A Study of Senate Bill 1239

A Report to the New Jersey State Senate by the

Mandated Health Benefits Advisory Commission

June 11, 2012

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Table of Contents

Introduction

On February 15, 2012 the Mandated Health Benefits Advisory Commission (Commission) was asked to issue a report on Senate Bill 1239 (S-1239), a bill originating in the 2012-2013 Legislative Session. S-1239 extends the current requirement for carriers (and the Public Employee Health Benefit Programs) by requiring coverage of screening mammograms, on a provider's recommendation, for women younger than age 40 who lack a family medical history due to adoption (or a parent's adoption).

The Commission prepared this report using its own resources, including New Jersey Department of Banking and Insurance (DOBI) staff. Commission members contributed significant professional expertise in providing direct input, evaluating published research, and drafting and reviewing the report.

The Commission contemplated engagement of an actuarial consultant and issued a scope of work. After evaluation, we determined that due to time constraints and the nature of the analysis required, the report could be prepared using Department staff.

The Commission is mandated by statute[1] to examine the "social, financial, and medical impact of proposed mandated health benefits." While the economic costs of S-1239 are estimated to be modest, the medical effects, in particular, have the potential to be significant. In addition to cost, this report addresses the effectiveness of screening mammography for younger women, possible side effects, and other impacts.

The report comments on the need for the bill's mandate in the commercial market. To that end, we address the current practices of New Jersey's commercial carriers in covering mammograms for women younger than age 40.

The Commission posts bills referred to it for study on its web site and invites the public to submit comments. The Commission received no public comments or been provided with any submitted testimonies or statements on S-1239. However, the Commission did receive a February 23, 2012 letter from the bill's primary co-sponsor Senator Joseph F. Vitale which is attached as an Appendix.

Summary

S-1239 applies to the state-regulated commercial health insurance market[2] and the state-operated State Health Benefits Plan.[3] There are slightly fewer than two million

[1] P.L.2003, c.193.
[2] The regulated health market consists of individual and group coverage sold in New Jersey by insurers, Health Maintenance Organizations, and Horizon Blue Cross Blue Shield of New Jersey. It includes coverage in the Individual Health Coverage (IHC), Small Employer Health (SEH) and large group markets.
[3] This also includes the separate School Employees' Health Benefits Program (SEHBP) which was established by P.L.2007, c.103.

people covered by the State-regulated market of the 8.7 million residents of New Jersey. This market has annual premiums of approximately $9 billion. In addition, the State Health Benefits Plan covers approximately 850,000 employees, retirees and dependents at an annual cost of approximately $4.8 billion. This bill does not apply to the benefits provided by private employer or labor union self-funded plans due to federal preemption pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"; Pub. L. 93-406; 29 U.S.C § 1002 et seq.).

S-1239 is a slight expansion of the screening mammography mandate already in effect in New Jersey. The existing law[4] requires coverage of screening mammograms annually for women 40 and older following a baseline mammogram sometime between ages 35 and 40. The existing law also requires coverage of screening mammograms for women younger than age 40 when indicated by family history or other breast cancer risk factors and recommended by the provider. S-1239 expands this mandate to require coverage for women younger than age 40 who were adopted or whose parent was adopted, again when recommended by the provider.

Elements of Senate Bill 1239

As noted above, existing law already requires extensive coverage of screening mammograms. S-1239 seeks to assure that the benefits of existing requirements are extended to women younger than age 40 who were adopted or whose parent was adopted.

The bill and existing law both require carrier coverage of screening mammograms, which, as discussed further below, are an element of comprehensive screening for breast cancer. The bill does not require coverage of other screening procedures. Additionally, neither the bill nor existing law requires coverage of any follow-up procedures to clarify an ambiguous result or diagnostic procedures to confirm an apparently positive result.

The bill and existing law both extend the mandate in the case of personal or family history. Guidelines for screening generally distinguish between different degrees of family history (focusing on ovarian and breast cancer and first degree relatives and multiple relatives with history).

The bill and existing law both mandate a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider. The bill and existing law both make coverage of screening mammograms for women younger than age 40 conditional on the recommendation of the medical provider.

The synopsis of the bill refers to adoption and adopted parents and lack of family history. But the text of the bill does not refer to relevant family history, so the Commission has assumed that the bill requires coverage of mammograms for women

[4] P.L.1991, c.279 amended by P.L.2004, c.86. These are codified separately in the statutes by market and type of carrier, e.g. NJSA 17B:27-46.1f for group health insurance.

younger than age 40 who are adopted or whose parent is adopted because such women may not have access to a complete family medical history. For example, virtually all references to family history in breast cancer screening are to female relatives.

Analysis

Social Impact

This bill is based on certain facts or assumptions about family structure. Statistics on the adoption rate are quite sparse. A fraction of the population (estimated at six to ten million individuals nationwide, or two to three percent of the population)[5] is or was cared for as children by adoptive parent(s). The adoption rate appears to be little changed from year to year, so these percentages likely approximate the percentage of women younger than age 40 who are adopted as well.

A subset of the adoptive population may not have access to the medical history of their parents. One reason for this, but certainly not the only one, is legal restrictions on disclosure of the identity of or information about biological parents. By extension, a person raised by biological parents, one or both of whom is adopted, for similar reasons may not have access to the medical history of their grandparents.

However, many people, whether or not they are adopted, are raised under circumstances where family medical history is incomplete or unavailable. Biological parents may be absent due to separation, divorce, or abandonment as well as adoption.

Even people raised in two-biological-parent families may have little information about the medical history of their deceased parents and grandparents beyond what is reported on the death certificate. The absence or presence of biological parents is only one factor in the availability of medical information.

The Commission is concerned that S-1239 identifies adopted persons as being uniquely disadvantaged because of the lack of a complete family medical history. The inability to access a complete family medical history is not unique to adopted children. There is no research known to the Commission that establishes that adopted children are disproportionately affected in their access to preventive health care or effective treatment by the lack of a complete medical history.

The Commission is aware that the unavailability of family medical history is, for some adopted children, a matter of state laws restricting access to that information and the existence of registries in which the information might be available. However, because this does not solve completely the issue of knowing family medical history, we did not analyze such laws as part of this study.

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[5] "Adopted Children and Stepchildren: 2000," http://www.census.gov/prod/2003pubs/censr-6.pdf, United States Census Bureau, (2003). This report indicates that 2.5 percent of children younger than 18 are adopted. Assuming the adoption rate is held constant; this percentage would be appropriate for the entire population and suggest approximately 7.5 million adopted individuals nationwide. The same census study indicates that 2.3 percent of children in New Jersey are adopted.

Medical Effectiveness

On the average, a woman has an approximately 1 in 8 chance of developing breast cancer over her lifetime. The incidence of breast cancer increases markedly with age. A woman aged 40 has about 25 times the chance of developing breast cancer in the next 10 years as a woman aged 20. A woman aged 60 has around 2.4 times the chance of developing breast cancer in the next 10 years as a woman aged 40. On the other hand, the cancers which do occur infrequently at the younger ages tend to be more aggressive and consequently the average survival time is shorter for these cases.[6]

Treatment is generally more effective the earlier the cancer is detected. Therefore, preventive health care for women includes screening to detect possible cancers, including breast cancer.[7]

Routinely used screening methods include clinical examination, mammography, and self-awareness (self-examination is no longer generally recommended). There are additional screening methods available if the mammography result indicated follow-up that include ultrasound, MRI or biopsy (These methods are used diagnostically for positive results as well as for follow-up).

Various organizations differ in their recommendations for routine screening in terms of starting age (40 or 50) and frequency (annually or less frequently). ACOG Bulletin No. 122[8] summarizes five such recommendations. ACOG, the American Cancer Society (ACS), the National Comprehensive Cancer Network (NCCN) and the National Cancers Institute (NCI) all recommend screening beginning at age 40. The US Preventive Services Task Force (USPSTF) recommends a starting age of 50. Three of the organizations recommended annual screening. The NCI recommends screening every one to two years and the USPSTF recommends screening every two years.

"Risk factor" refers to characteristics suggesting a higher than average probability of developing breast cancer at a certain age. The risk factor most relevant to this discussion is membership in an ancestral group with cancer in one or more close relatives. Family history is considered a risk factor because it could be an indicator of another risk factor, specifically the BRCA1 or BRCA2 genetic mutation. It is estimated that three to five percent of breast cancers have a genetic basis, that is, are due to these or other mutations. However, this small percentage is a somewhat misleading indicator of the risk, because the prevalence of the mutation in the overall population is low, somewhere in the range of 0.125 percent to .333 percent. A woman with a BRCA1 or BRCA2 mutation has a lifetime probability of developing breast cancer of 65-74 percent (as well as a higher risk of developing ovarian cancer).[9]

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[6] CDC Advisory Committee on Breast Cancer in Young Women, *Detailed Meeting Minutes* January 31, 2011-February 1, 2011 ("Five year survival rates in younger women are considerably lower than in older women"); "Breast Cancer Before Age 40 Years," Seminars in Oncology, Anders et al., June 2009 ("Breast cancers diagnosed at a younger age harbor aggressive clinicopathological features…").

[7] "Breast Cancer Screening" Practice Bulletin No. 122, American College of Obstetricians and Gynecologists (ACOG), August 2011 ("Tumors detected at an early stage that are small and confined to the breast are more likely to be successfully treated…").

[8] Id.

[9] "Hereditary Breast and Ovarian Cancer Syndrome" Practice Bulletin No. 103, ACOG, April 2009, reaffirmed 2011.

A separate ACOG Bulletin discusses the relationship between family history and the appropriateness of screening mammography for women younger than age 40.[10]

To summarize, when a BRCA1 or BRCA2 mutation is known (as a result of testing) to be present, surveillance or enhanced screening is an option, as are treatments such as chemoprevention or prophylactic surgery. Recommended surveillance includes semiannual clinical examination, annual mammography, and annual MRI, with imaging beginning at the earlier of age 25 or earliest cancer onset from family history. Based on family history (including but not limited to cancer or presence of a mutation in close relatives) "hereditary cancer risk assessment" (which may involve testing) may be recommended or suggested. Testing may show the presence of a BRCA mutation. If someone with a family history chooses not to be tested, then the recommendation is that the patient be treated, e.g., that they receive at least surveillance, as if they had tested positive for the BRCA mutation. If there is testing and the BRCA mutation is negative, management based on family history is still recommended because not all hereditary risk is explained by BRCA1 and BRCA2 mutations. Depending on the seriousness of the family history, enhanced screening including mammography may still be recommended.

The negative aspects of screening mammography in women younger than age 40 are cost, radiation exposure, the anxiety and cost of false positive results, and ineffectiveness or failure to detect tumors due to breast tissue density or to detect tumors in a timely manner due to rapid growth in the interval between screenings. Cost implications are discussed separately in this report.

It is generally accepted that the radiation dosage from mammography could itself generate breast cancer. There are differences of opinion on how accurately one can model the impact of low dosage radiation based on data from the consequences of incidents involving high doses. This concern is one factor in the setting of the starting age and frequency of periodic screening. The measure that is sometimes used is to estimate the ratio of life years saved from screening to life years lost due to radiation induced cancers. This measure improves (i.e. increases) with age because for younger women there are more doses, a longer time period for the disease to be detected, and fewer cancers to be discovered. Studies in women older than age 40 suggest that at that age the cancers induced by radiation are far outnumbered by the cancers which are detected.[11] We found no comparable studies for women younger than age 40.

Mammography is less effective in younger women because of tissue density. As a result, certain tumors may go undetected when imaging takes place. In addition, there is a high frequency of positive results which prove to be non-cancerous on further testing.[12]

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[10] Ibid.

[11] "Risk of Radiation-Induced Breast Cancer from Mammographic Screening," Yaffe and Mainprize, *Radiology* Vol. 258, No. 1, January 2011.

[12] "Performance of First Mammography Examination in Women Younger Than 40 Years," Yankaskas et al., *Journal of the National Cancer Institute*, May 19, 2010 (Based on analysis of data in six mammography registries, it was concluded that for 10,000 screenings of women ages 35-39, 1,266 [12.7 percent] would receive follow up for a positive result and from this there would be 16 cancers detected and 1,250 findings of false positive).

Mammography is less effective in younger women because the infrequent cancers in younger women tend to grow rapidly. Thus, even if the tumor is detected on screening, the progression of disease may be more advanced. In addition, the cancer in younger women tends to be more aggressive and hence even detection at an early stage may not result in a good outcome.[13]

As we have noted above, family history is important in the assessment of a woman's risk of developing breast cancer at any age. Clinical guidelines suggest factors that could lead to mammography for women younger than age 40. However, these guidelines do not include lack of family medical history (for adoption or any other reason) as a risk factor.

All five commercial health insurance carriers in New Jersey have confirmed to the Commission that they currently provide coverage for a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider for any female enrollee in an insured plan who was adopted or whose parent was adopted.

In conclusion, it appears that both clinical guidelines and carrier practice allow for considerable judgment (on the part of both the provider and the patient) in performing mammography for women younger than age 40. There is no recommendation for routine screening of the entire population of women younger than age 40. Additionally, carrier statistics show a very low rate of screening mammograms for women younger than age 40. This suggests that screening mammography for women younger than age 40 does take place when considered appropriate by the provider, but the situations in which that happens are infrequent.

Financial Impact

The cost impact of this mandate is developed in the attached Appendix I. The estimated cost of this mandate is very low. There may be a small increase in the number of mammograms ordered by providers and covered by carriers.

The cost of screening mammography provided pursuant to the current law in the commercial market is approximately $47 million for women older than age 40 and approximately $2 million for women younger than age 40. This cost represents approximately .6 percent of the total commercial claims of $7.5 billion in 2010. This is approximately $24 per year for each of the estimated 1,940,000 lives covered in the commercial market.

The current rate of screening mammograms for women younger than age 40 in the commercial market is about two percent per year based on data submitted by carriers (Note that other population-based data shows a higher rate of screening mammography among women younger than age 40).[14]

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[13] Anders et al, Ibid. at page 4. "Breast Cancer in Young Women" on WebMD, http://www.webmd.com/breast-cancer/gude/breast-cancer-young-women

[14] http://www.cdc.gov/brfss/

This screening almost certainly includes some women with a known family history of breast or ovarian cancer, and probably includes some women with no family history whose provider recommends screening.

As noted above, at most three percent of women younger than age 40 may be adopted. Even assuming all of them: a) have no family medical history; b) have providers who recommend screening; and c) that none of them are being screened currently (all conservative estimates increasing the estimated cost and overstating cost), the additional mammograms might cost an additional $10 million per year (as discussed in Appendix I). However, it is also possible that virtually every woman younger than age 40 whose lack of family history, whether due to adoption or otherwise, is a basis for screening already receives coverage for such screening. In that situation the mandate would have no cost.

A correct estimate probably falls somewhere in between. If this bill became law, it could suggest or implicitly recommend the procedure to patients younger than age 40 or their providers. In that case, the increased cost could be approximately $1 million per year.

The Commission believes that when considering this potential cost, the Legislature may also wish to consider the possible interaction of the proposed mandate with the federal Affordable Care Act (ACA), should the ACA be upheld by the United States Supreme Court. The ACA requires state governments to bear the cost of mandates that were not in force in the first quarter of 2012. Such mandates cannot be retroactively incorporated into the Essential Health Benefit benchmark plan required by the Act.

Impact on the State Health Benefits Program (SHBP)

A similar bill (S-3070; A-4308 during the 2010-2011 Legislative Session) was reviewed by the Pension and Health Benefits Review Commission on December 9, 2011. That organization recommended against the bill because mandated health benefits usually drive up the cost of employer health care. It also noted that the state health benefits are subject to collective bargaining and suggested that any expansion of employer-provided health benefit coverage should be negotiated.[15]

Other States

Commission staff reviewed summaries of laws in other states for similar provisions, but found no similar mandate. They also found no analysis of proposed legislation with similar provisions.

Colorado did enact a law in 2010[16] that generally provides that a medical provider determines whether or not a screening mammogram is appropriate. This mandate is broad enough to encompass all of the requirements of the existing and proposed New Jersey mandate.

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[15] Pension and Health Benefits Review Commission Vote Results December 9, 2011, http://www.state.nj.us/treasury/pensions/pension_hb_review_commission11.shtml#decv.
[16] Colorado Revised Statutes 10-16-104 (18) (b) III (D).

Assembly Bill 137, pending in California, would require "health insurers" to cover screening mammograms when ordered by a provider (without regard to age, family history, adoption status, or any other risk factor). "Health insurers" refers specifically to insurance companies regulated by the California Department of Insurance. Managed care plans such as HMOs regulated by the California Department of Managed Care, which provide the majority of commercial in California, are already subject to this more extensive mandate. The analysis of this bill by the California Health Benefits Review Program (the California counterpart of the Commission) concluded that there would be no effect because health insurers, even in the absence of the mandate, already cover any screening mammogram ordered by a provider.[17] As in the case of Colorado, the California screening mandate would be broad enough to encompass the coverage of the existing and proposed New Jersey mandate.

Conclusion: Balancing the Social Impact, Financial Impact and Medical Effectiveness

The bill extends mandated coverage of screening mammograms to women younger than age 40 who are adopted or who have a parent who was adopted. We think that between two and three percent of the population as a whole, and thus of women younger than age 40, is adopted. Not all of these women lack a family medical history. Additionally, since mammography does not appear to be recommended for women in this situation with no other risk factor, the potential impact, both in cost and number of procedures, is slight.

The Commission acknowledges both the factual basis and the social concerns which motivated this bill. Mammography is an important element of screening to detect and treat breast cancer at an early age. Family history is an important risk factor in determining when mammography should take place. Adoption is one reason that family history may be unavailable or incomplete.

The Commission is generally convinced that carriers already cover screening mammography for women younger than age 40 when recommended by the provider without the requirement of a family history, and therefore does not believe the bill is necessary. Obviously, a strong family history of cancer is one, and clinical guidelines suggest a common, reason that a provider might make this recommendation. However, if we are correct in our conviction, the current mandate requiring coverage of mammography when there is a family history is unnecessary, and for the same reason this bill requiring coverage for adopted women with unknown family history, is unnecessary as well.

In fact, the current and proposed requirements regarding screening for women younger than age 40 may be misleading regarding insurance coverage. A mandate

[17] "Analysis of Assembly Bill 137: Mammography: A Report to the 2011-2012 California Legislature," California Health Benefits Review Program, March 18, 2011, http://www.chbrp.org/docs/index.php?action=read&bill_id=112&doc_type=3.

implies (although this may not be its intent) that certain procedures are being denied by carriers and that the mandate is necessary to assure coverage. In the case of mammograms for women younger than age 40, there is no evidence that they are being denied by carriers or that coverage is being limited to cases meeting the conditions of the existing or the extended mandate.

A related, but very minor, concern is that mandates often mirror, at least approximately, appropriate clinical guidelines. In the case of screening mammography, the existing mandate for annual mammograms for women 40 and older is consistent with some recommendations. The existing mandate for screening mammography for women younger than age 40 with a personal or family history is also (with some specificity as to the details) consistent with some recommendations (although the same recommendations for screening mammography also recommend other imaging as well). In contrast, we did not find any guidelines or research supporting screening of women with an unknown family medical history and to the extent that screening of women with unknown history is considered equivalent to general screening, that is not currently recommended for women younger than age 40.

The Commission admits the possibility that this bill, on its own, might lead to additional screening mammographies for women younger than age 40. The Commission thinks this possibility is unlikely. The Commission is not aware of evidence that carriers deny payment for screening mammograms for women younger than age 40 when recommended by a physician.

The Commission advises carriers, providers, the Legislature and DOBI to consider concrete steps to address the concerns expressed by the bill's introduction. Most immediately, carriers could clarify, if necessary, their clinical guidelines to confirm that the determinant of coverage for screening mammography for women younger than age 40 is the judgment of the provider.

APPENDIX I

DOBI STAFF COST ANALYSIS OF S-1239

The Department of Banking and Insurance (DOBI) is assigned to provide support to the Mandated Health Benefits Advisory Commission (Commission) in its analysis of a mandated benefit. One component of the analysis is an estimate of the additional costs to the commercial insurance system of the mandate, that is, the additional procedures or increased cost per procedure that will result from the mandate. DOBI either performs the analysis or hires a consultant. This analysis was done by DOBI staff.

DOBI designed and circulated a data request to carriers. Carriers were cooperative in their completion of the request and provision of data. For various reasons, not all data could be used.

Current Status of Commercial Market Coverage for Screening Mammography

All commercial contracts (individual, small group and large group) are subject to the mandate requiring coverage of annual screening mammography for women older than age 40. In addition, commercial contracts are subject to the mandate to provide screening mammography to women younger than age 40 with a personal or family history indicating that screening is appropriate.

Data provided by major New Jersey carriers indicates that the rate of screening mammography for covered women older than age 40 varies between 40 and 65 percent. There is some variation based on carrier but little variation based on market or plan of coverage. This data appears to be consistent with information from HMOs, Healthcare Effectiveness Data and Information Set (HEDIS) data provided to the National Committee for Quality Assurance (NCQA) showing that the percentage of enrolled women between the ages of 42 and 69 who have had a mammogram in the last two years ranges between 65 and 70 percent.

The current rate of insured screening mammography for women younger than age 40 varies between 1 and 2.5 percent. This is somewhat lower than would be expected from the Center for Disease Control's Behavioral Risk Factor Surveillance System data that suggests that the rate of screening mammography for New Jersey women between the ages of 18 and 39 is between 5 and 10 percent. This discrepancy is interesting but for purposes of this analysis we will rely on the data provided by the carriers.

The reimbursement for a screening mammogram varies by carrier between $100 and $400, with the majority of costs towards the lower end of the range. There is no obvious pattern of variation of this unit cost within a carrier by market, plan or age group. These rates represent

the amounts reimbursed by the carriers, typically under managed care contract rates, which are likely lower than the list or “retail” price of a mammogram.

On the basis of this data, we estimated that the current cost of screening mammography for women of all ages is $24 per year per covered person. Based on a commercial market of 1,940,000 covered lives, the cost of screening is approximately $45,560,000 per year or about 0.6 percent of total claims of $7.5 billion in 2010.

There is some variation in frequency and unit cost by carrier, market and product. However, for purposes of this study, the possible additional refinement of the estimate from such a breakdown did not appear justified.

The maximum possible cost of the additional mandate is approximately $5 per covered person or $10 million. This assumes that 3 percent of the women younger than age 40 are: a) adopted; b) all lack family medical history; c) all get screening mammograms; and d) none of them are currently getting screening mammograms.

The minimum possible cost is $0, which assumes that coverage is currently not being denied for screening mammograms for women younger than age 40 and that no screenings are foregone as a result of the lack of a mandate.

Our cost estimate is $1 million. This assumes that the passage of this bill will lead to a higher rate of diagnostic mammograms in adopted women younger than age 40.

Description of Model

The Department used a simple model to estimate the current cost of mammography screening in the commercial market. This model was also used to estimate the potential impact of the mandate. Based on a subset of data provided by carriers, we calculated frequency of screening and cost of each screening per covered woman, and per enrollee, for that subset.

Analysis of Data

The data analysis for 2011 showed:

Large group (over 50 covered lives)

Women 40 and older	41,195
Percent screened during the year	56.8%
Unit Cost of Procedure	$158.54
Cost per covered woman aged 40 and older	$90.01

Women younger than age 40	52,268
Percent screened during the year	2.2%
Unit Cost of Procedure	$209.16
Cost per covered women under age 40	$4.57

Using these factors to estimate the total cost in the large group market of 1.1 million people, it is estimated that the cost of such screening is $23.31 per covered person and the total cost of screening women of all ages in the large group market was $25,640,000.

In 2010, the total claims in the large group market were $4.286 billion. As a result, the cost of screening was about 0.6 percent of all large group claims.

Small Group (2-50 covered lives)

Women 40 and older	170,134
Percent screened during the year	48.8%
Unit Cost of Procedure	$155.83
Cost per covered woman aged 40 and older	$76.07

Women younger than age 40	197,807
Percent screened during the year	1.8%
Unit Cost of Procedure	$156.78
Cost per covered women younger than age 40	$2.90

Using these factors to estimate the total cost in the small group market of 700,000, it is estimated that the cost of such screening is $28.24 per covered person and the total cost of screening women of all ages in the small group market was $19,767,000.

In 2010, the total claims in the small group market were $2.769 billion. As a result, the cost of screening was approximately 0.7 percent of all small group claims. Although the frequency and unit cost of screening was lower in small group than large group, our data showed that adult women are a higher proportion of the small group covered population than the large group covered population and hence, the cost impact of mammography was slightly higher in the large group market.

Individual

Our data on individual coverage was limited. In the individual market of 140,000 enrollees, only 50,000 in the Standard plans are affected by the current or proposed mandate. The Basic & Essential (B&E) plans enrolling about 90,000 people are exempt from most mandates.

As an approximation, we used $28.24 per covered person applied to 50,000 people to obtain a total cost of $1,412,000. This is only 0.3 percent of individual claims for 2010 (but these claims include B&E claims).

Analysis Results

Mammography Screening Currently Costs a total of $46,819,000.

Large Group	$25,640,000
Small Group	$19,767,000
Individual	$1,412,000

This approximates out to $24.14 per covered person or 0.62 percent of $7.523 billion in claims for 2010.

Cost of Follow Up

Screening Mammography can result in follow-up procedures if the result is “positive.” Positive in this case does not necessarily imply identification of a tumor. It is any result for which additional investigation is required. Follow-up procedures could include a repeat mammography, MRI, ultrasonography or biopsy.

Estimates of follow-up costs were not considered necessary for this report. Neither the existing nor the proposed mandates require coverage of necessary follow-up procedures. Such procedures would almost certainly be considered diagnostic and thus be routinely covered.

Nevertheless, one carrier was able to provide information on follow-up costs. Based on this information we estimate that follow-up costs are about four times the initial screening cost for women older than age 40 and about ten times the initial screening costs for women younger than age 40.

The difference should not be surprising given that women younger than age 40 are probably screened because they have additional risk factors such as family history which make the likelihood of a positive result higher. Furthermore, the breast tissue density of younger women might require more extensive imaging or other testing to verify a positive result.

Impact of the Mandate Contained in S-1239

We provide a range of estimates of the possible cost of this mandate.

The lowest estimate is $0. This assumes that carriers currently approve all screening mammograms for women younger than age 40 that are ordered by a provider (even in the absence of supporting personal or family medical history) and that providers are not being deterred from ordering mammograms in these circumstances because they perceive the lack of a mandate as an indication that the carriers will not cover the procedure.

The highest estimate assumes all of the following are true:

- Three percent of women younger than age 40 are adopted;
- None of these women have access to family medical history due to adoption;
- The provider recommends, and the woman agrees to, a screening mammogram; and
- No women in this situation are currently being screened.

Under these circumstances, the rate of screening of women younger than age 40, and hence the cost of screening women younger than age 40, would increase by 136 percent (3.0/2.2) in the large group market and by 167 percent (3.0/1.8) in the small group and individual market.

So the additional cost in the large group market under this estimate is 1.36(4.57)($1,100,000) = $6,837,000 or an increase in total claims of 0.16 percent.

The additional cost in the small group market is 1.67(2.90)($700,000) = $3,390,000 or an increase in total claims of about 0.12 percent.

We also estimate that individual claims would increase by about 0.12 percent.

The total increase under this set of assumptions would be slightly more than $10 million.

A most likely estimate would be somewhere toward the low end of this range. For example, if we assume that 50 percent of the adopted women do not have a family medical history and that in only 25 percent of the cases will a provider order a mammogram, the cost will be 1/8th of the high cost, or between $1 million and $2 million.

Summary

For purposes of evaluating the impact of this mandate, we do not think that cost will be a factor. It is unlikely that providers will order, or that carriers will pay for, a significant number of additional mammograms for women younger than age 40 as a result of this mandate. If a specific cost estimate is considered necessary, the estimate is $1 million for the entire regulated commercial market. In other terms we very conservatively estimate (on the high side) that approximately 5,000 additional covered mammograms per year at cost of $200 per procedure could occur as a result of the passage of this bill.

SENATE, No. 1239

STATE OF NEW JERSEY

215th LEGISLATURE

INTRODUCED JANUARY 30, 2012

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)

Co-Sponsored by:
Senator Weinberg

SYNOPSIS

Requires health benefits coverage for mammograms for women under 40 who lack access to family medical history due to their or their parent's adoption.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 2/14/2012)

AN ACT requiring health benefits coverage for mammograms for adopted women and daughters of adopted parents, and amending P.L.1991, c.279 and P.L.2004, c.86.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 1 of P.L.1991, c.279 (C.17:48-6g) is amended to read as follows:

1. No group or individual hospital service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in conducting: one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors or was adopted or whose parent was adopted, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider.

These benefits shall be provided to the same extent as for any other sickness under the contract.

The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.1)

2. Section 2 of P.L.1991, c.279 (C.17:48A-7f) is amended to read as follows:

2. No group or individual medical service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in conducting: one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors or was adopted or whose parent was

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

adopted, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider.

These benefits shall be provided to the same extent as for any other sickness under the contract.

The provisions of this section shall apply to all contracts in which the medical service corporation has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.2)

3. Section 3 of P.L.1991, c.279 (C.17:48E-35.4) is amended to read as follows:

3. No group or individual health service corporation contract providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in conducting: one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors or was adopted or whose parent was adopted, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider.

These benefits shall be provided to the same extent as for any other sickness under the contract.

The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.3)

4. Section 4 of P.L.1991, c.279 (C.17B:26-2.1e) is amended to read as follows:

4. No individual health insurance policy providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the policy provides benefits to any named insured or other person covered thereunder for expenses incurred in conducting: one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors or was adopted or whose parent was adopted, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider.

These benefits shall be provided to the same extent as for any other sickness under the policy.

The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.4)

5. Section 5 of P.L.1991, c.279 (C.17B:27-46.1f) is amended to read as follows:

5. No group health insurance policy providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless the policy provides benefits to any named insured or other person covered thereunder for expenses incurred in conducting: one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors <u>or was adopted or whose parent was adopted</u>, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider.

These benefits shall be provided to the same extent as for any other sickness under the policy.

The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

(cf: P.L.2004, c.86, s.5)

6. Section 7 of P.L.2004, c.86 (C.17B:27A-7.10) is amended to read as follows:

7. Every individual health benefits plan that is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) or approved for issuance or renewal in this State, on or after the effective date of this act, shall provide benefits to any woman covered thereunder for expenses incurred in conducting: one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors <u>or was adopted or whose parent was adopted</u>, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider.

The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan.

The provisions of this section shall apply to all health benefit plans in which the carrier has reserved the right to change the

premium.
(cf: P.L.2004, c.86, s.7)

7. Section 8 of P.L.2004, c.86 (C.17B:27A-19.13) is amended to read as follows:

8. Every small employer health benefits plan that is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) or approved for issuance or renewal in this State, on or after the effective date of this act, shall provide benefits to any woman covered thereunder for expenses incurred in conducting: one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors or was adopted or whose parent was adopted, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider.

The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan.

The provisions of this section shall apply to all health benefit plans in which the carrier has reserved the right to change the premium.
(cf: P.L.2004, c.86, s.8)

8. Section 6 of P.L.1991, c.279 (C.26:2J-4.4) is amended to read as follows:

6. Notwithstanding any provision of law to the contrary, a certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued by the Commissioner of Health and Senior Services on or after the effective date of this act unless the health maintenance organization provides health care services to any enrollee for the conduct of: one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors or was adopted or whose parent was adopted, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider.

These health care services shall be provided to the same extent as for any other sickness under the enrollee agreement.

The provisions of this section shall apply to all enrollee agreements in which the health maintenance organization has reserved the right to change the schedule of charges.
(cf: P.L.2004, c.86, s.6)

9. Section 9 of P.L.2004, c.86 (C.52:14-17.29i) is amended to read as follows:

9. The State Health Benefits Commission shall provide benefits to each person covered under the State Health Benefits Program for expenses incurred in conducting: one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors or was adopted or whose parent was adopted, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider.

The benefits shall be provided to the same extent as for any other medical condition under the contract.

(cf: P.L.2004, c.86, s.9)

10. This act shall take effect on the 90th day after enactment and shall apply to all contracts and policies that are delivered, issued, executed, or renewed or approved for issuance or renewal in this State on or after the effective date.

STATEMENT

This bill requires health insurers, including health, hospital, and medical service corporations; commercial individual, small employer, and larger group health insurers; health maintenance organizations; and the State Health Benefits Program (SHBP) to provide health benefits coverage for expenses incurred in conducting an annual mammogram for women under 40 years of age who may be at risk for breast cancer but may not have access to their family medical histories because they were adopted, beginning when the woman's physician deems the mammogram to be medically necessary.

For women with a family history of breast cancer, many physicians recommend they begin annual mammograms 10 years prior to the age at which their family member was first diagnosed; for some women, this means that they should start having annual mammograms as early as age 25. Currently, most insurers are required to provide benefits for expenses incurred in conducting mammograms for women with a family history of breast cancer at an age and interval deemed to be medically necessary by a woman’s health care provider. Adopted women and daughters of adopted parents may not have access to their family’s medical history, and thus may not be able to prove their family history to receive insurance coverage for this potentially life-saving screening.

According to the Centers for Disease Control and Prevention, breast cancer is the second most fatal cancer among American

women. Women with a close relative who has been diagnosed with breast cancer face twice the risk of being diagnosed themselves. Although an estimated 40,000 women died from breast cancer in 2010, earlier detection through screening has helped to steadily decrease this number since 1990.

Thus, in order to ensure that younger women without knowledge of their family history, but still at great risk for breast cancer, have access to this potentially life-saving test, this bill extends the annual mammogram requirement to cover adopted women and daughters of adopted parents under the age of 40, as recommended by their physicians.

NEW JERSEY SENATE

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CHAIRMAN:
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VICE CHAIRMAN:
ECONOMIC GROWTH

February 23, 2012

Ronald J. Librizzi, D.O.
c/o Carol Miksad
New Jersey Department of Banking and Insurance
Mandated Health Benefits Advisory Commission
P.O. Box 325
Trenton, NJ 08625

Dear Chairman Librizzi and Members of the Commission:

I am in receipt of Chairwoman Nia Gill's letter to the Mandated Health Benefits Advisory Commission requesting that the Commission conduct a review of S-1239, which would require health benefits coverage for mammograms for women under 40 who lack access to family medical history due to their or their parent's adoption. As the primary sponsor of this bill, I would like to share information regarding the genesis of this legislation as well as questions I have that the Commission may be helpful in answering.

As you know, current law requires health insurance companies to cover mammograms for women who are under 40 years of age and have a family history of breast cancer at such age and intervals as deemed medically necessary by a woman's health care provider (NJS 17B:27-46.1f). Adopted women and their daughters unable to establish a family history of breast cancer are unable to avail themselves to this mandated health benefit.

While S-1239 would provide adopted women insurance coverage for early mammograms, I am concerned that it will also expose some women unnecessarily to radiation. I look to the expertise of the members of the Commission to determine whether or not this concern is valid and I request that the Commission address this point in their report to the Legislature.

I also request that you consider other mandated health benefits whereby one must establish a family history of the disease to trigger coverage of the benefit. In my review, these include: colorectal cancer screening (N.J.S.A. 17B:27-46.1y) and prostate cancer screening (N.J.S.A. 17B:27-46.1o). Should the Legislature expand the scope of S-1239 to provide adopted persons

and their children direct access to these screening services which are already mandated? Are there other screenings or tests available that adopted persons and their children may benefit from having broader access?

Please know that I am also the sponsor of S-832, which provides adopted persons access to their original long-form birth certificate as well as their birth parent's updated medical history. Unfortunately, I have not been successful in passing that bill through the Legislature in more than ten years. This is the reason why I introduced S-1239 and the reason why I seek your input about other practical measures the Legislature may consider that would help adopted persons and their children identify and monitor possible hereditary diseases.

Thank you for your time and consideration of these issues.

Best wishes,

Joseph F. Vitale
Senator, District 19

JFV/lm
Via: Electronic and regular mail
C: Hon. Nia Gill, Chair, Senate Commerce Committee

NEW JERSEY SENATE

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SENATE PRESIDENT PRO TEMPORE
COMMITTEES
COMMERCE, CHAIR
JUDICIARY, MEMBER

February 15, 2012

New Jersey Mandated Health Benefits Advisory Commission
P.O.Box 325
Trenton, NJ 08625

Dear Members of the Commission:

As the chairwoman of the Senate Commerce Committee, I respectfully request the Commission to review and prepare a written report of S.1239 sponsored by Senator Joseph Vitale. The bill would require health benefits coverage for mammograms for women under 40 who lack access to family medical history due to their or their parent's adoption.

If you have any questions please do not hesitate to contact Lynn Haynes, Senate Commerce Committee Aide, at (609) 847-3700. Thank you for your immediate attention.

Very truly yours.

Nia H. Gill /ldh

Hon. Nia H. Gill, Chair
Senate Commerce Committee

Via: electronic & regular mail
c: Hon. Joseph Vitale, Chair, Senate Health Committee