following enactment than is presently the case.

If health plans and insurers were not prohibited from applying their medical necessity criteria for purposes of coverage determinations, the bill would not be expected to result in an increase the number of screening tests that would be ordered by a provider; therefore, there would be no cost attributable to this mandate.

An explanation of why there would be no cost attributable to this mandate is provided on pg. 39 of the report, which reads:

“How Will Utilization Change as a Result of the Mandate?

If insurers retained discretion over whether tests were needed, utilization would be expected to remain unchanged as a result of AB 1774. As noted above in Current Coverage of the Mandated Benefit, plans are already covering gynecological cancer diagnostic tests for symptomatic women and medically appropriate screening tests for asymptomatic women. As described below in Impact on Access and Health Service Availability, no evidence exists to suggest that medically appropriate gynecological cancer tests are currently being denied coverage. The screening tests not currently covered have not been shown to be medically effective, so would continue to be denied if carriers were still allowed to use evidence-based guidelines to determine coverage. Although media campaigns to educate the public about the need for such tests could increase utilization of tests already being covered, these campaigns are likely to be mounted even if the bill did not pass, so their effects could not necessarily be attributed to the mandate. Moreover, in the absence of benefit changes, raising awareness alone may be insufficient to ensure that women will obtain necessary tests (Burack et al., 1998).”

My colleagues and I appreciate the opportunity to answer your question and will be happy to respond to any additional questions you may have. Please feel free to contact me at your convenience.

Sincerely,

Susan Philip, MPP
Director, CHBRP
Office of Health Sciences and Services
University of California Office of the President
CC:  Assemblymember Mervyn Dymally, Chair,
Senator Sheila Kuehl, Chair, California Senate Committee on Health
Assemblymember Fabian Nunez, Speaker of the Assembly
Senator Don Perata, President Pro Tem of the Senate
Assemblymember Alan Nakanishi, Vice Chair, Assembly Committee on Health
Assemblymember Joe Coto, Chair, Assembly Committee on Insurance
Assemblymember John Benoit, Vice Chair, Assembly Committee on Insurance
Assemblymember Mark Leno, Chair, Assembly Committee on Appropriations
Assemblymember Mimi Walters, Vice Chair, Assembly Committee on Appropriations
Senator Samuel Aanestad, Vice Chair, Senate Committee on Health
Senator Tom Torlakson, Chair, Senate Committee on Appropriations
Senator Dave Cox, Vice Chair, Senate Committee on Appropriations
Ambar Carlisle Salgueiro, Legislative Consultant, Office of Assemblymember Hector De La Torre
Deborah Kelch, Chief Consultant, Assembly Committee on Health
Allegra Kim, Consultant, Assembly Committee on Health
John Gilman, Consultant, Assembly Committee on Health
Peter Hansel, Staff Director, Senate Committee on Health
Lark Park, Consultant, Senate Committee on Health
Bob Franzoia, Staff Director, Senate Committee on Appropriations
Mary Ader, Principal Consultant, Assembly Committee on Appropriations
Almis Udrys, Consultant, Assembly Republican Caucus
Tim Conaghan, Consultant, Senate Republican Caucus
Kevin Hanley, Consultant, Assembly Republican Caucus
Elizabeth Hill, Legislative Analyst, California Legislative Analyst’s Office
Agnes Lee, Director, Senate Office of Research
Steve Poizner, Insurance Commissioner, California Department of Insurance
David Link, Deputy Commissioner, California Department of Insurance
Cindy Ehnes, Director, California Department of Managed Health Care (DMHC)
Sherrie Lowenstein, Senior Supervising Counsel/Legislative Coordinator, California DMHC
Ana Matosantos, Chief Deputy Finance Director, California Department of Finance
Robert Dynes, President, University of California, Office of the President (UCOP)
Bruce Darling, Executive Vice President, University Affairs, UCOP
Karen French, Interim Assistant Vice President and Director, State Governmental Relations, UCOP
Jeffrey Hall, Director of Legislation and Policy, Division of Health Sciences and Services, UCOP
Paul Schwartz, Communications Director, Strategic Communications, University Affairs, UCOP
W. Rory Hume, Provost, Executive Vice President, Academic and Health Affairs, UCOP
Cathryn Nation, Associate Vice President, Division of Health Sciences and Services, UCOP
Lauren LeRoy, President and CEO, Grantmakers In Health and
CHBRP National Advisory Council Chair

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