



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

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 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

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