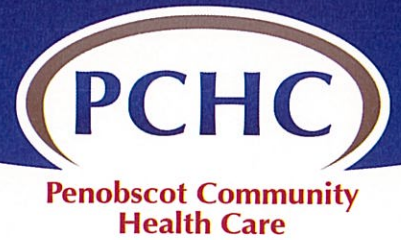


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Submitted by: Lori Dwyer, Esq., President & CEO, and
Theresa Knowles, Chief Quality Officer,
Penobscot Community Health Care

Written Testimony in Support of LD 555: An Act to Reduce Colorectal Cancer Incidence and Mortality by Updating Screening Coverage

Please accept this testimony in support of LD 555, An Act to Reduce Colorectal Cancer Incidence and Mortality by Updating Screening Coverage. As the CEO and as the Chief Quality Officer of Penobscot Community Health Care, a community health center that provides integrated primary care and wraparound services for over 65,000 patients at 12 clinical locations located in Penobscot, Waldo and Somerset Counties, we see the tremendous benefit this small change in the law will have on our patients and the system of care. This change will save lives by eliminating an unintended loophole in current law that discourages early colorectal cancer screening and drives up the total cost of care, and will require insurance reimbursement for colorectal screening in a manner that adheres to evidence-based guidelines.

The current Maine law, found at 24 MRSA §2847-N, §2763, and §4254, does not cover all necessary colorectal cancer screenings once a test has been deemed "diagnostic." Rather, it memorializes a loophole whereby insurance companies do not have to pay for additional screenings once there has been a positive test (abnormal stool test or a screening colonoscopy with a finding of polyps). Additionally, it reimburses screenings for those at high risk, but after 50 years of age or older, which is now deemed an arbitrary age designation and does not conform to current evidence-based guidelines.

As a general matter, screening colonoscopies and stool tests (FIT or IFOB tests) are typically covered 100% by insurance. The stool tests are very inexpensive, particularly when compared with the cost of a colonoscopy - \$24 for a FIT or IFOB as compared with the \$2000-\$5000 cost of a colonoscopy. If the much less expensive FIT or IFOB is negative, no further testing is needed. If a stool test comes back positive, however, then, based on the ACS guidelines, the patient must undergo a diagnostic colonoscopy to determine whether the result is a false positive or if there is a pathological issue that needs to be addressed. Unfortunately, once a *positive* FIT or IFOB result is received, the follow-up colonoscopy is deemed "diagnostic," rather than screening, and is thus not covered by insurance because the 100% ACA-required coverage typically does not extend to diagnostic colonoscopies. That expensive procedure then hits the patient's deductible before coverage kicks in. Many Mainers on high deductible plans would, therefore, be responsible for the full cost out of pocket, meaning between \$2,000-\$5,000.

We have several examples of patients who received positive stool tests, and then refused a diagnostic colonoscopy because they could not afford the colonoscopy arbitrarily deemed "diagnostic".

Conversely, if a patient decides to have a colonoscopy initially rather than a screening FIT or IFOB test, the colonoscopy is typically covered at 100% by insurance as a cancer screening test. However, when a patient goes into a screening colonoscopy symptomless thinking the procedure will be covered 100% by their insurance and a polyp is found, insurance often will deem the colonoscopy "diagnostic" *ex post facto* and deny preventive coverage. Though the original colonoscopy was a screening, preventative procedure, the after the fact determination based on finding a polyp unfairly transforms that cancer screening into a diagnostic procedure. In this situation, patients have no way of knowing ahead of time whether they will face a large bill, in spite of a prior determination of coverage. This, too, discourages patients from undergoing this critical screening test in the first place.

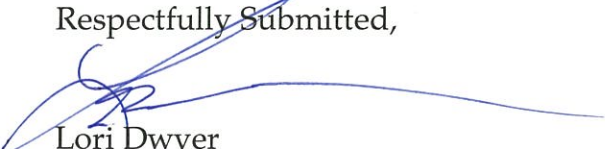
The unintended consequences of these loopholes in the preventive screening law are as follows: (1) they discourage patients who would be more likely to undergo the FIT/IFOB test rather than a colonoscopy from getting tested in the first place; (2) they discourage patients from getting a follow-up colonoscopy - even if that colonoscopy screens negative for any cancer - because they cannot afford it; and (3) by discouraging use of the much less expensive stool tests, they increase the total cost of care to the system.

The cost for cancer treatment for those who do not receive an early diagnosis is significantly higher than simply covering the cost of a colonoscopy every 3-10 years (depending on findings and evidence-based standards) and catching colon cancer in its earliest stages. Additionally, treatments for advanced stage cancers are burdensome financially, logistically, and, more importantly, emotionally on the Mainers and their families living in rural areas and forced to travel many hours to receive this care.

In short, the law in its current form drives up mortality rates and late diagnoses because many will opt out of the test due to unaffordability, fails to follow evidence-based guidelines for those at high risk of developing colon cancer, and drives up the total cost of care because patients are often diagnosed far later in the process, when the cancer is more advanced and most treatments are either ineffective or minimally effective. Any policy that discourages early screening is short-sighted, results in higher morbidity and mortality rates, and increases the cost of care by failing at early detection.

For the health of Maine citizens and to ensure responsible use of Maine's limited resources, we strongly support LD 555.

Respectfully Submitted,



Lori Dwyer
President & CEO



Theresa Knowles
Chief Quality Officer

3/11/19